# NATIONAL HEALTH INSURANCE, 1978

DOCUMENTS

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# HEARINGS

BEFORE THE

## SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

OF THE

## COMMITTEE ON HUMAN RESOURCES

## UNITED STATES SENATE

NINETY-SIXTH CONGRESS

FIRST SESSION

ON

EXAMINATION ON THE SOARING PRICE OF MEDICAL AND HOSPITAL COST AND WHY WE SHOULD HAVE A NATIONAL HEALTH INSURANCE PROGRAM TO MEET THE HUMAN NEEDS OF THIS NATION

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**Part 2**

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OCTOBER 23, 1978, DETROIT, MICH.
OCTOBER 27, 1978, OSAGE, W. VA.
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DECEMBER 14, 1978, QUEENS, N.Y.
DECEMBER 15, 1978, GARDEN GROVE, CALIF.

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# NATIONAL HEALTH INSURANCE, 1978

MONDAY, OCTOBER 23, 1978

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE COMMITTEE ON HUMAN RESOURCES,
*Detroit, Mich.*

The committee met, pursuant to notice, at 12:10 p.m., Cobo Hall, Detroit, Mich., Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senator Kennedy.

## OPENING STATEMENT OF SENATOR KENNEDY

Senator KENNEDY. We'll come to order. I'm very pleased to have the opportunity to bring the Subcommittee on Health and Scientific Research to Detroit to open this series of hearings around this Nation on national health insurance.

This is indeed a fitting place to begin, for it was here that Walter Reuther lived and worked for so many years and it is here that he first had a vision of forming a grassroots coalition for national health insurance.

Today that coalition has grown in size so that it includes not only the workers in this country, but the senior citizens, the religious groups of every denomination, the American Nurses Association, the NAACP, the Urban League, ministers, young physicians, interns and residents, the National Farmers Union, and many other individuals and groups.

I believe the coalition will continue to grow in size as the middle class begins to feel the pinch of rising premiums, increases in deductibles and coinsurance, and diminishing benefits.

There are many in Congress who believe that national health insurance's time has come and gone in the United States. I wish that they could be in this hearing room today. They would draw very different conclusions.

If health insurance is an idea whose time has gone, the American economy is in grave difficulty. If it is left unchecked, it will bankrupt this Nation.

If health insurance is an idea whose time has gone, then millions and millions will continue to share the blight, the needless suffering and anguish of those Michigan families who will testify here today.

If national health insurance is an idea whose time has gone, then 26 million Americans will continue to have no coverage at all, and another 18 million will live with totally inadequate coverage, and 52 million will have inadequate access to health care.

Every industrialized nation in the free world except the United States and South Africa have a comprehensive national health insurance program, and there isn't a single political leader in any of those countries who wants to turn the clock back and repeal the national commitment for this right for all their citizens.

The economics of the present situation in this country are really frightening. Health care costs are out of control. The rampant health inflation takes its toll everywhere, from the Federal budget, where the percentage of the Federal dollar spent on health has risen from 4.3 percent in 1963 to 12.7 this year; on State budgets where medicaid costs have become the single most rapidly escalating cost; on corporations who pay more and more each year for health care benefits, and on the American family which must pay $2,115 today, $3,590 in 1983 for benefits which cost $533 in 1963; on the elderly people who pay more for their care today out of their own pockets than the year medicaid was implemented.

The Nation as a whole will spend $252 billion in 1981 on health care and that money will pour into a system without cost controls, without quality controls, with uneven access to care and without any prospect for improvement.

National health insurance is the last best chance to halt this staggering economic waste. Cost containment is at the very heart of the health insurance debate. Every American family knows what it means to live within a budget. It is time the American health care system learned to live within a budget. The proposal I introduced last week imposes such a budget and under this approach all health care costs will be respectively budgeted. The American people will no longer have to hand a national blank check over to the health care industry.

No other program to guarantee comprehensive benefits to all Americans will cost less than this proposal. In fact, once cost containment takes effect, the Nation will pay less for health under a national health care insurance program than if the current nonsystem is left unchecked. That is a fundamental point.

The choice is not, as opponents would have us believe, between an expensive new program or no program at all. The choice is between comprehensive benefits for all Americans in a system with cost controls at every level, or it is a continuation of the current patchwork system with millions and millions of Americans are denied care and costs are continuing out of control.

The economics of this situation alone makes a compelling case for national health insurance, but the testimony we will receive today from Michigan residents make an even more compelling case.

I might just show from these charts basically what we are talking about for you who come to our hearing today; this compares the light yellow in Canada with the United States, and here we can take, say, 1968, Canada, 6.8 percent of GNP, and the United States, 6.5. They enacted national health insurance in 1968 and they now pay 7 percent of gross national product on health insurance, but we are at 8.8 and they have a national health insurance program. They have effective cost controls with respect to budgeting. We're 8.8 and climbing to 9.7.

This gives you some idea of what happens if we do nothing at all. That's without any health insurance proposal whatsoever, $252 billion by 1981. That is if we do nothing at all with the rate of inflation that we are talking about. This would be the catastrophic—this would be the premium financed and this would be the premium and this would be the F–3, which would have had a heavy burden on the budget, but in terms of the total expenditures would have been less. There are three ways that you have expenditures, either out of your pocket, out of the industry, or out of the Government.

Where this would have provided more of a budgeted item in terms of the budget, still the total cost of it would be less than if we would do nothing at all, and those are the differences.

This chart here is what the difference is between a family of four for the average cost of health care; 1978 we find $2,115 and we have here the contrast—Mr. Fraser's testimony contrasts this with the premiums that were paid by auto workers for their health insurance here and in Canada, and this gives general figures about the burden on the budget in terms of the—and the chart we don't have up here, but which we refer to as the fact of what has been the growth in terms of expenditures in local and State governments, which reflect itself in increased property taxes and other factors.

So with the story that we will hear today from Michigan residents, their stories will be repeated by citizens in every community of the Nation. I hope this morning here in Detroit will convince you that this national health insurance is not an idea whose time has gone.

We'll start off with a panel of families. We've got five pairs that will match up an American family with our friends from Ontario, Canada. Ms. Barbara Dearhamer from Detroit, Mich., and Mrs. Ilene Gallant from Windsor, Ontario. Mr. and Mrs. Milton Winnon of Battle Creek, Mich., and Mrs. Pearl Beneteau of Windsor, Ontario, Mr. and Mrs. Charles Beach of Grand Rapids, Mich, Mrs. Lillian Koscis of Windsor, Ontario, Mr. Alex Kovacs, Detroit, Mich., Mr. Edward Norris of Windsor, Ontario, and Mr. and Mrs. David Bater, Detroit, Mich. and Mr. and Mrs. Meloche of Windsor, Ontario.

What we're going to have here are some live comparisons between people that live here in this community, who come from different walks of life, different types of employment, and effectively their counterparts in Canada where there is a national health program.

At the opening of our hearings in Washington 2 weeks ago, we had a similar type of hearing. We had a blue collar worker from both the United States and from Canada, we had a farm family, a middle-income family. It seems to us that this is one of the things that we might consider because there are many different issues that are raised about health care. It's quite interesting to hear from people who are experiencing it and living it, and hear their reactions. What we've tried to do is hear from some rather typical families, who have got some rather tragic cases. We're enormously grateful to them for coming and sharing some of their background with us.

Mrs. Dearhamer, as I understand it, you are divorced and you're going to school and you have four children. Initially, did the four children live with you after the divorce?

## STATEMENT OF BARBARA DEARHAMER, DETROIT, MICH., AND ILENE GALLANT, WINDSOR, ONTARIO

Mrs. DEARHAMER. Yes.

Senator KENNEDY. And what kind of insurance did you have at that time?

Mrs. DEARHAMER. At that time we were receiving medicaid.

Senator KENNEDY. Well, when you were first married, what kind of coverage did you have?

Mrs. DEARHAMER. In the very beginning I had experienced different aspects of the health care system in Michigan, from being in the privileged position of having Blue Cross and private care to being on medicaid, as I stated before, and also being a clinic patient, so I have had an opportunity to see the discrepancies, the inequities, and the differences basically.

Senator KENNEDY. Now when you were first married you were covered through your husband's employment, were you?

Mrs. DEARHAMER. Yes, afterward, right.

Senator KENNEDY. And you had pretty good coverage at that time; is that correct?

Mrs. DEARHAMER. Right.

Senator KENNEDY. And what kind of medical problems did you run into after your divorce when your children were living with you?

Mrs. DEARHAMER. Well, nothing to speak of, like any major kind of medical problem, just the fact, I guess basically, that you either fit one place or another. You either have insurance, Blue Cross-Blue Shield or else you have medicaid.

Senator KENNEDY. Didn't you go see a urologist?

Mrs. DEARHAMER. Yes, at various times I've utilized clinic care and run into the dehumanization of that system, and——

Senator KENNEDY. Now, what I'm trying to get at, if I could, you had good coverage when you were married and your husband was working?

Mrs. DEARHAMER. Right.

Senator KENNEDY. Then you got divorced.

Mrs. DEARHAMER. Right.

Senator KENNEDY. Then you were only eligible for the medicaid program sometimes.

Mrs. DEARHAMER. Uh-huh.

Senator KENNEDY. And then you had to see a urologist at some time, didn't you?

Mrs. DEARHAMER. Yes, I did.

Senator KENNEDY. OK, what was the difference between when your husband was working and you were covered by pretty good coverage, and the kind of coverage that you were getting when you were under medicaid? Did you see a difference?

Mrs. DEARHAMER. Very much so.

Senator KENNEDY. Well, OK, tell us about it.

Mrs. DEARHAMER. Indeed, it was inferior care. I just saw it demonstrated very clearly, the unequal access into the health care system.

Senator KENNEDY. Well now by access, were you meaning finding a doctor that would see you?

Mrs. DEARHAMER. No; having the resources, the financial resources. I see a very direct relationship between one's own resources and the quality care one can receive.

Senator KENNEDY. Did you have trouble finding doctors in Oakland County to accept medicaid patients?

Mrs. DEARHAMER. Yes, indeed.

Senator KENNEDY. Tell us about that.

Mrs. DEARHAMER. Just simply the fact that both as a recipient myself and as a counsellor trying to find doctors to accept medicaid from clients of my own, it was almost impossible to find a doctor in Oakland County who would accept medicaid.

Senator KENNEDY. So where did you go?

Mrs. DEARHAMER. To the city of Detroit.

Senator KENNEDY. And did you see a different doctor each day?

Mrs. DEARHAMER. If you're on medicaid, you just—generally if you can find a doctor, a good doctor, you would continue to see that doctor. If you go to a clinic, you end up seeing a different doctor each time. I had a child born through the clinic in Detroit, and you see interns, you don't see doctors. Normally a resident would deliver the child. He in fact asked if he could use an experimental new technique of anesthetic with me, which I don't think would have happened had I had my own private doctor, numerous things like that.

Senator KENNEDY. Well, I think what we see is different ranges of coverage which you received. One range of coverage when your husband was employed, another when you got separated and divorced.

At this time you had your four children and you had to go through it with medicaid and the difficulty that you find getting doctors taking medicaid patients, yourself included and the others that you counseled with and there is also the concern on your part about whether you were getting the kind of real quality of care. All of this was at a time when I imagine there was a good deal more personal demands upon you because you had your four children and you were trying to provide for them and also trying to ensure their well-being. The fact of the matter is that the coverage was not related to the issue of health. It was related to the issue of whether you were married or unmarried or the size of the income, isn't that it?

Mrs. DEARHAMER. I would say the size of the income and your ability to provide for your own coverage in one way or another.

Senator KENNEDY. OK, Mrs. Gallant, is that right?

Mrs. GALLANT. Yes, that's right.

Senator KENNEDY. You're from Windsor, Ontario?

Mrs. GALLANT. Yes.

Senator KENNEDY. You're separated from your husband, is that correct?

Mrs. GALLANT. Yes.

Senator KENNEDY. And how many children do you have?

Mrs. GALLANT. I have four.

Senator KENNEDY. You have four children too?

Mrs. GALLANT. Yes.

Senator KENNEDY. Well, what kind of medical problems have you run into?

Mrs. GALLANT. Well, my son had had plastic surgery.

Senator KENNEDY. He was, as I understand it, bit by a dog in the face; is that correct?

Mrs. GALLANT. Yes; he was.

Senator KENNEDY. And that necessitated plastic surgery?

Mrs. GALLANT. And I have had a daughter who had to have her appendix out.

Senator KENNEDY. How about yourself?

Mrs. GALLANT. Myself, I have been hospitalized, I've had a hysterectomy and 5 weeks ago I had to have a bypass on my back and I went in for tests and I see the doctor regularly and any X-rays or any tests or anything is paid by OHIP.

Senator KENNEDY. Well now, have you had to pay for any of this care?

Mrs. GALLANT. No, I haven't.

Senator KENNEDY. So even though you have been separated it has made no difference in whether your medical needs have been attended to; is that correct?

Mrs. GALLANT. The Government has paid for it.

Senator KENNEDY. All of the bills, your son's, your daughters, and your own medical bills?

Mrs. GALLANT. Right.

Senator KENNEDY. And what has this meant to you? Have you been satisfied with the quality of the care too? Did you ever feel that since you were separated or divorced, you were getting a different standard of care?

Mrs. GALLANT. No; the care has been just the same. I just live on a limited income.

Senator KENNEDY. You just have limited income?

Mrs. GALLANT. Yes; I just receive a small amount of money a week.

Senator KENNEDY. Has it been important to you, since you're living on a small amount of money a week, that your health bills are being met?

Mrs. GALLANT. Yes.

Senator KENNEDY. What sort of thing does that mean to you in terms of your own——

Mrs. GALLANT. If I wouldn't have had the coverage, I would have went without it, I wouldn't have bothered with doctors or anything, but it just——

Senator KENNEDY. And that's the concern that Mrs. Dearhamer has got and I think many others.

Could you tell us what your income is approximately a week?

Mrs. DEARHAMER. I receive $116 a week supoprt.

Senator KENNEDY. And how many children do you have?

Mrs. GALLANT. Four.

Senator KENNEDY. And all your medical concerns are taken care of under your coverage?

Mrs. GALLANT. Yes.

Senator KENNEDY. And do you get the same care with your $116 and your four children than somebody else gets that can pay a good deal more? Do you feel that you do?

Mrs. GALLANT. Yes. If you pay for your own coverage, you can have semiprivate or a private room, but I have a ward. It is only four beds in a ward.

Senator KENNEDY. Only four beds in a ward?

Mrs. GALLANT. Yes.

Senator KENNEDY. But at least you feel when you go you're getting good coverage. That people aren't, based on your limited income, providing less than good coverage?

Mrs. GALLANT. No.

Senator KENNEDY. Now, I think the point that here we see an example of the difference between what happens here between a woman that is a mother and has been separated, in Canada as well as the United States, and where in the American situation, no longer covered by her husband's insurance, had serious illnesses and has faced some difficulties in getting access to doctors. There's a real difference at least in terms of the quality of care. In Canada, under health insurance that the coverage applied to the individual, whether they were separated or not. I don't think you can minimize, although we haven't really developed here at this point the psychological impact of one of being ocvered and one not being covered. You must feel that, don't you, Mrs. Dearhamer, the fact that you're——

Mrs. DEARHAMER. Indeed, there's a direct correspondence between mental and physical health.

Senator KENNEDY. Do you want to just develop that a minute, the anxiety you——

Mrs. DEARHAMER. Well, everyone knows that stress has a great impact on one's physical health, and when you are constantly under the stress of knowing that a medical problem could either wipe you out or you just simply cannot afford the $20 or $25 to see a doctor, that adds a lot of stress and certainly does not help your health.

Senator KENNEDY. Would you agree with that, Mrs. Gallant, from a Canadian point of view?

Mrs. GALLANT. Yes; if I had the added pressure of medical bills, it would be extremely—I never would have been—it is hard to manage now with the food and everything.

Senator KENNEDY. OK, thanks. Mr. and Mrs. Milton Winnon, Battle Creek, Mich. Why don't you just raise your hands. We are going to have you here, and Mrs. Pearl Beneteau, is that correct? Just raise it one more time.

Now, Mr. Winnon, as I understand it you are retired from the UAW?

## STATEMENT OF MILTON WINNON, BATTLE CREEK, MICH.; AND PEARL BENETEAU, WINDSOR, ONTARIO

Mr. WINNON. Yes.

Senator KENNEDY. How old are you?

Mr. WINNON. Sixty-five.

Senator KENNEDY. And the UAW has a retirement insurance program, don't they?

Mr. WINNON. Yes.

Senator KENNEDY. And in May of 1977 did you have a medical problem?

Mr. WINNON. Yes, I had a hip operation, total hip operation.

Senator KENNEDY. Was it successful?

Mr. WINNON. Yes, very successful.

Senator KENNEDY. Was the hospital bill paid?

Mr. WINNON. The hospital bill was paid.

Senator KENNEDY. Do you remember what the surgeon's bill was?

Mr. WINNON. Yes, the surgeon's bill was $1,600 and his helper was $324. It totalled $1,924.

Senator KENNEDY. You've got a good memory there.

Mr. WINNON. I'm reading.

Senator KENNEDY. Now, the medicare allowed $700 and the Blue Cross paid $148?

Mr. WINNON. That's right.

Senator KENNEDY. You owed—how much did you owe them?

Mr. WINNON. I owed——

Senator KENNEDY. I've got $1,200?

Mr. WINNON. Right.

Senator KENNEDY. You had coverage and you still owed that amount of money, is that correct?

Mr. WINNON. Yes.

Senator KENNEDY. We hear a great deal from some that appear before our committee and always talking about the fact that people are covered yet you still owed $1,200.

Mr. WINNON. Yes, that's right.

Senator KENNEDY. Why did you owe that if you had coverage? Why don't you tell us.

Mr. WINNON. Well, the medicare, they say that they would pay $700 of this operation and that's their standard. I guess that's their standard price, they will pay $700.

My doctor didn't have the—my doctor didn't have a profile and I don't understand this at all because they knocked down a doctor for not having a profile or not having—I have a bill here of another lady who had the same operation, just a few months ago before me, and they paid her twice as much as they paid me, same operation.

Senator KENNEDY. Well, now as I understand the medicare starts the first day of the month of your 65th birthday, is that right?

Mr. WINNON. Yes, but I wasn't 65 yet when I had the operation.

Senator KENNEDY. Well, if you had the operation on the 30th of April what would Blue Cross have paid?

Mr. WINNON. Blue Cross would have paid it totally.

Senator KENNEDY. So by missing it by 1 week, you ended up with a doctor's bill that you otherwise wouldn't have had?

Mr. WINNON. That's right.

Senator KENNEDY. $1,200, is that correct?

Mr. WINNON. Yes, that's right.

Senator KENNEDY. So just by the fact of a changing of a date for 1 week, it's made a $1,200 difference to you and your family in terms of your savings, is that right?

Mr. WINNON. That's right.

Senator KENNEDY. How do you feel about that?

Mr. WINNON. I think it's terrible. I don't have the money in the first place to pay it.

Senator KENNEDY. Does it make any sense to you that if you would have had the operation a week earlier, you would have been covered and the fact that you had it a week later——

Mr. WINNON. Not a bit. If I would have really known the true facts, I would have been in there 5 days sooner.

Senator KENNEDY. Does it make any sense in a system or a non-system to have that kind of a situation, $1,200 difference whether you would be operated on 1 week or another? Does it make any kind of sense to you?

Mr. WINNON. No, you just have to go by their book.

Senator KENNEDY. Well, I'm not sure we have to go by their book if we make some changes.

Mr. WINNON. That's what I'm here for.

Senator KENNEDY. You weren't supposed to say that. All right, Mrs. Beneteau, how old are you?

Mrs. BENETEAU. Seventy-one.

Senator KENNEDY. Now, as I understand your husband had some heart problems, is that true?

Mrs. BENETEAU. Yes, he has.

Senator KENNEDY. Could you tell us a little bit about that?

Mrs. BENETEAU. Well, shall I go back to when—before we had coverage when I had to pay for everything or just this?

Senator KENNEDY. We'd like to get a brief on both. You had sickness in your family before you had health insurance and maybe you can just mention that and what it meant to you, and both of them and then tell us since you've had national health insurance and what that has meant to you. Would you do that for us?

Mrs. BENETEAU. To begin with, we have five children and they were all born at home when we had to pay for every cent, and all of the bills for the childrens' ailments such as pneumonia and we had to pay for that when we had no money, and in 1947—up to 1956 we were in the hospital four times and we had to pay all our bills when we had no money, but after that in 1959, we had coverage under co-op, Essex County co-op which paid our medical bills.

Now the hospital bills were paid. Now, my husband's first coronary was in 1960 and another in 1961. All these bills from 1959 were completely covered. We never saw a bill. The doctors and hospitals and everything were paid.

My husband also had kidney stones and I had a breast cyst removed. My husband was in for prostate surgery and an arterial bypass in his leg in 1977 and all this was covered.

Senator KENNEDY. All those were covered, your husband's various illnesses and sicknesses were covered and your own, is that correct?

Mrs. BENETEAU. Yes.

Senator KENNEDY. Those are the coronary bypass, prostate surgery and two heart attacks?

Mrs. BENETEAU. Yes.

Senator KENNEDY. And has your son had surgery?

Mrs. BENETEAU. Our son, no, our son-in-law.

Senator KENNEDY. Son-in-law.

Mrs. BENETEAU. Well, that is a different case all together, but I think it is worth mentioning. He had brain surgery in June, which was something very difficult. He was in London Hospital a total of 2 weeks, and with the examinations and the tests and all, he came out

of there not paying a cent for the hospital or doctors except 10 percent out of the $200 for anesthetic.

Senator KENNEDY. Now, we're talking about thousands and thousands and thousands of dollars, are we not, in terms of——

Mrs. BENETEAU. Yes, because in the case of our son-in-law in a specialized hospital in London, the rate was $600 and some a day, excluding doctor bills, and it was a 4½ hour surgery under a microscope, so you know that that is expensive.

Senator KENNEDY. So we're talking about medical expenses that you, your husband, your son-in-law had since the enactment of national health insurance in Canada.

Mrs. BENETEAU. Yes.

Senator KENNEDY. You've lived in Canada before the health insurance and after the health insurance?

Mrs. BENETEAU. Yes; we did.

Senator KENNEDY. What would you say to the American people about your experience with health insurance and the importance of it to you?

Mrs. BENETEAU. Well, the time that we had to pay all our bills and we didn't have insurance of course was during harder times and although the bills were not as heavy as they are now, they were still heavy for us because of the very low income of a farmer.

When it came along, it was a godsend, that's for sure, and at the age of 65, everyone gets it free.

Now, before that we had to pay something like $2 and something a month, I think, I don't recall the exact figure. Now those working in industry I would say the majority of that was paid by the company for which they worked, but even if they paid it privately, it still was not much when you consider that we were in and out of hospitals about seven times besides doctor bills for your own family doctor.

Senator KENNEDY. Tell me, Mrs. Beneteau, how do your other friends who have retired—how do they feel about the health care system in Canada generally? Would you share with us for the American retirees?

Mrs. BENETEAU. When you speak to retired people, that means 65 and over and everyone in Canada gets it free. There is no—you pay no premium on it.

Senator KENNEDY. Are they pretty well satisfied?

Mrs. BENETEAU. Yes, very well.

Senator KENNEDY. Do you think you get a tax dollars' value for what——

Mrs. BENETEAU. We certainly do.

Senator KENNEDY. You can say that quite quickly. There are a lot of people around here that wonder whether they do but you think you do with your health program in Canada?

Mrs. BENETEAU. Right now I don't know. There's rumors that it isn't in the financial position that they would like. I don't know anything about that but I'm sure that if the time ever comes, there will be money poured into it from somewhere because I don't think that the people would let it drop.

Senator KENNEDY. If you were advising an American politician, would you advise them to support health care for the elderly people here in this country?

Mrs. BENETEAU. I certainly would advise and I'm in no position to advise Senator Kennedy but——

Senator KENNEDY. I'll take this advice, and any other that you have to give.

Mrs. BENETEAU. I certainly would—I have a daughter living in Michigan and I know what a hardship it is for her.

Senator KENNEDY. Well, I think that's important too. OK. We have the next family who is Mr. and Mrs. Charles Beach of Grand Rapids, Mich., and Mrs. Lillian Koscis from Windsor, Ontario.

Mrs. Koscis, would you raise your hand and Mr. and Mrs. Beach, if you would raise your hands.

Now, Mr. Beach, as I understand it, you're retired from the Penn Central Railroad, is that correct?

## STATEMENT OF CHARLES BEACH, GRAND RAPIDS, MICH.; AND LILLIAN KOSCIS, WINDSOR, ONTARIO

Mr. BEACH. That is correct.

Senator KENNEDY. And how long did you work there and what kind of income did you have?

Mr. BEACH. I worked as a conductor for the railroad for 24 years.

Senator KENNEDY. Just bring that mike up a little, and then Mrs. Beach had some medical problems about 3 years ago. Can you describe what happened?

Mr. BEACH. She had bowel problems in 1975, I believe it was.

Senator KENNEDY. What kind of care did she need?

Mr. BEACH. She needed surgery which was done at Grand Rapids Osteopathic Hospital. They operated two different times and in February of 1976, around the 20th, they sent her home in worse condition than what she was in when we put her in with bowels coming out of her sides, and then on the 1st of March, I took her to Mayo Clinic, in Rochester, Minn., and in 3 weeks they sent her home in a cured condition.

Senator KENNEDY. Now, how much did the insurance company pay for you with the two hospitalizations?

Mr. BEACH. The insurance company paid approximately $32,000 to Grand Rapids Osteopathic Hospital and they paid approximately $4,500 to Mayo Clinic. The doctor bills and so forth brought it up to a total of around $42,000 to the osteopathic hospital or $5,032 to the Mayo Clinic.

Senator KENNEDY. Now, did you owe any money?

Mr. BEACH. Yes, sir, we did.

Senator KENNEDY. And how much?

Mr. BEACH. We paid $466 to Mayo Clinic. We paid around $1,000 to doctors in Grand Rapids and we have to sell our home to pay the osteopathic hospital.

Senator KENNEDY. You mean, the hospital is still pressing you?

Mr. BEACH. I have summons here that show the hospital waited until the malpractice time had run out, which we had consulted an attorney and being that she did get good care at the hospital, it wasn't—we can't say it was from negligence, but she did get good care at the hospital, so we were advised not to file a malpractice suit. Four months from the day that the malpractice suit was outlawed, we were served

a summons and consequently we have to sell our home, which we have worked 30 years to pay for the bill.

I have the judgments and everything in my file here.

Senator KENNEDY. How many years did you work now?

Mr. BEACH. Twenty-four and a half years on the railroad.

Senator KENNEDY. And all your savings are gone?

Mr. BEACH. I have no savings.

Senator KENNEDY. And now you're faced with selling your home in order to pay the hospital bills?

Mr. BEACH. That is correct.

Senator KENNEDY. How much money is involved here?

Mr. BEACH. $4,562.

Senator KENNEDY. How do you feel about that kind of health care?

Mr. BEACH. Well, not very good.

Senator KENNEDY. Well, it's a real tragedy; it's a national disgrace that anyone who has worked as hard as you have is effectively being wiped out because of these bills——

Mr. BEACH. Well, when I get through paying the bills that are here, if I get $5,000 left out of the home, we're lucky, and I'm 57 years old, unable to work because of a heart attack in 1973, which the railroad put me out in January of 1974, and I'm on a fixed income. My insurance premiums for myself and my wife at the present time is $98.45 a month.

Senator KENNEDY. Now this is, as I understand it, 24 years of working retired because of illness on your heart, and now, being forced to sell your home because of medical bills. Do you know we're the only country in the world that that could happen to outside of South Africa? We're the only country in the world. That's the American health care system, U.S.A. 1978, that's wrong.

Mr. BEACH. Under the insurance I had with the railroad, they carried me for 3 years. I was told at the end of 3 years if I wanted to pick up the premium that insurance I could do so at a price of $125 a month for the wife and myself. That premium today if I was to carry that insurance would be $140 a month. I carry a lesser insurance for $98 a month, which I pay out of the $500 a month pension and that's kind of hard.

Senator KENNEDY. So it's virtually impossible to be able to get a—afford the kind of premiums to get the coverage.

Mr. BEACH. I can't afford the premiums.

Senator KENNEDY. People are having to make a choice, I suppose, on this. They just can't afford it. Mrs. Koscis, how old are you?

Mrs. KOSCIS. Fifty-seven.

Senator KENNEDY. You're 57, same age?

Mrs. KOSCIS. Yes.

Senator KENNEDY. As I understand it, 4 years ago you had an operation, is that right?

Mrs. KOSCIS. A very big one. I had a colestomy and I think most people know what that is, and I was in the hospital twice with it and come home and I never seen a bill, and since then I've had three other major operations.

I just had one 3 months ago, a total knee replacement and I never seen the bill. I just happened to see the bill when I came out of the

hospital, but nobody handed me one and the hospital bill alone was over $5,000.

Senator KENNEDY. You mean the health insurance paid for everything?

Mrs. KOSCIS. Everything. I never seen a bill at any time.

Senator KENNEDY. Did they pay for the nurse to come to your home?

Mrs. KOSCIS. They're paying even now. He was there this morning and they pay for the nurse to come every day.

Senator KENNEDY. And the nurse came to your home and checked your bandages and you don't get any bill for that?

Mrs. KOSCIS. Nothing.

Senator KENNEDY. How about cab fare when you have to go to the clinic?

Mrs. KOSCIS. They pay the cab fare.

Senator KENNEDY. They pay the cab fare to go to the clinic?

Mrs. KOSCIS. I go twice a month.

Senator KENNEDY. And all of this within a system that is spending less of their gross national product on health care then we are spending on ours, the 7 percent, 8.8 percent, paying for the cab fare, the visiting nursing services and you live on a modest——

Mrs. KOSCIS. I live on a disability pension from the shop right now. I worked in a factory.

Senator KENNEDY. So both effectively have a disability, you had the disability and he had the disability, both virtually the same age, both had serious illnesses both within the family.

In the United States they're having to sell their home to pay. In the other, they are having a visiting nurse and looking after your needs. Would you have been able to manage it if you hadn't had a health insurance?

Mrs. KOSCIS. No, never. I couldn't have paid those kinds of bills. I don't have any money. I put my son through school myself and I never put any money aside, so I never had anything to pay these bills with.

Senator KENNEDY. You think there's a worthwhile program for the people of Canada?

Mrs. KOSCIS. Definitely, I don't know how they did without it.

Senator KENNEDY. Well, we can't do without it here. You see what happens when they are doing without it, they're losing their homes. OK, Mr. Kovacs and Mr. Norris.

I noticed that Senator Griffin is here. Bob, do you both want to come up here? You're welcome to join us here.

Can we have order, please. We'll be in order.

Now, Mr. Kovacs of Detroit, Mich., and Mr. Edward Norris of Windsor, Ontario. They're both retired UAW members, one from Detroit and one from Canada. Mr. Kovacs, would you tell us how old you are and where did you work?

## STATEMENT OF ALEX KOVACS, DETROIT, MICH.; AND EDWARD NORRIS, WINDSOR, ONTARIO

Mr. KOVACS. I'm 62 years old. I worked at Dana Corp, UAW contract.

Senator KENNEDY. And why did you retire at the age of 56?

Mr. KOVACS. Due to illness of my wife. I decided to retire early so that I could help her out.

Senator KENNEDY. What happened to your wife?

Mr. KOVACS. In 1964 she had a stroke and a series of illnesses after 1964, which led to my retirement in 1972. She had—well, you know, when you have a stroke you have little problems, poor circulation and they always laid it on poor circulation and she had duodenal ulcers and a kidney infection plus—I can't think of it right now.

Senator KENNEDY. Was there adequate coverage for you?

Mr. KOVACS. Yes, there was.

Senator KENNEDY. Now, did it cover all your needs?

Mr. KOVACS. Yes.

Senator KENNEDY. Did it run out at any point?

Mr. KOVACS. 1974, in June of 1974 it ran out.

Senator KENNEDY. Did you have to take Mrs. Kovacs out of the nursing home for 60 days?

Mr. KOVACS. Yes, I did.

Senator KENNEDY. Why, was this because of her condition improving or what?

Mr. KOVACS. No; the UAW contract says if you are in a nursing home for 730 days, that is 2 days off for every day in the hospital and your insurance runs out. If you take them out for 60 days or more, then under your skilled care again you can readmit them and your coverage starts over again, but when I took her out for 60 days and readmitted her, they said she was basic and her coverage was canceled.

Senator KENNEDY. My understanding is the reason you took her out, did it have anything to do with her medical condition or did you do it in order to conform with the policy?

Mr. KOVACS. If I wouldn't have taken her out, I would have had to pay out of my own pocket.

Senator KENNEDY. But taking her out was not because of her medical condition, was it, it was because you had to do it in order to qualify for the policy?

Mr. KOVACS. Yes.

Senator KENNEDY. All right. Now you took her out. Then what happened when you wanted to have her come back in?

Mr. KOVACS. I brought her back to Allen Park Convalescent Home in September and her insurance was canceled. They said she was basic care and they fought it but they didn't get no where with Blue Cross.

Senator KENNEDY. Did the people from the clinic come down and think that she ought to be back in the clinic, that they needed the additional kind of skilled trading?

Mr. KOVACS. Some of them did and some of them didn't. I had some registered nurses that would go along and I don't know whether they go along with Blue Cross or whatever, but the doctors have a chart and they go by the doctor's chart.

Senator KENNEDY. So then what happened, did you pay for the care after that?

Mr. KOVACS. I did from June of 1974 until February of 1977 or November of 1977, I'm sorry.

Senator KENNEDY. Was it back in the nursing home?

Mr. KOVACS. Yes, sir.

Senator KENNEDY. So she went back into the nursing home, but this time you paid for it?

Mr. KOVACS. She went into three of them, Allen Park, Marian Manor and then she was in Baptist Park, where she is now.

Senator KENNEDY. And you dipped into your pension checks and savings; is that correct?

Mr. KOVACS. I sure did.

Senator KENNEDY. What was the total cost to you?

Mr. KOVACS. Approximately about $19,000.

Senator KENNEDY. And is that pretty much your total savings?

Mr. KOVACS. Yes, sir. I've got enough for burial and I might be able to sell my home.

Senator KENNEDY. And you have medicaid, is that it?

Mr. KOVACS. Well, we've got a little relief from November of 1977, we got relief as an individual person from medicaid. They take her social security check and they didn't touch my pension check, but it is not that much. I have to live on that pension check. Now, I went on social security myself as of August and I presumed they're going to dip into my social security in order to pay for my wife's care.

Senator KENNEDY. Well, now would this have been different if you would have been separated?

Mr. KOVACS. Yes; the reason a lot of these cases are picked up on medicaid was because there was a lot of divorces going on and people couldn t afford to pay for the care of their family and they were selling their homes and getting divorced so that they could pay for their care.

Senator KENNEDY. So just so that we understand it, if you were separated or divorced, it wouldn't have wiped out your savings. But because you stay married, you had to go through all of your savings, the $19,000 worth of savings, wiped out a lifetime of savings while if you would have been separated you probably could have held on to your savings. So here is the question of whether or not you are going to be separated or divorced or stay together.

People are forced to that kind of decision in order to meet their health bills.

Mr. KOVACS. I have seen a number of cases happen like this in Allen Park Convalescent Home. A husband who was able to talk and sign his name signed his house over to his wife, and he was able to get medicaid on his own after he signed the home over to his wife.

Senator KENEDY. It doesn't make any sense, does it.

Mr. Norris, where did you work?

Mr. NORRIS. Chrysler.

Senator KENNEDY. Are you working with them now?

Mr. NORRIS. I'm on disability pension. I anticipate going back.

Senator KENNEDY. What kind of medical problems does your wife have?

Mr. NORRIS. Three major back operations, one by an osteopathic surgeon, two by a neurosurgeon. The last one they drove stainless steel pins down her spine so she could walk straight.

Senator KENNEDY. And how many weeks—you were in the hospital too?

Mr. NORRIS. Well, I collapsed on the 22d of September 1976 but preceding that for a period of 2½ or 3 years, I had a basic illness which

I couldn't identify and I ended up collapsing, as I said, and I had been off work since and how it ended up was, I needed brain surgery. There was a blockage in the canal in the spine that facilitates the spinal fluid from going down and being disbursed and instead of that it was collecting in my brain pan and my brain was pushed over against the left side of my skull and also—can I finish?

Senator KENNEDY. Sure.

Mr. NORRIS. And also I've had Bell's Palsy and that accounts for this eye patch, but I have 90 percent vision back, and also in conjunction with the Bell's Palsy, my left leg became totally paralyzed, which put me in the hospital for another 2 weeks. In total I've been in the hospital approximately 7 months in 1977 at approximately $100-plus a day.

Senator KENNEDY. And how much did you pay?

Mr. NORRIS. Zilch.

Senator KENNEDY. What has the health insurance meant to you?

Mr. NORRIS. The difference between shooting myself to get my insurance to pay my bills and being here, and may I say something, Senator?

Senator KENNEDY. You certainly may.

Mr. NORRIS. The main reason I agreed to come here is because my father and my sister are here in Detroit.

Senator KENNEDY. And would you like to see that they have the kind of coverage or protection——

Mr. NORRIS. That is what I meant.

Senator KENNEDY. That is why you were willing to come down and tell the story of Canada so that your family who live here would be able to get the same?

Mr. NORRIS. Could I mention something else, Senator? I know that most people here wouldn't believe this, but I'm very spoiled. We have had the Windsor Medical in Windsor or socialized medicine since 1935.

Senator KENNEDY. Well, I think this case illustrates that Mr. Norris is covered whether he is actively working or not working and whether he is retired or not retired, where Mr. Kovacs who had very fine coverage even after he retired had to worry about specific benefits running out and take his wife out of the facility in order to become eligible again, then argue with the insurance company as to whether the benefits were covered or not and had to shell out $20,000 while waiting to become eligible for medicaid.

There is quite a difference in anxiety and emotional stress between the two families.

Our final panel will be Mr. and Mrs. David Baer of Detroit, Mich., and Mr. and Mrs. Meloche of Windsor, Ontario. Would you just raise your hands.

I think we'll start with Mrs. Baer. You have two children as I understand it?

## STATEMENT OF MRS. BAER, DETROIT, MICH.; AND MRS. MELOCHE, WINDSOR, ONTARIO

Mrs. BAER. Yes.

Senator KENNEDY. Could you tell us about the medical problems that your daughters have?

Mrs. BAER. My daughter has had a kidney disease since when she was born and she has had——

Senator KENNEDY. Your daughter has had a kidney disease and she was born with this?

Mrs. BAER. My daughter has a kidney disease and she was born with this and we have had medical bills since she was born nobody told us. We have paid $16,000 out of our own pockets since she was—from the time she was born till the time she was 5 and then just recently we have been on medicare and they have picked it up, some of the bills from them, since last year.

Senator KENNEDY. Now, at what time did they find out that she had a kidney disorder?

Mrs. BAER. She was 9 months old.

Senator KENNEDY. And this was over the next several months and years that she was in the hospital for four or five times; is that correct?

Mrs. BAER. Yes.

Senator KENNEDY. And then when she was 6 years old, the doctors made a decision to do what?

Mrs. BAER. They gave her a transplant.

Senator KENNEDY. Is that a kidney transplant?

Mrs. BAER. Kidney transplant.

Senator KENNEDY. Has it been successful?

Mrs. BAER. So far.

Senator KENNEDY. That's wonderful, and where does Mr. Baer work?

Mrs. BAER. At Detroit Chemical Industry.

Senator KENNEDY. He has a group policy there?

Mrs. BAER. Yes.

Senator KENNEDY. And what were the bills from the transplant?

Mrs. BAER. Well, the transplant itself cost over $23,000 and that was just the transplant. The doctors' bills were over, I'd say, about $2,000 because we kept getting some every couple weeks, we would get a different kind.

Senator KENNEDY. Now all of the transplant was covered as I understand it; is that correct?

Mrs. BAER. Yes.

Senator KENNEDY. And the Crippled Children helped pay for some of the remaining; is that correct?

Mrs. BAER. The Crippled Children, since we have been on there, have been very good because they picked up whatever the insurance company would not pick up.

Senator KENNEDY. What about the early period where the 5 years proceeding, were you covered by Aetna?

Mrs. BAER. Yes; we were covered by Aetna. We had to pay a $100 deductible first and then they picked up 80 percent and we had to pay the rest.

Senator KENNEDY. How much did that come to?

Mrs. BAER. We paid over $16,000.

Senator KENNEDY. $16,000 beyond what the coverage was?

Mrs. BAER. Yes.

Senator KENNEDY. And was this a financial strain?

Mrs. BAER. Yes, it was.

Senator KENNEDY. Emotional strain?

Mrs. BAER. Yes.

Senator KENNEDY. What has it meant to your family?

Mrs. BAER. Very bad because we are now separated and I have a feeling that that was a lot or part of it, but also—I'm sorry, what is our biggest problem is that when she gets to be 18 or 21, no insurance will cover her any more. They will not pick her up because she is a bad risk.

Senator KENNEDY. What do you mean by that? I know what you mean by that, but let's make sure everyone else does.

Mrs. BAER. Well, she can't be covered by the insurance, so she's on medicaid.

Senator KENNEDY. You mean the insurance company won't cover her?

Mrs. BAER. My husband's insurance drops her when she is 18 and medicare or crippled children drops her between 18 and 21, so therefore she won't have anything.

Senator KENNEDY. So that is something that you are already worrying about, it's a burden on you now. It's the fear and anxiety that you have thinking of what you're going to do down the line?

I hope we have national health insurance long before that time, but I'm glad that point was raised because in instance after instance you find it with other children, mentally retarded children and other kinds of handicapped children. It is a very real problem.

Mrs. Meloche, you have a daughter. Could you tell us a little bit about what happened to her?

Mrs. MELOCHE. She had brain surgery. She had a tumor on her brain and she's gone through six operations.

Senator KENNEDY. How old is she?

Mrs. MELOCHE. She was four when it all started.

Senator KENNEDY. And how old is she now?

Mrs. MELOCHE. She will be six in a couple of weeks.

Senator KENNEDY. How many thousands of dollars would you say you've accumulated in hospital bills?

Mrs. MELOCHE. We have an approximate estimate of almost $16,000, but that is just her hospital visit care and in London or Windsor and London and visits to doctor in London. That doesn't include the cost of any operations.

Senator KENNEDY. Did you have to pay for any of those?

Mrs. MELOCHE. All we had to pay was $70 because of the anesthesia. They overcharged and OHIP will only pay 90 percent.

Senator KENNEDY. Out of the several thousands of dollars——

Mrs. MELOCHE. That's all we paid.

Senator KENNEDY. And do you have any anxiety about the future of your daughter for her health needs or coverage?

Mrs. MELOCHE. Everything. She goes to Crippled Childrens now and we have never had to pay anything there and she has a brace on her leg——

Senator KENNEDY. How about when she gets a little older? You've heard Mrs. Baer's concern about what happens when her daughter grows up. Are you concerned about the health aspect of what will happen to your daughter when she is grown?

Mrs. MELOCHE. We don't.

Senator KENNEDY. Because the national health program covers her?

Mrs. MELOCHE. Yes.

Senator KENNEDY. I want to thank our panelists. I think it has been told in human terms as graphically as could be possibly stated about

the contrasting systems that exist in the United States and exist in Canada, not only about the gaps that we've heard about, about being covered up to a certain day and then not being covered after a certain day, not just to mention the questions about where after retirement the family has been virtually wiped out in fear of having to sell their house, or the United States, the fact that the mother continues after spending their life savings and bringing extraordinary kinds of tension and anxiety to their family, emotional problems to that particular family, worries about what is going to happen to her child when she grows up, and the dramatic contrast between what happens in Canada where we have heard from the senior citizens about different health problems that they have had and yet their bills have been met. We have heard about retirement, young mothers dealing with young children, about the continuing kinds of medical problems and all of the financial aspects have been paid.

I think beyond that is the emotional problem and the anxiety and although our Canadian friends have described that and I think that is a very important factor in terms of adoption of a health insurance proposal, the relief of anxiety to parents and to senior citizens and others in our community from the anxiety of health care bills, and I think the final point is the Canadians are able to do this with even paying for the taxi service to the clinic and visiting nurse services.

We had and I'm sure our friends from Canada wouldn't be surprised we had testimony in our health committee where our friends from Canada came to the United States and felt sick and ill and were admitted to hospitals here and had those bills paid for completely and they do it at a remarkably economic cost.

They do it spending less percent for GNP for health care than we do in the United States, and so they do it from a sound economic point of view, a cost effective point of view and from a human point of view, and I think through the experience of these families here I think it spells up the contrast between a country that has a comprehensive health insurance program and one that does not.

We're enormously grateful to all of you and I don't know whether Senator Griffin would just——

Senator GRIFFIN. I just want to say I'm glad as a fellow senator to be here and to welcome you to Michigan.

We're exceedingly proud of the fact that you have picked Detroit as the site of this hearing.

Senator Kennedy, of course, is the chairman of the health committee of the human resources committee in the Senate.

We used to serve together on that committee when it had a different name, the Labor and Public Welfare Committee years ago.

There isn't any question that Senator Kennedy is providing outstanding leadership in this field, controversial to be sure, but without question it touches the lives of every American.

He's leading not only Republicans and Democrats but even is leading the administration as far as this particular subject is concerned, and over the course of some time I'm sure that some changes are going to be made in the kind of health care system that the United States provides.

I don't other than to pay him my respects and to welcome you, Senator Kennedy, to Michigan.

I know that these hearings are going to be important, not only to the people of our State but they are going to be important to the Congress as they consider this subject. Thank you very much.

Senator KENNEDY. Well, we would love to have your cosponsorship on that, Bob. We've got a little room on that bill for that. Thank you very much.

I want to thank all of our participants again. We will be in order now.

We want to give a warm word of welcome to Mr. Fraser, who is the president of the UAW and is also chairman of our technical committee on health insurance. It is a coalition group of church leaders, senior citizens, representatives of farm and labor organizations combined with the AFL–CIO, and have been one of the real important forces to try and achieve a comprehensive health insurance program for all Americans.

All of us are enormously grateful and we are very mindful that the UAW through the work of Mr. Reuther and Mr. Fraser and Leonard Woodcock have a very good health care program for their employees. It is a great tribute to their leadership that they're not just pursuing this for their own employees, but they are pursuing it for all Americans. It is a great tribute to the leadership of that organization, and I think it is something all Americans should understand.

Mr. Fraser is an old friend and one of the most thoughtful men and knowledgeable men about this issue in these United States. We're pleased and grateful to have you, Mr. Fraser. We will ask you to proceed in your own way.

## STATEMENT OF DOUGLAS FRASER, PRESIDENT OF THE UNITED AUTO WORKERS

Mr. FRASER. If you don't mind, Senator Kennedy, I'll submit a statement and just make a few remarks. With me, is Mel Glasser, director of the NAW Social Security Department. I want to thank you for this opportunity to appear before you to testify and I also want to thank Senator Griffin for being here today.

I appear before you today on behalf of the Michigan contingent of our union. We are some 550,000 members, including our retirees, and taking into account the UAW family, we represent some 2 million citizens just in the State of Michigan.

I appear here to support the new national health insurance proposal which was developed by the Technical Advisory Committee of the National Health Security Action Council, and which you recently introduced. Mr. Chairman, for a long time we have been critical of the current health care delivery system in our country, but today we want to concentrate upon our home State, because Michigan is an example of a health care system is disarray.

The problems in Michigan are familiar because they follow the national norm, but I think they are accentuated here.

Health care costs are completely out of hand. Increasing numbers of Michigan citizens are being priced out of the health care market and this has an impact upon unions and their negotiations. We're approaching the point where one dollar an hour from the collective bargaining package is being spent on health care. Unfortunately at times

I think that cost is invisible. People ask, why should it concern the UAW? Does not General Motors, Ford, and Chrysler pay those massive premium dollars? The answer to that is yes and no.

They pay them all right, but it really comes out of the wage settlement and the negotiations—when we go to the bargaining table every 3 years. It is an elementary fact of collective bargaining that sooner or later you negotiate and agree to an economic pie that is so big and if you're paying $1 for hospital, surgical and medical premiums, that is $1 an hour that you cannot get in wages and pension and holidays and vacations and a shorter workweek.

Senator KENNEDY. Just on that point, how big a factor is this in the forthcoming negotiations?

Mr. FRASER. If I can back up to the 1976 negotiations, increases in health care costs were a principal cause of the Ford strike in 1976; and in 1979 I think it is safe to assume that the corporations will be making two demands upon our union. They are going to give us the privilege of letting our members pay for some of these premiums and we will of course fight that off; and then they will have a back up position prepared in advance which will say, maybe it is too much to expect a change in the system, but we will want the members to pay any increases in premiums that occur during the life of the agreement; and hopefully, we will be able to fight that off as well.

But having done all that, we have done nothing more than make the plan more expensive. The same plan, without any improvement in benefits, continues to escalate.

In 1977 national increases in the price of medical care services were 9 percent. The situation in Michigan is even worse. Detroit physicians fees rose 40 percent more than the national increase. Hospital service charges last year in Detroit increased one-third more than the national rate of increase. In Detroit the cost of medical care in the past year rose twice as fast as the increase in the overall Consumer Price Index.

The Blue Cross-Blue Shield premiums in the State of Michigan for auto workers have increased fourfold in the past 10 years, and as I pointed out, in 1976 it was a principal cause of a strike. Let's stop 1 minute and examine one corporation, Chrysler Corp., which has a heavy concentration of workers in Michigan.

In Michigan, the Blue Cross-Blue Shield basic family health plan premium, is now $167 a month.

I selected Chrysler because the UAW has an international collective bargaining agreement with Chrysler which covers the American and Canadian workers. Our Canadian counterparts in the Chrysler Corp., are not paying $167 a month, they are paying $38 a month.

Senator KENNEDY. I think that's worth underlining. Do you want to run that by us again?

Mr. FRASER. $167 a month in the State of Michigan for the Blue Cross-Blue Shield family plan compared to $38 a month the Chrysler Corp., is paying for what we call the OHIP, Ontario Health Insurance Plan; and in addition to that, Senator the plan includes that which we don't have in Detroit; namely, doctor's office visits.

Senator KENNEDY. Does that mean that those are benefits that otherwise could have been used by those that work——

Mr. FRASER. Absolutely.

Senator KENNEDY. He could have, I suppose, had that money for his own?

Mr. FRASER. For wages or a better pension, or more holidays, or more vacation. In addition to that, it is worth noting that the Canadian plan is superior to the plan which we have here. Just as one example, they have house calls and office calls in Canada which we do not have here and if we would factor that cost into our system we would increase costs by 10 percent.

Another factor that we should keep in mind is that we have annualized rating in Chrysler. It is rated every February, so we are near the end of that year now and in February of 1979, we are going to see another dramatic increase, I'm afraid, in the premium costs and in physicians' fees. While it hits everyone, it hits, I believe, the older and disabled workers the hardest.

Many physicians in Michigan do not accept medicare assignments. People are paying more and more and more out of pocket because medicare reimbursement rates cannot keep pace with increases in prices being charged by doctors.

And if you turn to the medicaid program in the State of Michigan, it is really putting a strain on our State budget. From 1968 to 1977, the rate of increase in Michigan medicaid expenditures was 8 percent more than the rate of increase for the national average.

If you want to look at symptoms of a system in disarray, just look at the recently published scandal involving clinical laboratories where special kickback arrangements were made to some doctors for excessive laboratory tests that were not medically necessary and where some doctors even had an ownership interest in some of the laboratories with which they did business. We are now spending in Michigan, $100 million a year in blood tests alone.

I know you share with me a high regard for the medical profession and certainly the overwhelming majority of physicians are competent, dedicated and have integrity, but the system that we have in this country today allows and in fact encourages a small minority of doctors to exploit the system and to take advantage of the public, particularly the elderly and the poor.

I must say that the medical profession in Michigan does not come out with high marks in a couple of areas. They have resisted our efforts to have some sort of reasonable cost containment or cost controls. In 1976 for the first time we negotiated a hearing care program. Several ear, nose, and throat specialists in the State of Michigan with the support of the Michigan State Medical Society sued us. They refused to accept the provision in the benefit which limits payment to their usual and customary fees. I don't know what the hell they want. When they won't even accept usual and customary fees, it gets pretty discouraging.

Also in the State of Michigan we have an estimated 5,000 to 7,000 excess beds. As you know, it has been estimated that the cost to maintain a bed is between $20,000 and $30,000 a year annually. When you have all those excess beds, you have pressure to fill those beds because many hospitals run their operation like hotels—they try to get the maximum occupancy to bring the costs down and the profits up.

I should mention something about nursing home care. We have been focusing on the horrendous cost of the health care which has been

dramatized, but I don't think we have been paying enough attention to the quality issue—particularly in nursing homes. We have heard appalling stories of abuses and one of the difficulties at least in the State of Michigan is that it is almost impossible to close down bad nursing homes.

We have in Michigan medicaid mills that exploit and mistreat the poor and rip off the Government. We can detail example after example where that is going on. We made modest progress in the Detroit area where we tried to improve the quality of health care. We introduced a second opinion program for elective surgery which was developed by the UAW and the big three auto companies. Mel Glasser and I met with Wayne County Medical Society and tried to persuade them to give us their support and their encouragement, but we were unable to do so.

Let me address one or two other areas. We have in Detroit a lack of access and it is an absolute nightmare for people trying to get medical care. We have 20 percent fewer general practitioners in the city of Detroit than the national average. In 1974, the latest year for which figures are available, we have 1 physician for every 13,000 people in the city of Detroit; and there is also a shortage of doctors in the rural areas of Michigan.

Blue Cross-Blue Shield in the State of Michigan, an organization which we helped create, I believe, has failed in their mission. They've gone to experience rating rather than community rating and as you know that that creates a greater disparity between the haves and the have nots in the area of health care. And the commercial insurance carriers in the State of Michigan virtualy operate without any meaningful regulations at all.

One hope that we did have and still have, is trying to increase the number of HMO's. We believe it is a viable alternative to the current system, but we are not giving enough support to the HMO's.

In the State of Michigan there is only eight HMO's and it covers only 2 percent of the population; and of that group, 43 percent of those enrolled are on medicaid.

Senator KENNEDY. Why has that been so slow in growing?

Mr. FRASER. I think it's lack of support. The only meaningful one that we have is one that was organized by the UAW, the Metro health plan. Incidentally, hopefully by tomorrow, we will be merging with Ford Hospital and then we will have, I believe, the most meaningful HMO in the country. I believe that generally there has been a lack of support for HMO's. The legislation that you introduced Senator will be very very helpful, but we still have to do more in this area.

Any meaningful national health insurance plan like the one that you are sponsoring I think would serve to encourage the HMO's.

I've recited a couple of reforms that we have tried, but we frankly failed. I hope we have learned from these failures and from the errors that we have made.

The bill that is now being considered by your committee I think recognizes these failures and these shortcomings because that bill would provide for universal and comprehensive coverage. It would provide for meaningful cost and quality controls and would regulate the insurance industry and make them accountable to the consumer and public interest. I think it would serve to reform the way the health

care services are delivered and the way the system is organized, and it provides for consumer participation at every level of the program including a policy making role for consumers.

Now you know and I know that this year we will be spending $183 billion in health care in the United States, a staggering amount, and the Secretary of HEW said a few weeks ago that by the year 1983 we will be spending $313 billion.

I saw a statement the other day that down the road they can see us spending $1 trillion. That's unthinkable—there are too many other things we have to do in the United States and I think it's a fair question to ask, Senator, how much longer must the American people wait?

The problem as I view it is we've had too little help in the U.S. Senate. I think that the fact that we are holding a hearing at this time is good. I think the public debates will be beneficial and helpful in passing legislation and I think it is particularly good that the public debate comes upon the eve of the election because those people who have no interest in national health insurance suddenly get an awareness of the importance of the problem. Maybe we could have an election every 6 months, and then maybe we would have national health insurance.

Just let me say for the UAW that we have been in this fight for a long, long time. Walter Reuther, as you mentioned, established a committee for national health insurance in 1968 and we fought for national health insurance long before that period of time. Leonard Woodcock succeeded Walter and now I succeeded Leonard in the capacity of the chairman of the Committee for National Health Insurance. Our attitude is, Senator, that we're not going to stop fighting for national health insurance until every man, women, and child in our country has quality health care, not as a matter of privilege, but as a matter of right.

Senator KENNEDY. Thank you very much, Mr. Fraser. With all the social programs that the UAW is concerned with, where does health insurance stand?

Mr. FRASER. No. 1. I believe, Senator, that this is one of the most important pieces of social legislation since the enactment of the social security Act. I don't think that's an exaggeration at all. That's the way we feel about it.

Senator KENNEDY. OK. we'll have your full statement in its entirety in the record. It is enormously helpful on a number of the points with all the figures that you've mentioned here today.

We had testimony from you about 10 days ago at our Washington hearing and now again here today and this is a great value to our committee. We are delighted to have you here and we appreciate very much you joining with us and thank you very much.

All right, Mr. Shelton, we will be glad to hear from you.

## STATEMENT OF JACK SHELTON, MANAGER OF THE EMPLOYEE INSURANCE DEPARTMENT OF FORD MOTOR CO.

Mr. SHELTON. Mr. Chairman, my name is Jack Shelton. I am manager of the Employee Insurance Department of Ford Motor Co. In this position, I am responsible for the purchase and financial administration of the company's employee insurance programs.

I am appearing here today at the request of this subcommittee to discuss the impact of health care cost escalation on Ford Motor Co. As was indicated when the invitation to testify was accepted, it is not our intention to discuss the various national health insurance proposals.

For many years, Ford has been seriously concerned about the increasing cost of health services. In previous testimony before this subcommittee in 1976 we described the impact of these costs on the company. Earlier this year we appeared before Representative Paul Rogers' subcommittee on health and the environment to discuss a unique Michigan effort sponsored by a coalition of public and private interests to address the problem of surplus hospital capacity.

Our testimony today will cover the following areas, an update of Ford's health care benefit cost experience, our view of the major causes of the health care cost problem, and actions the company is taking and/or supporting to contain health care costs.

As one of the Nation's largest employer, Ford is a major purchaser of health care services for 1 million hourly and salaried employees, retirees, surviving spouses, and their dependents.

Ford provides one of the most complete benefit programs in the country. Benefits include hospital and physician services, prescription drugs, dental, hearing and vision care. Most of the primary health coverage are first dollar benefits; however, employees share in the cost of dental, hearing, vision, outpatient psychiatric care and prescription drugs. A brief description of our programs is attached.

Since 1965 Ford's health care costs have doubled every 5 years. Between 1965 and 1977, our total health care bill increased from $68 million to about $450 million or from an annual total cost averaging $350 per active employee to $2,000. For 1978, we are forecasting costs to exceed $500 million.

There are many reasons for the dramatic cost increases which Ford has experienced. New benefits have been introduced and the number of covered individuals has increased, but over two-thirds of the total cost increase since 1965 was caused by inflation and higher utilization.

Higher health benefit costs affect the price of goods and services in the U.S. economy including the cost of automobiles. Ford health care costs represented $22 per unit produced in 1965 and in 1977 they totalled about $120 per unit, an increase of almost $100 per vehicle.

Senator KENNEDY. Those figures are extraordinary. Now, as I understand it, the increases between 1965 and 1977—the increase from $68 million to about $450 million—is that $68 million?

Mr. SHELTON. $68 million.

Senator KENNEDY. In what year?

Mr. SHELTON. 1965.

Senator KENNEDY. And how much was just the increase last year?

Mr. SHELTON. Just the increase in premium rates?

Senator KENNEDY. Yes.

Mr. SHELTON. Well, our premium rates for 1977 over 1976 was about 13 percent.

Senator KENNEDY. Just give us some standard figures. What were they spending in 1965 and what did you do in 1978? Your testimony shows that you were increasing $68 million to about $450 million. Please give us what the figures were in 1965 and give it to us in 1978.

Mr. SHELTON. In 1978 our total cost will be over $500 million.

Senator KENNEDY. And what were they in 1965?

Mr. SHELTON. $68 million.

Senator KENNEDY. $68 million dollars in 1965 and $500 million in 1978, just on the health, is that right?

Mr. SHELTON. Right.

Senator KENNEDY. That's obviously a dramatic increase. What does it mean in the price of cars?

Mr. SHELTON. In 1978 it will be about $135 per car.

Senator KENNEDY. $135 and in 1968 what was it?

Mr. SHELTON. In 1965 it was $22 per car.

Senator KENNEDY. So that we can't make any mistake about it, those costs are being passed on certainly to the consumer in a major factor in terms of inflation and another part of our economy.

Mr. SHELTON. Our concerns over escalating——

Senator KENNEDY. What does it mean—let me ask you what does it mean in terms of negotiations with the UAW from the point of view of the company?

Mr. SHELTON. I think that question was answered very adequately by Mr. Fraser. It's a very serious part of the negotiation process and was a serious part of the 1976 negotiations and was one of the last items settled during the four week strike.

Senator KENNEDY. What do you anticipate in terms of the new negotiations, can you tell us?

Mr. SHELTON. I don't know at this point.

Senator KENNEDY. That is a cautious answer. OK, well, I think the point is this may be a principal item of difference which will have an enormous impact on peoples' lives. It obviously is going to be a key factor in terms of the negotiations and I think you might as well understand that.

Mr. SHELTON. Our concerns over escalating costs are shared by the UAW and are reflected in the list of joint cost containment programs incorporated in our 1976 UAW agreement.

The causes of the escalation of the health care costs are varied and, in large part, rest outside the direct control of Ford Motor Co. We believe the major problems are:

1. Lack of sufficient incentives to contain costs. Traditional market forces and economic incentives are almost completely absent from the health care system. This system is characterized by consumers and providers who are conscious of quality but insensitive to costs; facilities which are encouraged to provide the most sophisticated and specialized services available; and reimbursement policies which reward excessive utilization and do not reward institutional cost control. On balance, adequate incentives do not exist to encourage weighing medical services against their costs.

2. Excess capability and mal-distribution of resources. Most urban areas have excess hospital capacity, excessive amounts of diagnostic and laboratory equipment, and a surplus of specialty physicians. This contrasts with many small, rural areas which are deficient in many resources, especially primary care physicans.

3. Overutilization. There appears to be a substantial amount of overutilization of services initiated both by consumers and providers. There is evidence that too much surgery is practiced, too many drugs

are being dispensed, and people are being hospitalized when outpatient care would be medically appropriate, and too many outmoded procedures are being used.

Senator KENNEDY. In terms of overutilization, can the company institute practices to help in the area like second opinions or peer review?

Mr. SHELTON. Yes; in our 1976 contract we provided for just those types of programs. We have five concurrent hospital utilization review programs in a place, and three second opinion programs, as well as preadmission testing, model treatment screening, and several other cost containment programs.

4. High consumer expectations. In recent years, most Americans have developed higher and more unrealistic expectations of what the health care system can or should accomplish. We believe these expectations have lead to an over-reliance on medical intervention for maintenance of health rather than on the practice of a healthy lifestyle. Research indicates that major improvements of health status of Americans may best be achieved through changes in lifestyle and behavior rather than from increased medical care.

We recognize that there are no easy solutions. However, because of the seriousness of the health care cost situation, we believe that all interests, business, labor, government, providers, and consumers must accept some responsibility for the problem and for the design and implementation of innovative solutions.

Because of our cost experience, Ford Motor Co., has significantly increased its involvement in cost containment incentives. Our efforts, concentrated at the local and State level, emphasize the development of private sector solutions and the promotion of economic incentives for improved efficiency in the delivery of health care services.

We also coordinate our efforts with and support the public planning process established under Public Law 93–641, the National Health Planning and Resources Development Act.

We would like to review some of our cost containment efforts. Most of our cost containment programs have been implemented in recent years, and reliable measures of their effectiveness are not yet available.

One, promotion of economic incentives. We believe that a basic requirement for moderating health care cost increases in the long run is to strengthen market incentives and promote alternative health care delivery systems which improve quality and cost competition. For this reason the company supports the establishment of alternative prepaid health plans, such as health maintenance organizations, HMO's.

Senator KENNEDY. How many of your employees are HMO?

Mr. SHELTON. Approximately 11,000 or 4 percent who are——

Senator KENNEDY. What is your flow chart?

What do you expect to do?

Mr. SHELTON. We are doing several things. We have been very active in the launch of a new HMO called the health alliance plan of Michigan. This plan has been incorporated and hopefully will be licensed and operational early next year. It will use Ford Hospital as the provider base and will also use the Metropolitan Health plan

facilities. We deal with 13 different HMO's and are attempting to increase employee participation in HMO's.

Senator KENNEDY. How many do you expect to be members of HMO, say, in the next year or two years?

Mr. SHELTON. Well, that's very difficult to predict. Our experience has been employees don't entoll at the rate we think they should. Our present participation is four percent.

Senator KENNEDY. Go ahead.

Mr. SHELTON. HMO's as alternatives to the traditional fee-for-service system also elicits a competitive response from other providers often resulting in a reduced hospital utilization and, hopefully, lower health care costs.

Because we believe that well organized, cost effective HMO's can benefit the employee, employer and the general community, Ford has intensified its enrollments efforts and attempted to expand the opportunities for HMO's to tell their story. We also are working directly with business, labor and community interests to establish a new community HMO in Detroit.

The company also has been supportive of private initiatives to introduce incentives to contain costs. An example is the recently negotiated prospective payment system between Michigan hospitals and Michigan Blue Cross-Blue Shield which provides an incentive to reduce hospital costs. Also, negotiations are underway with Michigan physicians to develop a physician reimbursement program incorporating similar incentives.

Two, capacity reduction and reallocation of community resources. Ford encouraged participation in the resource planning process established by the Federal health planning act and supports the development of State programs requiring certification of need prior to the building or expansion of a health facility or the purchase of major equipment. We recently completed a major effort in Michigan where, working with representatives of labor, other businesses, the insurance industry, the legislature and the executive branch of Michigan's State government, legislation was developed and passed which addresses the problems of excess hospital capacity. This new law, designed in cooperation with the Michigan Hospital Association, strengthens the local planning process and establishes an equitable and rational process for the gradual phase out of surplus hospital capacity.

Three, reduction of unnecessary and inappropriate utilization.

Ford and the UAW are jointly working with insurance carriers to increase the delivery systems' cost efficiency and to improve the appropriateness of the care being provided. Joint projects in our 1976 negotiations with the UAW are hospital utilization review programs and a number of pilot programs including second opinions for elective surgery, preadmission testing, independent peer review, and model treatment screening. Our major carriers are required to conduct retrospective utilization review of hospital services, and four pilot new concurrent utilization review programs have been implemented and more are being planned in other locations.

The last area, promotion of health education. We believe consumers should be encouraged to assume greater responsibility for their health and the management of their health problems. To address these needs, the company has organized pilot programs to assist employees with

substance abuse counseling, cardiovascular risk intervention and hypertension screening. Ford also is increasing its efforts to communicate to employees information about the importance and means of maintaining good health.

In conclusion, rapidly rising health care costs adversely affect major segments of the U.S. economy including large employers like Ford Motor Co. Because the health systems' problems are well entrenched, the result of policies and programs which evolved over several decades, we do not believe it is reasonable to expect immediate solutions to the cost problem. The company's approach to cost containment relies on strengthening economic incentives in the health care system while simultaneously identifying and correcting major problem areas resulting from the lack of traditional market incentives. Our program embraces both public and private sector programs and requires the cooperation and involvement of business, labor, providers, consumers and the Government. By working together and preserving this balance of interest, we believe our programs will be successful in the long run.

We appreciate the opportunity to present our views before the subcommittee. Thank you.

Senator KENNEDY. Can you tell us what do you pay per worker in Canada and what do you pay per worker here in the United States?

Mr. SHELTON. Well, the average cost per employee in the United States is $2,000. As you know, Ford pays only part of the Canadian program costs in terms of direct payments. The bulk of the financing for the program comes from corporate and personal income taxes. Our direct premium cost in Canada for 1977 were about $915 per active employee, and these costs were up 107 percent over the past 5 years.

Senator KENNEDY. From what to what?

Mr. SHELTON. From $443 to $915.

Senator KENNEDY. What was the tax contribution?

Mr. SHELTON. I don't have that information.

Senator KENNEDY. What percent did you pay in terms of the premium?

Mr. SHELTON. We have no idea what our total costs would be.

Senator KENNEDY. OK, we want to thank you very much for your presentation. We'd like to thank all of the people here today. This has been an important hearing, first of all hearing the words of the consumers here in the United States on how they're impacted on health care. The first witness was Mrs. Dearhamer with just the routine problems that she has in finding a doctor for routine types of services, and the difficulty that she had, and then we heard some of the more serious problems of the retirees, and finally we heard the problems of those that had lost their total savings and who fear the loss of their home.

We heard the power of the fact that in Canada they don't have this anxiety. We have heard some statements or impressions about the quality of health care and the good health care that was received in Canada. There wasn't really a distinction between the need and ability to pay just people of very modest income and those that had very substantial income. That echoes what we heard in the Senate from some of our Canadian friends that testified in Washington.

We also heard, of course, the president of a great labor organization giving us some of the history, some of the dramatic economic im-

pact on the workers. He discussed how we are effectively taking dollars and cents from the workers by the out-of-control costs. And how this issue because of the power and the importance of the employees could be and would be a matter of major negotiations in the forthcoming negotiations. It is agreed to that it will be a matter of negotiations by the representatives of the Ford Motor Co.

So this process continues and we value very highly the ability to collect information from people in this community around this country. We can hear from them or representatives of the groups in Washington, but it is very useful for us to hear Mrs. Dearhamer and it is important for us to hear from Mr. and Mrs. Winnon from Battle Creek and Mr. and Mrs. Beach and Mr. Kovacs and Mr. and Mrs. David Baer all from Detroit or Grand Rapids or Battle Creek. It is important I think for the American public to hear from them and also hear what is happening in another system that has a national health insurance program. It is very close in range of benefits in terms of quality, and in terms of economic cost controls to the type of program that I support and that I know that Mr. Fraser and the UAW supports and many of the other people in this country.

We're grateful for your patience, for your attention and for your support.

At this point I order printed all statements of those who could not attend today's hearing and other pertinent material submitted for the record.

[The material referred to follows:]

# Insurance Economics Society

OF AMERICA

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GUIDANCE

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November 9, 1978

Richard Froh
Senate Subcommittee for Health & Scientific Research
U. S. Senate
Washington, DC 20510

Dear Mr. Froh:

Enclosed is testimony to be included in the record for Senator Kennedy's public hearing on National Health Insurance in Detroit, Michigan on October 23, 1978.

Sincerely,

Martha M. Niemann

Martha M. Niemann
Administrative Assistant

STATEMENT ON NATIONAL HEALTH INSURANCE BY JOHN B. O'DAY, PRESIDENT-MANAGING DIRECTOR OF THE INSURANCE ECONOMICS SOCIETY OF AMERICA, 175 W. JACKSON BLVD., CHICAGO, ILLINOIS PRESENTED TO THE SENATE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH, IN DETROIT, MICHIGAN ON OCTOBER 23, 1978

Mr. Chairman, my name is John B. O'Day and I am president-managing director of the Insurance Economics Society of America. The Society, founded in 1917, is an organization engaged in the continuous study of social and private insurance systems in the United States. Members of the Society consist of a select group of insurance companies who are among the pioneers in the development of America's unique and unprecedented health insurance system, and six thousand insurance agents who are engaged in marketing and servicing health insurance.

The Insurance Economics Society of America is pleased to report to this Senate Subcommittee that we have a great feeling of accomplishment that our 36 year effort to persuade Congress to abandon any idea of expanding the Social Security Tax mechanism to include National Health Insurance appears to be approaching success.

The Society has testified against this expansion of Social Security since 1943 before a number of Committees of Congress. Specifically we direct your attention to our testimony before the House Committee on Ways and Means, May 23, 1974, which has turned out to be a prophecy of the financial dilemma the Social Security Funds are now experiencing -- a dilemma that has forced Congress to sharply increase the Social Security Tax a magnitude of $225 billion over the next decade.

However, we will not fully celebrate the great victory for the American taxpayer in separating the National Health Insurance proposal from Social Security, thereby saving billions upon billions in taxes, until the 96th Congress sits in January 1979. At that time we assume that the sponsor of the Health Security Act, Senate Bill 3, Senator Edward M. Kennedy, Democrat, Massachusetts, will reintroduce this bill that has been debated in Congress for 10 years, with one resounding difference: the idea of a payroll tax is to be abandoned.

In its place, Senator Kennedy has announced that the new proposal to fund his National Health Insurance plan will encompass a yet to be clarified method involving insurance premiums.

This significant change indicates a welcome recognition that the American taxpayer and the national economy cannot handle the confiscatory health tax Senator Kennedy proposed in S-3, to wit:

| | | |
|---|---|---|
| General Revenues | : | 50% of Cost |
| Employers | : | 3¼% of payroll |
| Employees | : | 1% on first $21,150 of wages |
| Self Employed | : | 2¼% on first $21,150 of earned income and non-earned income. |

With a proposed National Health Tax hopefully dead after 36 years, our attention now focuses on the new financing method proposed by Senator Kennedy a few weeks ago. Unfortunately we find that the new proposal has all of the characteristics of a payroll tax. And, ominously, it contains all of the characteristics of a government take-over of the health insurance business and the health delivery system.

We can find no difference between a payroll tax and the newly proposed mandatory health insurance premiums paid to perhaps a few government "certified" and "federally regulated" insurance companies.

Therefore, the Insurance Economics Society of America, though pleased to see the health tax idea abandoned, must register its opposition to the new legislation until the sponsors remove the vestiges of an all government takeover of the private health delivery system.

Until such modifications are made and publicized the Society must consider the proposal nothing more that a euphemism for a National Health Tax and an egregious government encroachment into the private sector which would destroy freedom of choice, efficiency and innovation born of competition in the market place.

In our initial analysis of the new proposal we are disturbed by the sizable amount of government regulation that the proposal would visit upon the private sector and each and every American. We respectfully urge the subcommittee to consider the stifling effect over-regulation would have on the development of new technology and constantly improving efficiency that has been the hallmark of the phenomenal progress of the American health care system.

We urge this committee to investigate to the fullest extent the failures of National Health Insurance schemes in other western countries -- failures to deliver on the promises made by their proponents. Specifically we know you will find that none have solved the problems of rising health care costs that are plaguing all.

We urge you to question proponents on why they have abandoned the British National Health Service as an example for Americans to follow. Is it not because with each passing year the deficiencies inherent in the British National Health Service have been so widely publicized that it has lost all but a few adherents in America? Is it not because there is a waiting list of 600,000 Britons waiting in line for months and years for surgery under the National Health Service? Is it not because there is a wry national joke in Britain which is repeated

throughout the land: "You join the queue with a cold, and by the time you get treatment, you've got double pneumonia."

We ask you to study the Canadian national health plan, the new model now being paraded. Our observation is that Canada is experiencing several serious drawbacks and is beginning to suffer the economic and stagnation woes of that former model, Britain.

We dispute those who have testified that Canada has been able to control the cost of health care through National Health Insurance. The facts are that between 1960 and 1975, hospital costs in Canada increased 424 per cent compared to 382 per cent in the U.S. Doctor bills have increased 71 per cent there and 65 per cent here.

Costs in Canada have been rising so rapidly in the last few years that the federal government voted in 1977 to limit its contributions which generally amount to 50% of health care costs. The provinces, which collect a variety of taxes and fees, finance the remaining 50%.

We dispute those who disparage because Canadians are spending a lower percentage of Gross National Product (6.9%) than Americans (8.5%) when they fail to explain that Canada's GNP is capable of growing faster, and has grown much faster in recent years, than has the American GNP. "Most Canadians pay more for their medical care now that its free" according to a comprehensive study by the University of California at Los Angeles and published by Roche Laboratories.

It has been our experience over the last 36 years that the more Americans find out about National Health Insurance in foreign countries the less they want it here. That is why survey after survey show that 80% of Americans approve of our current system of health care. We urge the Congress to work to improve, not destroy, the uniquely American health care system which includes private health insurance for the vast majority and the proper use of government to care for those who are unable to provide health care for themselves.

AMERICAN DENTAL ASSOCIATION

WASHINGTON OFFICE • SUITE 1004 / 1101—17TH STREET, N.W. • WASHINGTON, D.C. 20036 • PHONE 202/833-3036

October 31, 1978

The Honorable Edward M. Kennedy
Chairman, Subcommittee on Health &
Scientific Research
Committee on Human Resources
431 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Kennedy:

I am writing on behalf of the American Dental Association concerning your recently introduced national health insurance outline. I ask that this letter be made a part of the record of your hearings on this outline.

As the second largest profession of health care practitioners in the United States, the dental profession is vitally interested in, and concerned with, proposed national health service plans. The profession has been actively involved in discussions on this issue for many years. We will want to offer our specific comments when legislation incorporating the principles of your outline has been introduced.

I have enclosed a copy of testimony presented on behalf of the Association before the Advisory Committee on National Health Insurance Issues of the Department of Health, Education and Welfare. This statement outlines the general principles of the Association with regard to national health service programs.

Thank you for your consideration of our views.

Sincerely yours,

Joseph P. Cappuccio

Joseph P. Cappuccio, D.D.S.
President

Enclosure

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION
BEFORE THE
ADVISORY COMMITTEE ON NATIONAL HEALTH INSURANCE ISSUES
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
OCTOBER 21, 1977

Mr. Chairman, members of the Committee, I am Dr. Frank P. Bowyer, of Knoxville, Tennessee, President of the American Dental Association which represents more than 127,000 members from throughout the country.

Over a period of many years the American Dental Association has actively participated in the continuing debate on national health insurance and the role for dentistry in such a program. We appreciate this opportunity to appear before you to briefly discuss this complex issue.

The stated purpose of this hearing is to provide information on the potential impact of national health insurance. In addition to discussing this subject in relation to new or existing proposals, we think it relevant to offer comment on where matters stand today in the willingness of the government to help provide dental care for those who need it most--the needy and near needy.

With few exceptions, dental care benefits under Medicaid, including the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) portion, range among the states from practically nothing to less than adequate.

This unhealthy state of affairs might have been avoided if recommendations of the American Dental Association had been heeded years ago, particularly since the early 1960's.

In 1964, for example, when the Association first testified before Congress on Medicaid, we urged that if resources would not permit coverage of all needy persons, at least dental care for children should be mandated. Such an amendment was adopted by the Senate but was dropped in a House-Senate conference with cost being cited as the reason.

In 1967, at the urging of the Association, the Administration submitted to Congress a bill authorizing dental projects under Title V of the Social Security Act. Following enactment, however, only minimal funds were ever requested and appropriated.

In 1967, as well, the Association vigorously supported amendments establishing the EPSDT program which included dental care among the mandated benefits. The program languished for more than two years until a lawsuit was brought to require HEW to carry out its provisions. Even so, progress has remained painfully slow.

In 1971, and again in 1975, Senator Warren Magnuson (D-Wash.) introduced a Childrens' Dental Health Act strongly supported by the American Dental Association. It was specifically designed to strengthen the floundering EPSDT program and to provide assistance to communities wishing to take advantage of the benefits of water fluoridation. The legislation was passed twice by the Senate but was never enacted into law.

Finally, we testified before Congress last month on the Child Health Assessment Act which would place further constraints upon the provision of dental care under EPSDT. It would require prior medical assessments and would invite states to reduce even further the level of dental benefits by offering a higher federal matching ratio for other health care services. I would ask permission to file a copy of the Association's testimony on CHAP with the Committee.

We present this brief review of some of the efforts that have been made by the Association to demonstrate our commitment to improving access to dental care for the poor people of our country. It seems obvious that we need substantial help from the government in this effort. I would make the observation that, at the present time, the annual private personal expenditure for dental care is 7.1 percent of the health care dollar or roughly $8.6 billion while the government expenditure is 0.4 percent, or roughly $469 million. Eleven percent of the population or some 23 million people are at the Federal poverty level; perhaps another 20 million people or about 9 percent of the population might be classified as medically indigent. Until the government is willing to make a realistic commitment toward making essential oral health care services available for the poor, it would seem a misplacement of priorities to launch a broad-scale, federally-funded program providing health benefits to others.

Briefly, let me also take note of two other related issues. The Association's strong support for the original Health Profession's Educational Assistance Act of 1963 and succeeding laws have resulted in increasing the number of dental schools from 48 to 59 and the number of first year dental places from 3,770 to 5,935. This has been accompanied by a vast increase in the number of training programs for dental auxiliary personnel. Also to be noted is the Association's long-time support of the activities of the National Institute of Dental Research and the Association's collaborative research program at the National Bureau of Standards. These have produced technological improvements and practice innovations that have increased dentists' productivity immensely.

Except for scattered problems of distribution of dentists, being addressed through the National Health Service Corps and other programs, we believe the resources exist to provide reasonable

accessibility to dental care for our people. In this connection I would ask the Committee to note that, unlike some other elements of the health care system, fees in dentistry have remained relatively even with services generally as measured by the Consumer Price Index.

To turn now to more specific national health insurance issues, we have attached to our statement a number of exhibits covering cost estimates for various levels and scopes of coverage for different income and age groups, the availability of dental manpower and other resources and additional data. We have attempted to identify categorical aspects of the national health insurance issue and address them separately.

1. Benefits - Because oral health is an integral part of total health, the American Dental Association believes that a national health policy cannot be truly comprehensive unless it includes a dental health component. The Association recommends that comprehensive dental services for children and emergency services for all be the highest dental priorities. The fact that many of the proposals before Congress include comprehensive dental services for children is consonant with the profession's longheld conviction that preventive dental care, undertaken in childhood, is a priority essential to any concerted effort to control and prevent dental disease. If, because of fiscal constraints, limitations on children's dental benefits are necessary, there should be a progressive schedule to phase-in children by age-group rather than to scale-down the comprehensive services. In cases where covered services may legally be performed by a dentist or a physician, benefits should not be denied based upon the patient's selection of a duly qualified and licensed practitioner.

2. Financing - The Association believes that public funds should be used to provide health care only for those who are unable to afford it. We adhere to this not because we wish to make any distinction between the accessibility or quality of services to be received by the indigent or medically indigent. On the contrary, we believe the opportunity to receive necessary services should be equal. We think this will be more likely to happen by concentrating public funding on those who need such support. On the other hand, the continued assumption of financial responsibility by the self-sustaining will, we think, help emphasize the role individuals should play without penalizing them in regard to necessary services. Deductibles and co-insurance at levels that do not seriously hinder accessibility are,

thus, generally desirable, The Association does not believe though, that they should be applied to basic services such as periodic examinations, diagnosis, prophylaxis, fluoride topical applications, plaque control programs and emergency treatment.

We would further recommend that private funds expended in the private sector should provide the financial base for any national health program. The American Dental Association considers acceptable several methods for financing in the private sector such as tax credits scaled to income or employer-employee contributions toward private insurance premiums. Public funds supporting dental health benefits for the needy should be provided through general revenues and should be clearly earmarked for such purposes.

Individuals and families prefer to select their own plans and make their own choices. Incentives to encourage healthier lifestyles and good health habits obviously are desirable. Some private dental plans provide lower copayments for beneficiaries who seek regular preventive care.

3. Administration - The Association believes that any national health program should be administered by non-governmental agencies. Approximately 35 million people are now covered under private dental prepayment plans with more efficiency and lower administrative costs than we believe would be achieved under a government administered program. Since the California Dental Service, a private non-profit prepayment organization, took over administration of the dental portion of that State's medicaid program, utilization has been increased and administrative costs have been reduced. The Association does not believe that private health insurance companies should be legislated out of business. Rather, the use of dental service corporations, insurance companies and other private agencies should be strongly encouraged.

States might well be given the responsibilities for monitoring carrier performance, verifying eligibility and providing such other administrative checks as are necessary.

4. Consumer Role - The Association endorses the concept of consumer representation in any national dental health program. Consumer representatives should be involved in an advisory capacity on such issues as: review of the program; education of the public on prevention of dental disease and appropriate utilization of the program; grievance procedures established for the program, and administration and evaluation of the program.

5. Cost Effectiveness - The Government's Consumer Price Index documents that, under the existing system, dental fees have not escalated beyond the rate of inflation for "services" in the economy during the last twenty years. It can be expected that this containment will continue without artificial and selective controls or health care rationing. In addition, emphasis on preventive dental care for children will itself be a cost effective measure for the future.

6. System Reform - As noted, we believe that the dental component of any national health program should be founded upon the traditional efficient system of delivering dental care. Such deficiencies as exist can, we believe, be remedied with necessary improvements and new demands being accommodated. This has occurred during the last decade as the number of beneficiaries of private prepayment plans quadrupled.

7. Payment Systems - The Association believes that the usual, customary and reasonable fee concept should be given priority. This has proved workable and controllable under a large number of dental prepayment programs operated on a risk basis. In many programs where this system has been realistically related to the cost of delivery of dental services and clearly explained to beneficiaries, it has proved satisfactory to practitioners, patients and carriers.

With respect to using the payment system to attract practitioners to medically underserved areas, it is believed that other alternatives are more likely to succeed; such alternatives include tax incentives and the National Health Service Corps.

8. Quality Assurance - Concurrent with the growth of dental prepayment has come the profession's more formal development of sound, viable and impartial peer review mechanisms, designed to assist in answering questions raised about the qualify of care. Beyond this, the Association is presently nearing the completion of a cooperative effort with HEW to identify and further refine existing quality assurance systems in dentistry. These mechanisms should be utilized in a national program. The review should include assessment of the quality of services performed, the appropriateness of procedures, diagnosis and treatment planning as well as whether the services are performed in accordance with professional standards. In the event Professional Standards Review Organizations are designated as review mechanisms, dentists must first be afforded full and equitable participation at all levels of these organizations. State governments should continue to have the responsibility for regulating the qualifications of health service providers.

9. Phasing-In - As already indicated, any phase-in should begin with comprehensive dental care for children by age group with emergency dental care for others. The first order of business for the Administration and the Congress should be a program that will provide accessibility of dental care for the poor, particularly children and the elderly. In this latter connection, the Association favors inclusion of dental services for the elderly under Part B of Medicare.

10. Use of Auxiliaries - The Association believes that the dental profession has been imaginative and progressive in the use of auxiliaries. The most recent Survey of Dental Practice documents the fact that over 90 percent of independent dental practices employ at least one dental auxiliary. At the same time, a number of dental practice acts have been changed to permit greater delegation of duties by the dentist. It is, of course, absolutely essential that the protection of the public be paramount in deciding what duties can be properly delegated.

11. Supply Personnel - The number of dentists and other members of the dental health team has grown greatly in recent years. Dental school enrollments, for example, are more than 50 percent larger today than they were in 1964.

There is, of course, always a concern as to whether the personnel supply will be adequate when additional insurance programs are enacted. A pragmatic answer to the question was at least partially given in recent years as group dental prepayment expanded. In some communities, prepayment beneficiaries in the thousands were created literally overnight. The Association attempted during the early 70's to monitor this growth with respect to accessibility. Everything we learned from observation and from inquiries to group purchasers such as corporations or unions indicates that the present system readily absorbed the increase in demand.

In this respect, it is worth noting that, in the last Survey of Dental Practice, only 8.6 percent of all dentists reported an average waiting time for initial, routine appointments of a month or more. Nearly 60 percent reported a waiting time of between 3 and 14 days for such non-emergency visits.

In order to continue and explore this question, the Association has spent over $400,000 in the past few years to mount and implement a dental planning information system. Already gathering data in nearly 20 states, the system attempts better to measure productivity of the dental team rather than by using the less useful dentist-to-population ratio. It also attempts to project

possible increases in demand according to demographic characteristics of the population. We believe the system--intially developed under contract with a disinterested academic agency--is proving a useful tool for providing more precise manpower information. The Association is also actively cooperating with the National Center for Health Statistics in this general area.

This, then, comprises the view of the American Dental Association in regard to dentistry's place in a national health insurance program. Government in our society is an instrument of massive influence. Because of its tremendous power and its potential to effect change, we sometimes are unwisely persuaded to charge it with the responsibility of curing all our ills and correcting all our deficiencies. But the record of government in health care should convince us of the advisability of proceeding in a deliberate way and directing the government's potential for change to specific problems in our society in a prioritized order. We submit that the first of these priorities must be the health of the nation's poor.

May I say once more that we are appreciative of this opportunity to appear before you.

DESCRIPTIVE INDEX OF EXHIBITS

Exhibit 1 shows estimated cost of covering the entire population between the ages of 1 to 17 (62.4 million) with a comprehensive dental care program with no deductible and no co-payments. The cost is $2.9 billion.

Exhibit 1 also shows same estimates, but with varying levels of co-payment, ranging from 100% paid by plan to 70% paid by plan.

Age groups are divided by 6 income groups.

Exhibit 2 shows cost of a comprehensive program with no co-payment for the total population, ages 1 to death. It gives a total estimated cost of $12 billion, about $3 billion more than is presently spent from all sources for dental care. The population is divided into 3 age groups and each age group is sub-divided into 3 income categories.

Exhibit 3 shows cost of emergency care for entire population between ages of 5 and death. It shows utilization by age group and gives a total estimated cost of $495 million. It includes a definition of what is encompassed in "emergency care".

Exhibit 4 shows cost of emergency care divided into 3 age groups which are further sub-divided into 3 income categories. The cost estimated is $493 million, slightly below the overall cost shown in Exhibit 3, which is merely an outcome of the different type of breakdown.

Exhibit 5 shows the history of personal dental care expenditures divided by private and public source, for 1960, and from 1965 through 1976. The 1976 total is $8.6 billion.

Exhibit 6 shows enrollment in private health insurance programs for dental, hospital and physicians' surgical services. It traces it from 1967 through 1975. For dental coverage, the total is divided between commercial insurance, Delta, Blue Cross-Blue Shield and independent plans (Total coverage in 1977 is 35 million).

Exhibit 7 shows payment of benefits under group dental prepayment, categorized by type of carrier, for 1968 through 1975. In 1975, benefits payments totally were just under $1.1 billion, about 14 percent of all payments made for personal dental care services.

Exhibit 8 shows utilization experience for various types of group dental prepayment plans over the first five years of each plan.

Exhibit 9 shows, for selected years from 1950 through 1976, total health care expenditures, dental care expenditures, and dental care expenditures as a percent of total health care expenditures. In 1976, 6.2 percent of the health dollar was for dental care.

Exhibit 10 shows per capita expenditures, for selected years between 1950 and 1976, for total health care expenditures, dental care expenditures and dental as a percent of total. In 1976, just under $40 was the per capita dental expenditure (including both users and non-users).

Exhibit 11 shows personal dental care expenditures, for 1967 through 1976, for 3 age groups. The figures are divided between private and public funds. In 1976, a total of $8.6 billion was spent: $2 billion by those under 19; $5.9 billion by those 19 to 64 years of age; $722 million by those 65 years of age or older.

Exhibit 12 shows, for 1967 through 1976, the percentage of dental care expenditures, both public and private, compared with total health care expenditures for all ages and 3 age groups. Note, in just the private sector, it is 11 percent for all ages.

Exhibit 13 shows aggregate private and public expenditures in dollar figures, from 1967 through 1976, for all ages and 3 age groups. It also shows percentage of total expenditure by private and public source.

Exhibit 14 shows per capita expenditures for dental care, in dollars and for all ages as well as 3 age groups, from 1967 through 1976. It divides total per capita expenditure between public and private source. This includes users and non-users. Per capita expenditure for those under 19 is $28 in 1976; for 19-64 years, $47; for 65+, $32.

Exhibit 15 shows public expenditures for dental care as a percent of total dental care expenditures. It lists such expenditures from 1967 through 1976 and shows figures for all age groups as well as 3 age groups. In 1976, 5.5 percent of all dental expenditures by all ages was from public sources.

Exhibit 16 shows Consumer Price Index movement of dental fees in comparison with other, selected CPI items for all years, 1950 through 1976. At the end of 1976, dental fees were less than medical care generally, services generally, physicians' fees or hospital costs.

Exhibit 17 shows growth of dental manpower supply and projected population increases for selected years. It also lists the ratio of the 3 dental auxiliaries to dentists as of 1973. Between 1964 and 1975, total dental school enrollment had increased 51 percent.

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November 1, 1978

ADMINISTRATIVE OFFICE:
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JOHN M. ROSENBERG,
DIRECTOR

Mr. Richard Froh
Sub Committee on Hearth and Science
Committee on Human Resources
Washington, D.C. 20510

Dear Mr. Froh:

Enclosed please find the written testimony regarding the National Health Insurance Bill from:

Jay Blevins
Nick Frasure
Regional Black Lung Association
Bill Worthington.

Please let me know if any further information is required.

Yours very truly,

Laura Bowers Vandergaw

Laura Bowers Vandergaw
Attorney at Law

Enclosures:

LBV/bc

TESTIMONY OF BILL WORTHINGTON PRESENTED
IN SUPPORT OF A NATIONAL HEALTH INSURANCE BILL

My name is Bill Worthington. I was born and raised in the Appalachian Mountain area, making my home in Harlan County, Kentucky for most of my life. I am a disabled coal miner, having spent 33 years in the underground mines. I am currently employed by the Council of Southern Mountains in Clintwood, Virginia as the director of the Mine Health and Safety program.

In my various capacities dealing with grasss roots organizations and my employment, I have always been aware of the tragic toll excessive medical costs reap upon poor people. However, I have never had to personally confront the immensity of the situation until this May when my wife was stricken with a life threatening stroke.

My income is limited to about $700.00 per month, derived partly through my employment and partly through my United Mine Workers of America Pension. Due to the severity of my wife's condition, she spent more than 5 weeks in intensive care at a hospital in Lexington and an additional 4 in the hospital. She is currently in a skilled nursing home in Corbin, Kentucky.

I have accrued hospital and medical bills in excess of $22,000.00 and must continue to provide hosptial care for my wife. She was receiving no benefits at the time of her illness and it took more than a month to obtain SSI benefits which carried with it a state medical card. During that period of time, because of the costs which included more than $400.00 in just ambulance fees, I was unable to pay my monthly debts. As a result, my pickup was repossessed, my utilities were cut off and all of my bills at this time are overdue.

In addition, my health is poor, but I cannot afford to take time off from work to see that I get proper medical care. My medical card from the United Mine Worker's of America is virtually worthless since many doctors, hospitals and pharmacists in the area refuse to accept them because they either never receive the proper amount of reimbursement or it comes 10 months after submitting a bill. I receive neither Social Security benifits nor black lung benefits.

If I were not fortunate enough to have the wherewithall to keep my job, my wife would not have survived her stroke. The hospital would not accept her without advance money and the nursing home required $500.00 to admit her. If she is ever fortunate enough to return home, she will require home nursing service--a comodity non-existent in my area. There is no

way of assessing the amount of medication it will take to improve her health let alone the cost of physical therapy it will take to make her strong again.

I strongly urge the congressmen in the country to support some sort of National Health bill that will cut the costs of health care to the consumer. Unfortunately all of us will be consumers at one time or another, usually at the most inopportune time. Without money, we are forced to see our loved ones do without proper care and do without it ourselves. Regardless of any social consciousness raising techniques, doctors will not accept patients who cannot pay the costs of medical care and we are left to do the best we can, which is monstrously inadequate considering the potential loss.

Respectfully Submitted,

Bill Worthington

Bill Worthington
Drawer N
Clintwood, Va 24228
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TESTIMONY OF NICK FRASURE
REGARDING THE NATIONAL HEALTH INSURANCE BILL
October 27th, 1978

My name is Nick Frasure and I have been a native of Eastern Kentucky all my life. I am employed by Appalachian Research & Defense Fund of West Virginia and have worked and organized around health care issues for over 12 years. Some of the issues we have organized around are:

1. Organizing and setting up the Mud Creek Health Project. This was the first clinic in Eastern Kentucky organized and controlled by poor people.

2. Organizing the Kentucky Miner's Health Care Corporation. An organization composed of disabled coal miners and their families who informed needy families of federal and state benefit programs available. This organization also provided lay-advocate representation at hearings, provided transportation, etc.

3. Through working with the Regional Black Lung Association, we were successful in getting respiratory clinics for miners and their families having respiratory problems.

4. After the Health Planning & Resources Development Act was passed, we organized the Eastern Kentucky Citizen's for Better Health Care for the purpose of dealing with the Health Systems Agency here in our area. The Eastern Kentucky Citizen's for Better Health Care had to force the Health Systems Agency to re-write their proposal and to include low-income and minority groups on their governing board of directors.

Our office is open to low-income people who need assistance in confronting the bureaucratic processes, in their attempts to obtain benefits rightly theirs. Inherent in these problems, one of the main issues addressed by us involves health care issues. Some of the problems we are plagued with are:

1. Emergency rooms being understaffed. People having to wait 3 or 4 hours - just to be told to come back tomorrow and see own physician.

2. Doctors and druggists are refusing to accept United Mine Workers medical cards because the UMWA are not paying their bills.

3. It is almost impossible to get local doctors to return to Eastern Kentucky. We are overly populated with foreign doctors who cannot speak English.

4. Drugs are too expensive and often unnecessarily prescribed.

5. Needless surgery is being given.

6. Dental care is non existant for the poor.

7. Doctors and hospitals often charge insurance/medical cards and their patients for the same services.

8. Home Health Care is obsolete.

9. Ambulance fees are very steep and all to often the ambulance attendants service is not good - too little training.

10. Old people are really hurting. Too often they have no transportation to get to a doctor - must put up cash for the physicians' bill and then must set 2 or 3 hours before seeing doctor. Then to be sent to a druggist to fill their prescriptions that rarely run under $50. Because of this many, many of our elderly people are doing without medical attention..

11. Machinery and office space too is expensive and this cost is passed down to patients.

12. Nursing Homes are outrageously expensive, and it is virtually impossible to pay $100 a day for a private nurse. Old people want to die at home and not in a hospital.

I could go on and on about our many health care needs and problems. The whole problem boils down to the lack of money to acquire adequate medical care and a National Health Insurance Bill would eliminate this problem.

Respectfully Submitted,

Nick Frasure

Nick Frasure
205 North First Avenue
Prestonsburg, Ky. 41653
(606) 886-8318

Statement of the Regional Black Lung Association in Support of a National Health Insurance Bill

My name is Bill Worthington. I am the chairman of the Regional Black Lung Association which includes Black Lung Associations from all of the Coal producing states and many of the counties within the various states. I am also on the National Client's Council, chairman of the Kentucky Client's Council and on the Board of Directors of the Appalachian Research and Defense Fund of Kentucky and the Appalachian Research and Defense Fund of West Virginia. I am the past president of the Kentucky Welfare rights organization.

Health care is a particular problem in Eastern Kentucky and the rest of the Appalachian states. It is very difficult to obtain highly qualified physicians because the area is so rural and there is not adequate access to the sophisticated medical equipment of large urban areas. Therefore, many of the local physicians are from foreign countries and they do not understand the residents way of speaking and neither do the local people understand them. The local hospitals are often over crowded and in cases of emergency it is a three to four hour drive to larger cities where sophisticated medical attention can be given a seriously ill patient.

Our organization has come into contact with dozens of people who are receiving no medical care at all. The miners who have a health card through the United Mine Workers of America are finding that physicians and druggists in the area refuse to accept the cards because the UMWA Health and Retirment Funds do not pay the bills or pay them as much as 10 months after they are submitted. If the computer system in Washington DC fails, and it apparently often does, then the people are without medical services. For instance, a man from Floyd County, James Prater, has a medical card. He also has a wife who was recently hospitalized and a child who suffers from cancer. The only aid he recieves is his miner's pension which carries with it the medical card. His doctor will not accept the card because of the bureacratic mess of not being paid, his son must go to Lexington monthly for treatment and those costs must be paid. Those costs are high and he often simply cannot obtain the necessary medical services. That problem is not uncommon.

Our organization met recently with a physician who is interested in obtaining some of the 7 1/2 million dollars recently appropriated for respiratory clinics under the new black lung bill. He has machinery which he claims costs him upward of $100.00 per patient to run and must pass that cost on to the patient. Therefore, the cost to a man for a respiratory diagnosis often runs to more than $150.00. That does not include medication, therapy, or hospitalization if any is required.

People who do not have the money to visit doctors must go without medical treatment completely. Preventative health care under these circumstances is a pipe dream. Therapy for victims of respiratory diseases such as black lung, cancer and other diseases is not available.

The poor and middle income people cannot afford to become ill. Even for the rich an extended illness can wipe out the family income, although the rich are usually well insured. The poor person cannot afford expensive insurance on an income of less than $300.00 a month, and often when they do get insurance, they are cheated because the policy contains more loopholes than coverage.

Our organization has lobbied extesively for adequate health care for old and disabled miners and has made some progress in that area. Still, our progress depends on the continuing success of the coal industry and the tenuous possibility of peace between labor and industry in the coal fields. Until the government becomse involved in keeping the price of health care down, poor and middle income people will not be able to obtain adequate medical care.

Without a national health insurance bill, preventative health care, the realistic answer to medical problems, is not even a remote possibility. People cannot afford the luxury of a needed yearly physical examination. The cost of the average doctor's visit is at least $20.00, and that increases with the amount of equipment used to give a patient various types of diagnostic tests. Medication is very high--very few people who are under a doctor's care pay less than $25.00 per visit to the druggist. Hospitals require cash in advance in the amount of anywhere from two to five hundred dollars. Home health assistance is not available because of the lack of trained personnel and the cost of obtaining the highly skilled nurses. A national health insurance plan or something akin to it is necessary for the survival of the poor in this country.

Respectfully Submitted,

Bill Worthington

Bill Worthington,
Chairman, Regional Black Lung Association

NATIONAL CONGRESS OF AMERICAN -INDIANS-

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October 11, 1978

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Mr. Richard Froh
Senate Sub-Committee on Health and Scientific Research
Committee on Human Resources
Washington, D.C. 20510

Dear Mr. Froh:

The National Congress of American Indians, representing more than 140 tribes, has viewed with great interest recent developments in a proposed National Health Insurance Plan.

Enclosed you will find a copy of an issue paper on National Health Insurance which was prepared and submitted by the Health and Social Welfare Concerns Committee at the 35th Annual NCAI Convention, which concluded less than three weeks ago in Rapid City, South Dakota. Please be advised that this paper was approved unanimously.

At this time, we would ask that this document be included for the record on the oversight hearings on Senator Edward Kennedy's new outline for National Health Insurance. We would also request that Indian representatives be invited to give testimony at forthcoming regional hearings.

We thank you personally for all your efforts on behalf of the native peoples of this country.

Yours sincerely,

Albert W. Trimble
Executive Director

AT/mm
Enclosure

AMENDED 1978 NATIONAL INDIAN POSITION
ON
NATIONAL HEALTH INSURANCE

I. Introduction

American Indians and Alaskan Natives (American Indians), along with other citizens, have been concerned about the planned adoption of a National Health Insurance Program in this country. On the basis of their unique legal, historical and moral relationship with the federal government, Indians receive their health care from the Indian Health Service (HEW) and more recently from tribally run health programs as well. NHI, as the largest health program ever adopted by the federal government, promises to have a major impact on the Indian Health Programs. NHI could be of great benefit to Indian people, helping them to improve their level of health, which is now the lowest of any population group in the country. On the other hand, NHI could result in great harm to the Indian people, destroying the existing Indian health system, which they wish to retain and to which they are entitled. These issues must be resolved before NHI legislation is adopted.

Indian tribes, health boards and organizations have spent more than a year analyzing the various NHI proposals and discussing their possible impact on the Indian health system. Out of this effort, the Indian community has developed a consensus, Indian position on NHI. The position, which is presented herein, is in the form of certain basic principals that the Indian community believes must be incorporated into any NHI legislation to insure that it benefits Indian health and does not diminish the level of health services now available to Indian people. Whatever NHI approach is

adopted by the federal government, it must, in the legislation, recognize and build on the dual rights and status that Indians hold.

II. Statement of Position

The core of the Indian consensus position is that Indians should be included in the basic NHI programs with a separate Indian Title, so that Indians can continue to build their own unique Indian health programs.

A section of the NHI legislation must specifically address Indian concerns by (1) reaffirming Indian people's right to their special Indian program; (2) defining the relationship between NHI and Indian health program; and (3) strengthening the IHS by incorporating several of the basic elements of NHI into the IHS system.

NHI legislation must also recognize and preserve the principles of tribal sovereignty and tribal self-determination. It must also define the relationship between non-reservation Indian health programs and NHI.

Because the Indian health system is unique, the principles set out will not fit precisely into NHI legislation; instead, it will require a separate section dealing specifically with Indians. However, because of the significant impact NHI could have on the existing Indian health care system, we believe that this separate section is justifiable, and in order to protect Indian rights, the Indian community considers it essential. Since the final shape of the NHI legislation has not yet been determined, it was not possible to provide specific legislative language. However, when the final form of NHI is determined, representatives of the Indian community will be pleased to work with the federal government to transform the basic principles contained in their position into concrete statutory language.

III. The Indian Position on NHI

Principle #1: The NHI legislation must specifically support the continuation of the IHS-tribal-urban Indian health system as the special federal mechanism for financing and delivering health services to Indians; and as such, NHI must not supplant, but rather become an additional financial resource for this financing mechanism to the delivery system.

The NHI legislation must reaffirm the legal, historical, and moral federal responsibility for health care to Indians through the IHS-tribal-urban financing and delivery system. In the Indian Health Care Improvement Act, the Congress once again recognized the special legal and historical relationship that has existed between Indians and the federal government for over 160 years. The Act states: Sec. 2 The Congress finds that -

(a) "Federal Indian health services to maintain and improve the health of Indians are consonant with and required by the Federal government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."

This responsibility has been carried out through the direct financing of Indian health programs by Congress to IHS and the direct delivery of health programs. (NHI must be used as an additional financial resource and not supplant this direct financing method.) NHI must not contain any provision which directly or indirectly lead to a dismantling of the IHS direct delivery system.

The need for the continuation of the existing delivery and financing system is explained below:

A. The Direct Delivery System

The IHS-tribal delivery system of hospitals, clinics, staff, outreach and preventative programs, etc. must be continued because:

(1) It is the only health system available to the majority of Indian people and no NHI proposal provides for the establishment of a delivery system that could replace IHS. If NHI was used as the basis for dismantling the IHS delivery system, Indians would be required to depend on the private medical system which has demonstrated that it is neither willing nor able to serve the remote areas where most reservations are located and to provide culturally sentsitive services to Indian people.

(2) The Federal policy of Indian Self-Determination offers tribes the option of assuming policy and/or operational control of the IHS programs serving their people--if the tribe wants to assume the responsibility and at a pace determined solely by the tribe. Dismantling the IHS delivery system would leave no program over which tribes could exercise their right to Self-Determination.

B. The Existing Financing Mechanism

The existing financing mechanism must be maintained because:

(1) Direct Federal financing of health services to Indians, from Congress to IHS, is the clear and visible manifestation of the special federal commitment to Indians on health. Our history has shown us that as soon as a separate appropriation for Indians is eliminated, all of the rights and obligations that accompany that appropriation are quickly forgotten. The Indian situation is a unique one, and a separate appropriation is the only mechanism that has ever guaranteed proper consideration of our special situation.

Since there is no intrinsic merit in switching appropriation sources and since any perceived collateral benefit cannot sufficiently compensate for the dangers such a switch poses to the Indian people, it is the consensus Indian position that NHI should become an additional financial resource for direct appropriations to I.H.S. and tribal health programs.

(2) The Indian health financing and the delivery systems must be kept unified if there is to be proper accountability--to Congress, and to the Indian people. Since the source of funding is ultimately the same, it makes little sense to develop a complicated and confusing series of channels and levels in order to "involve" IHS and Indians in NHI. Such a system would be administratively awkward, would impose additional administrative costs, and by separating delivery and financing, would make accountability that much more difficult.

(3) IHS provides a range of services that are not covered under any NHI proposal--environmental and sanitation services, etc. If the IHS financing system was replaced by NHI, Indians would end up receiving fewer services than are now available to them--thereby adding to the serious health problems which Indians are already facing.

Principle #2: Indian People should be exempted from any compulsory NHI financing charge. Indians do not have to pay now for their use of IHS and tribal health services. As stated by the Director of IHS, "IHS is like an HMO, in that Indians have prepaid for their services many times over--

with their land, water, and resources." Since Indians will be continuing to use IHS-tribal services, it would be unjust to suddenly begin to charge them for the health services that they have always received at no cost. It would also be in violation of the special federal obligation to Indians.

Indians are presently required to pay the Medicare payroll tax and many elderly Indians also, unknowingly, pay the monthly Medicare premium. Yet, because they have IHS, their utilization of Medicare is extremely low. As a result they end up subsidizing the Medicare program. This situation must not be repeated under NHI.

Therefore, the legislation should specifically provide an exemption from compulsory financing charges for Indians who use IHS-tribal services. However, voluntary participation in NHI should be left open to those Indians who would prefer to use non-IHS-tribal services or for whom the IHS facilities may not be convenient.

Principle #3: Certain elements of the NHI approach, the guaranteed benefit package, the individual's entitlement to that package, and prospective funding to implement that guarantee should be incorporated into the IHS system in conjunction with the adoption of NHI.

IHS is the Indian's own health system and we want it to be continued; but we also want it strengthened. IHS, which assumed the federal responsibility for health care to Indians in 1955, is severely underfunded at the present time. Its own internal review found that its existing appropriation allows it to provide only 53% of the services it is supposed to be providing to Indian people. This severe underfunding means that many Indians who need surgical procedures get put on waiting lists and must wait 2-4 years

to receive them (the infamous IHS surgery backlog). In the outpatient clinics, it means long waiting lines, overworked staff, rushed examinations, and insufficient equipment to perform necessary tests and diagnoses. The end result is an inadequate health delivery system which causes unnecessary death, deterioration of health, and suffering among the Indian people.

Statistics show that the rate of tuberculosis for Indians and Alaska Natives is 6.5 times higher than the rate for all other U.S. citizens; the rate for diabetes is at least three times higher than all other U.S.citizens; and while respiratory and gall bladder illness statistics are not reported in the general population, Indian Health Service officials state emphatically that the rates for these diseases among Indians and Alaska Natives are significantly higher than that of the general population. Otitis media, an infection of the inner ear, continues to be a leading cause of disability among Indians and Alaska Natives. Although surgical treatment can generally prevent the long-term and serious disabilities of deafness and learning disabilities resulting from Otitis media, only a fraction of this essential surgery is now being provided. The infant mortality rate among Indians is 1.1 times the national average, while the Indian birth rate continues at a rate twice that of other Americans.

Indian communities have an extremely high incidence of mental illness, alcoholism, accidents, homicide, and suicide. The suicide rate within Indian communities is approximately twice as highas the total U.S. population and the Indian and Alaska Natives have an average life span of 65.1 years, while every other American can expect to live to the age of at least 70.8 years.

The underlying cause of this situation can be traced to certain inadequacies in the IHS authorizing statute and appropriation system. The IHS authorizing legislation does not contain a guaranteed health benefit package--the specified list of covered basic health services that is found in all NHI proposals. Instead, it simply authorizes services "for the relief of distress and conservation of health." (42 USC 13, The Snyder Act.)

More importantly, the IHS appropriation process is not structured in a manner that insures IHS the funding necessary to provide a basic benefit package to all Indians who need basic medical services. IHS does not have the open-ended funding that is available to Medicaid. Nor is its appropriation determined through the prospective funding method recommended in many NHI approaches--where a facility's funding from NHI funds would be directly tied to its projection of expected utilization by its client population. Rather, IHS is funded on a "historical budget", which has no rational relationship to the actual rate of utilization of IHS services by the Indian population. The "historical budget" consists of the arbitrary base amount IHS was allocated in 1955, (when it was established in HEW) plus the annual increases it has been given since then. While at times the increases have been generous (in a relative sense), they too have been arbitrary in that they were based on the previous year's budget which was arbitrary to begin with and never on a determination of actual utilization rates and the actual cost of providing these utilized services.

The result of this "historical budget" is IHS's present situation, in which it is trying to "squeeze" all needed services into a budget that realistically can pay for only 53% of them; with the long backlog of needed

surgery, overcrowded and underequipped facilities, unnecessary deaths and disabilities, etc.

This situation is in conflict with the principles behind and the mechanics of most NHI approaches. One of the motivating principles behind NHI is that every American should have financial access to at least the basic kinds of health services; e.g., no American should have to wait 2-3 ~~years for needed~~ surgery. NHI guarantees that funds will be available to pay for the services specified in the benefit package whenever a person needs those services. Many of the NHI approaches recommend that hospitals and other health facilities be reimbursed through a prospective funding mechanism; a facility will project its expected utilization for the coming year for NHI covered services, estimate the cost of providing those services, and then be given that amount by NHI (with adjustments to be made at the end of the year). This is in direct contrast to the way IHS is funded; it is given an arbitrary amount and then required to provide all needed services--whether demand is for one, a hundred, or a thousand of those services. To permit IHS to continue to operate under this system, while all other Americans have a guaranteed benefit package, is truely to relegate Indians to a second class status in health because of their desire to retain their special relationship with the federal government.

It is therefore, the consensus Indian position that the benefit package contained in the NHI Act should also be guaranteed to Indians through IHS. The special Indian section of the NHI legislation should amend the IHS authorizing legislation to 1) incorporate a benefit package into the IHS program comparable to that provided by NHI to all other Americans; and

2) establish an appropriation mechanism that guarantees IHS the funding needed to provide the services in the benefit package to all covered Indians. That is, the legislation should require IHS to project the number of NHI covered services it will have to provide in the forthcoming year and the cost of providing those services. IHS would then automatically be entitled to have that amount appropriated to it by Congress through IHS's existing appropriation channels, (the Sub-committees on Interior and Insular Affairs of the House and Senate Appropriations Committees). Funds for services which IHS provides but which are not covered in the NHI benefit package would continue to be appropriated in the same manner as they are now. The legislation should also define eligibility for the IHS benefit package to include all federally-recognized Indians.

Principle # 4: Indian tribal governments must be recognized as the appropriate governmental entities for administration of health programs on their reservations. The NHI legislation must not give State governments authority or jurisdiction over Indians or Indian health programs.

Various NHI approaches propose to rationalize the health system in this country through increased governmental regulation. Many of these proposals would give state and local governments a significant role in this increased regulation--planning, institutional certification, monitoring, fee-setting, etc. None of these proposals recognize the sovereign status of Indian tribes or prohibit state and local governments from exercising these regulatory powers on Indian reservations. Thus the regulatory portion of NHI promises to erode the sovereignty of Indian tribal governments. These provisions must be changed to reflect the sovereign status of Indian tribes.

An unbroken line of court cases over a period of 150 years has recognized the sovereign status of Indian tribal governments over Indian

reservations, and the complete exclusion of state governments. The cases have ruled that states cannot exercise civil or criminal jurisdiction over Indians on reservations, cannot tax Indians, and generally cannot exercise any other authority over Indians living on Indian lands.

The federal government has recognized the importance of tribal sovereignty to the future of Indian people. In recent statutes, Congress has included specific language to protect tribal sovereignty and to prevent state erosion of it. For example, in the National Health Planning and Resource Development Act, tribal health programs were specifically exempted from the authority of Health Systems Agencies to review and approve proposals for federal health funding. Title II of the Social Security Act (Grants to States for Social Services) permits Indian tribes to establish their own standards for reservation day care centers, institutions, and foster homes.

Therefore, it is the consensus Indian position that Indian tribal governments be given the sole authority for regulating health programs, funds, and resources, and carrying out any other governmental function on their reservations; and that State governments be given no authority under NHI to carry out governmental functions on Indian reservations.

Principle #5: The principles of Indian tribal Self-Determination must be incorporated in NHI legislation.

The federal government has formally adopted the policy of Self-Determination for Indian Tribes. As established by the Indian Self-Determination Act of 1975 (P.L. 93-638), Indian tribes, not the federal government, are to make determinations regarding the needs and priorities of their tribal members; the federal government will respect those determinations and will

assist tribes in developing the capability to implement tribal goals and objectives. The principles must be incorporated into NHI, in so far as NHI affects health care to Indians, in the following manner:

> The Self-Determination Act gives the tribes the option of taking over BIA and IHS programs and running them as tribal programs. The Act and the Regulations specifically state that the federal government will not require tribes to take over federal programs; it is a function of the tribe to decide if it wants to do so and how and when it wants to do so. NHI must not be used to compel tribes to assume responsibility for IHS health programs at a pace different or faster than that determined by the tribe. NHI must not be structured to reward tribes that take over IHS programs and to punish tribes that do not. Health benefits to Indians must flow equally to them, whether the health program on their reservation is administered by the tribe or by IHS.

Tribes must also be given authority to revise or adapt IHS standards for the delivery of health care in order to make that delivery more responsive to the tribe's values and traditional methods of providing for the health of its people.

Resources must be made available to tribes so they will have capabilities to carry out these functions. Under the National Health Planning Act,

the federal government authorized the creation of Health Systems Agencies throughout the country to carry out health planning for their areas. The Act set the minimum level of staff and staff competency required to perform these planning tasks and then provided the HSA's with the funding needed to obtain this competency. The Act also established Health Planning Centers to provide backup to the HSA's. No comparable program has been established to enable tribes to obtain an equivalent level of competency. Most tribal health boards have no full-time staff; tribal health departments have no steady and adequate source of funding to permit them to meet their Self-Determination responsibilities. It is the Indian consensus position that Congress must provide Indian tribes with resources and backup support comparable to that provided HSA's so that tribes will have the capability to carry out their responsibilities under NHI, responsibilities which appropriately should reside in the tribe under the principles of Indian Self-Determination.

Principle #6: Urban Indian Health Programs must be designed as eligible providers for the purpose of receiving reimbursement from both IHS and NHI when those clients provide covered services to eligible persons.

Non-reservation Indian people usually have little direct access to Indian Health Service and are largely dependent on the non-Indian health care system. In some urban areas there are Indian health programs that provide some health services to Indians. At present urban Indian health programs do not have sufficient funds to deliver the quantity and range of services required. Hence, national health insurance is regarded by many non-reservation Indians as a means by which they can obtain greater access

to care. Similarly urban Indian health programs are generally looking to national health insurance as an additional source of funds.

According to the 1970 U.S. Census reports, 48% of the total Indian population resided in urban areas. Current estimates indicate the total population now residing in urban areas exceeds 50% of the total Indian population. The current IHS budget is only sufficient to serve 53% of the health needs of reservation based people. This means that up to 75% of the total Indian population does not receive adequate health care and could not if needed.

Indian people residing in urban areas have relocated mainly because of economic reasons. However, the move to the city has not led to an improved standard of living. In many cases it has represented a diminished standard of living from that which they experienced prior to moving to urban areas. Poverty among Indian people in cities ranges from 30% to over 50%.

The fact that there is a high degree of poverty among Indians directly affects their ability to obtain health care. Accessibility to health care in cities is primarily based on ability to pay. Most hospitals in cities require proof of ability to pay prior to admittance. This fact alone prohibits many urban Indian people from seeking health care from local health providers, i.e., state, city, county, or PHS hospitals or clinics. This lack of low cost health care providers,often times forces Indian people to do without health care rather than face the embarrassment of being denied health care by the existing systems. In some areas Indian people can use existing IHS facilities if they present themselves. But to make use of these facilities requires time off, loss of pay, travel ranging from 40 to 50 miles, and the added expense of that travel.

Congress, during recent years has recognized the need to provide some form of health care for Indians in urban areas and has begun appropriating limited funds supporting urban Indian health programs in a number of cities across the country. These programs, which have been delivering primary health care services to Indian people since 1970, are non-profit private organizations, directed by Indian consumers and providers. Also, some of the urban Indian health programs serve as contract providers for the IHS and are reimbursed for care provided to IHS eligible Indians. NHI legislation must not change this already established relationship as it concerns Indians eligible to receive care under the IHS financed benefit package.

Recognizing the fact that IHS funding is inadequate, the lack of low cost health providers, and that urban Indian people are denied accessibility to the existing systems because of inability to pay, the existing demand for health care is great. The creation of NHI will increase demands for health care which the existing health delivery systems will be inadequate to meet. For this reason, urban Indian health programs must be continued to assure Indian people in cities of the availability and accessibility of health care.

Submitted by the Health and Social Welfare Concerns Committee

Chairman

Senator KENNEDY. The subcommittee stands in recess.
[Whereupon, at 2:30 p.m., the subcommittee recessed.]

# NATIONAL HEALTH INSURANCE, 1978

FRIDAY, OCTOBER 27, 1978

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE COMMITTEE ON HUMAN RESOURCES,
THE SHACK NEIGHBORHOOD HOUSE,
*Osage, W. Va.*

The subcommittee met, pursuant to notice, at 9 a.m. in the Shack Neighborhood House, Osage, W. Va., Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy and Randolph.

Also present: Representative Harley Staggers.

## OPENING STATEMENT OF SENATOR KENNEDY

Senator KENNEDY. We will come to order.

This is the second opportunity I have had since becoming chairman of the Senate Health and Scientific Research Subcommittee to come to West Virginia to explore the need for a national health insurance program.

American society has changed in many ways since our last visit 7 years ago. But the human and economic need for a universal and comprehensive national health insurance program is more compelling now than ever.

The economics of the situation are truly frightening. Everyone today agrees that health care costs are out of control. This rampant inflation takes its toll everywhere—on Federal budgets where the percentage of the Federal dollar spent on health has risen from 4.3 percent in 1963 to 12.7 percent this year; on State budgets where medicaid is the single most rapidly escalating cost; on corporations which must pay more and more each year for health benefits; on the American family, which must pay $2,115 today, and $3,590 in 1983, for benefits which cost $533 in 1963; on the elderly, who pay more for their care today out of their own pockets than the year medicare was implemented.

The Nation as a whole will spend $252 billion in 1981 on health care. That money will pour into a system without cost controls, without quality controls, with uneven access to care, and without any prospects for improvement. Make no mistake about it: Left unchecked, the health care costs will bankrupt this Nation.

National health insurance is the last, best chance to halt this staggering economic waste. This is because cost containment is at the very heart of the health insurance debate.

Every American family knows what it means to live within a budget. It is time the American health care system learned to live within a budget. The proposal I recently introduced imposes such a budget. Under this approach, all health care costs will be prospectively budgeted. The American people will no longer have to hand a national blank check over to the health care industry. No other program to guarantee comprehensive benefits to all Americans will cost less than this proposal. In fact, once cost containment takes effect, the Nation will pay less for health care under national health insurance than if the current nonsystem is left unchecked. That is a fundamental point. The choice is not, as opponents would have us believe, between an expensive new program or no program at all. The choice is between comprehensive benefits for all Americans in a system with cost controls at every level, or a continuation of the current patchwork system, with millions and millions of Americans denied care and costs continuing out of control.

The economics of the situation make a compelling case for national health insurance. But even more compelling is the case that will be made here today by residents of West Virginia, as they relate their stories—of needless personal anguish, of fear of bankruptcy, of fear of bill collectors, of fear of not being able to provide what is needed for loved ones—it is well to remember that it need not be that way. It is not that way for any citizen of any other industrialized nation in the free world except South Africa. In those countries, health is a matter of right. Care is provided whether a person is married or divorced, young or old, employed or unemployed.

It is immoral for a society to tie a family's ability to pay for medical care to the husband's employment status; it is immoral to have coverage removed for a sick youngster because he turns 18; it is immoral to force an elderly couple to sell their home in order to pay medical bills. Yet earlier this week, the residents of Michigan testified to each of these problems. And we will hear more today from the people of West Virginia. We would hear similar stories in every town in this country.

There are many in Congress who believe that national health insurance is an idea whose time has come and gone in the United States. I wish they could all be present in this hearing room today. They would draw very different conclusions. For if health insurance is an idea whose time has gone, then the millions of Americans will continue to share the plight—the needless suffering and anguish—of those West Virginia families who will testify here today. If national health insurance is an idea whose time has gone, then 26 million Americans will continue to have no coverage at all, another 18 million will live with totally inadequate coverage, and 42 million will have inadequate access to health care.

National health insurance is about peoples' lives. It is about the quality of life at times of greatest emotional stress. How a nation cares for its sick is a measure of its humanity, and its humanity is a measure of its greatness.

Today, this committee of the Congress is in the midst of serious consideration of national health insurance. It will last for many months. The debate will be carried to every part of this Nation. We will listen to all sides, to all viewpoints. And in the next Congress,

it is my hope to report a bill from this committee that will, within a system that controls costs and improves quality, provide comprehensive benefits for all Americans.

We want to welcome all of you, and particularly we want to thank Reverend Ebley, who has been kind enough to provide this excellent forum for us here this morning here at the Shack. I think all of us are very mindful that this is a 50-year-old facility which honors the members of the miners—and it is, in a very real respect, a miners' memorial. We are honored to be here to express our very deep appreciation to the reverend and to the Presbyterian Church, and to all the others who keep this facility available to the community. We understand it has very active programs, working with young people, the ceramics class, tutoring and recreation, and a variety of different other functions. It works with some of the special children of the area; we have some the retarded children here today, and that is a matter of very special interest, I know, to our full committee.

We have the handicapped. The children's legislation comes to the Handicapped committee chaired by Senator Randolph. As one who has a sister who takes great interest in the special Olympics programs, which are available to many of the children in West Virginia as well as my own State of Massachusetts, we are very glad that they are here this morning.

We appreciate all the assistance that we have received from the community, the reverend, and all of the guests joining us here this morning to learn about an issue which is of great importance, not only to the people of this county, but the people in other parts of our Nation. We are enormously grateful, of course, to have Congressman Harley Staggers here, who has been a great friend, and who is very interested in the issue of health care. Many of the matters that become legislation on health have been worked out between Congressman Staggers' committee and our own committee. We are extremely grateful and are going to call on the Congressman here in just a moment.

We are most grateful to our witnesses that will be joining us this morning. I do not think it is very easy to talk about illness and sickness in one's family. Most of us would like to keep those kind of issues quiet and private; if we have illness or sickness, we would rather try to deal with it ourselves or in our immediate family. It is not something that you talk about very much. I think that is true in most parts of the country, and it is probably equally true here.

But in order for us to try and legislate, we have to share our experiences and find out what the problems are. I think there is important testimony to be heard this morning. We are going to hear from your neighbors, and your friends. The stories we are going to hear this morning are, quite frankly, not much different from the stories we have heard from the others in different parts of the country. We have had a series of hearings in different parts of the country.

I was here in West Virginia, about 7 years ago, looking at some of the health facilities, and other utilized facilities. I visited, as well, one of the outstanding medical schools at your University of West Virginia, talked to some of the students. There I saw some of the excellent teaching, in addition to the idealism and compassion of many of those young students.

But what are we really talking about today is an issue of whether this country is going to provide health care as a matter of right in our society; not as a matter of privilege. We are the only industrial society of the world that doesn't have a national health insurance program; the only one with the exception of South Africa. I don't think we want to be compared in this respect to that particular country.

From the charts you could ask whether we can afford national health insurance. But the fact of the matter is, if we do nothing at all, we are going to be spending, nationwide, some $252 billion.

That is under current policy. By 1981, according to Congressional Budget figures, the rate of inflation of health is just going to keep going up, because we do not have effective cost control programs on it. If we do a catastrophic program, that means we just look out after those who have catastrophic illness, we are still going to spend a good deal of our resources, about $263 billion. If we do a premium finance program, which means that the employers will be required to provide a comprehensive health insurance, we are still about at the same as if we do nothing at all. And then, if we do the "comprehensive program," we are very close to the figures.

So the question is not whether we pass national health insurance as far as cost goes, because it is all very much the same; if we do nothing at all or if we pass a comprehensive health insurance program. People ought to understand that, because generally, people think we are talking about a new program. We have concerns about new programs, and therefore it is not warranted or justified.

I would like to mention here a rather interesting chart, just so we can talk about the issues. Now this chart up here compares the growth in health care costs in the United States and Canada. Look at 1968. For those in the back of the room, the lighter yellow is Canada, the orange is the United States.

In 1968, Canada was spending 6.8 percent of their gross national product on health care. The United States was 6.5 percent. Now, look what happens to 1978. Canada spends 7 percent. They go from 6.8 to 7 percent and ours goes from 6.5 percent to 8.8 percent.

You know what happened? In 1968, Canada passed a national health insurance program that had progressive budgeting. That it would have guaranteed everyone of these guests here this morning, that their bills would have been stamped "Paid in Full."

We heard from our Canadian friends last week in our hearings in Detroit. We had five families from Canada, five from the United States. We had similar hearings in Washington, D.C., with four families from Canada, four from the United States—a working family, a farm family, a small business family, and a middle income family. And their bills say "Stamped in Full." Yet still their nation only spends 7 percent of their gross national product, and we spend 8.8 percent. This means more taxes for you. It means more taxes for the people in my own State because we do not have cost controls and we are still not getting the kind of coverage here that would have met the needs of these people that we are going to hear about this morning.

Do you know what happened in 1968 in Canada? They said if you pass a national health insurance program, the doctors are going to go on strike. Well, they passed a national health insurance program in

Canada and the doctors did go on strike. And you know something? The death rate went down.

[Laughter and applause.]

We need a little order in here to set a hearing. Not too much. We have come a long way, people have traveled a lot.

This gives you some idea of where the escalating costs are going, in hospital rooms, medical care, all other items. You have decided it is going up too fast anyway, but health is going up the way it is. Now the only way you are going to get a handle on this is what we call prospective budgeting. Everyone understands it; your families understand it—you have so much to spend and you do not spend anymore, prospective budgeting. And then we bring the costs under control. And they still do it in Canada and meet the kinds of health care problems that we are facing here this morning.

Now, a final point that I would just like to mention is that the quality of your health care, I don't believe, ought to depend upon whether you move from job to job. That does not have any significance on whether you are sick or well. If you transfer jobs, it does not make you well overnight. If you change in your family situation, if you are separated, it should not make a difference whether your particular needs for your family is going to be covered or not covered. This makes no sense at all. If some people retire and are able to get an operation a day or two before or a day or two after the retirement date should not make a difference between wiping out the savings of a particular family because of a date on the calendar. We will hear about how some families found out that they needed surgery at a certain date and if they waited 6 or more days all their medical bills would have been covered, It is ridiculous.

So we are going to have a hearing and what we are trying to show and trying to find out is what the human impact of these issues. You know we can talk about dollars and cents. And that what we have talked about for the last 7 or 8 minutes. But the fact is we have not talked about the human tragedy and the anxiety the people and their families have. I mean, how do you mention that in dollars and cents? You cannot do it. But the anxiety of our children that are growing up—what is going to be their future? Or the anxiety a husband has for a wife, or wife for a husband, let alone the dollars and cents in costs. And that is certainly something in our society that is the richest and that most powerful Nation in the world we ought to be able to provide for it.

We have, quite frankly, in the Congress of the United States, a policy that we provide for ourselves very well. So we want to make sure, at least I do—and I am sure Congressman Staggers does—and others do that will provide for the people of this country.

Harley, I am going to ask you to speak; I get a little carried away, you know—when I get back to West Virginia.

Mr. STAGGERS. Thank you, Senator Kennedy, and thanks for coming to West Virginia and for having these hearings here because it affects the people of this mountain State as well as any other State in the Nation.

I know you have been holding hearings in Chicago and on the West Coast, and, as you say, in Detroit and other parts of the Nation. I am

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glad you are bringing the hearings here, to the very heartbeat of West Virginia, here at the university and the coal fields, because it affects our people more than it does those in other areas of the Nation.

I believe, like you do, that we should not certainly in this rich and beautiful Nation, let people die because of the lack of attention or because they do not have money or because it affects our people more than it does those in other areas of the Nation.

I believe, like you do, that we should not certainly in this rich and beautiful Nation, let people die because of the lack of attention or because they don't have money or because they just cannot get attention at the time. I do not think this is a Christian way of living. I do not believe the Good Lord means for us to have and prosper ourselves and not to, I don't mean to have a socialistic state, and I am sure Senator Kennedy does not believe in that, but I believe in the bare necessities of life. We should be able to care for each other in some way.

I want to thank all of you for coming and listening and I want to listen to these witnesses and I noticed, when we came in, we had a good many officers out here taking care of us arranging everything, so I want to thank Sheriff Wriston for your help and all your forces you have here.

Thank all of you for coming, and Ted, I want to thank you, and as Ted said, we have a little something to do with the health matter too as it finally passes through the committee of which I happen to be the chairman, and we handle all the health legislation on the House of Representatives; it comes through our committee.

So, with that, Ted, I would say thank you for coming, and we will turn it over to you what the witnesses have to say.

Senator KENNEDY. We have two panels of witnesses this morning, and what we will try to do is open it up for either statements or questions that people from the audience might have. We will put a yellow pad up here, and I will ask one of the staff to take the names and order and we will divide up whatever time you may have among those who have signed up during the course of the hearings. You don't have to sign up right now, just sign up as you hear the witnesses; anyone who wants to say a word or make a comment, you are welcome. We will welcome that.

We have come here today really to hear people and their stories. As Congressman Staggers said, we started our hearings with 3 days of hearings in Washington; we have had one in Detroit, and we are having this here. We are having them after the election next Tuesday in Chicago, Denver, and Los Angeles. We are trying to get different situations and reports.

Mr. STAGGERS. Senator, I do not care where you have your hearings, you will not find a finer group of people than you will find in West Virginia. The real American product.

Senator KENNEDY. Of course—they are mountain people.

Reverend Bowyer is the campus minister of Fairmont State College, pastor of the Trinity United Methodist Church of Fairmont, and we will have Mrs. Doris Lee Jordan, of the Fairmont Clinic Home Day Care Service; why don't you just raise your hands so that we will see.

Mr. Raymond Walker is a retired mine worker, and he has a son, Mr. Ronald Walker. Meet the Walker family here.

And, Mr. and Mrs. Grayton Quickle; he is a retired mine worker and Douglas Wriston, who is president of local 1353, district 29.

Senator KENNEDY. Reverend Bowyer, could you tell us a little bit about how long you have been living in West Virginia and associated with health care problems and mine workers?

Reverend BOWYER. Senator, I am a native of West Virginia and have lived here all but 4 years of the 43 years of my life. My association with the United Mine Workers programs is a result of my having been on the board of directors of the Fairmont clinic for the Monongahela Valley Association of Health Directors for the last 10 years. I have been on the first board of directors of the Health Systems Agency and was involved previously in comprehensive health planning.

Senator KENNEDY. Could you tell us what the benefits were prior to the last strike?

Reverend BOWYER. Senator, before the latest United Mine Workers Association contract, there was a system of clinics throughout not only West Virginia, but the whole Appalachian corridor, ranging from Pennsylvania down into north Alabama. There were some 50 clinic operations situated in 75 different locations throughout Appalachia. The benefits which were provided under the old contract made it possible to do the kind of thing you were speaking of in your opening presentation. It was done on the basis of retainers and other forms of prepayments to these clinics and to physicians on an established participation list. This made it possible for the clinics and facilities to provide a planned range of services, providing preventive health care and programs which simply could not have been afforded otherwise.

It was possible for coal miners and their families and for pension coal miners to go to these facilities and receive a full range of comprehensive services simply by showing their card—which said—that they were participants in the UMW Welfare and Retirement Fund.

Senator KENNEDY. Now I think this is important, because, as I understand, it was comprehensive and it also had the preventive aspects of health care. I often think that in our system we really have insurance, or sickness care, we do not really have preventive care. As I understand, prior to the last contract you had those elements of prevention for disease and preventive services, which is an important element, am I correct?

Reverend BOWYER. That is correct. There were programs of health education for example, and that is the kind of thing that gets cut first when there is a cutback in the funding that is available. Indications that have been done on about 13 to 15 clinics in West Virginia by West Virginia University Office of Health Services Research and comparable studies done by other programs throughout Appalachia indicate that there is now about 30-percent decline in the use of the facilities that now exist. A great measure of the decline is precisely—people coming in for physical examinations, prenatal care, baby clinics, and other kinds of things where people feel that they might be able to stave things off until they got sick. I think Mrs. Jordan will be able to give some real information on that.

Senator KENNEDY. Before we hear from her, why don't they come in now, you believe?

Reverend BOWYER. Well, what has happened under the new contract is that for a working miner and his family, it is to pay a deductible.

Now you know, and perhaps others do, that the only thing deductibles solve is family solvency; that is, it will destroy it.

They have to pay $7.50 for each physician's visit, up to 20 visits. If this is a family that has some sickness or some history of illness, they are going to have to pay that off the top. Consequently, there is a great tendency to wait until they are sure they are sick before they go in for care. For the pension miner, the rate is not as high, but their income is certainly not as high. It is $5 per visit. It also provides for drugs. Drug programs were provided with prescribed lists of medications that were available in clinics and other pharmacies. And now there is the same $5 deductible to receive medications. Consequently, if a family needs a $4 drug, they have got to pay for that every time they go in. If they need a $6 medication, they have got to pay the first $5. The clinics say it is not worth the money to send off for the insurance company to try and collect the extra dollar or whatever it may be. So preventive care and quality care has been devastated.

Senator KENNEDY. I gather from this last comment that your sense is because of the deductible, the amount of preventive health care has been seriously, significantly reduced. Am I correct?

Reverend BOWYER. That is correct, and that has been adequately documented in various studies already.

Senator KENNEDY. Doris, you work in the Fairmont clinic as a home care service worker. Is that correct?

Ms. JORDAN. Yes, sir.

Senator KENNEDY. Perhaps you could tell us, what is a home care service worker?

Ms. JORDAN. The United Mine Workers Health and Retirement Fund did a wonderful job of caring for miners and families. They took care of all their medical needs in the past. It was my job to take care of coal miners and their families. A year ago at this time I had 200 patients on my service and a staff of 5 people working, 3 nurses, a secretary, and an aide. At the present time we are down to 53 patients and I am the only one that is working as a home care nurse, caring for the coal miners and their families. They say there is skilled nursing provided through the medicare program. But medicare has defined "skilled" in such a way that unless you have a certain illness and are needing certain treatments, you are not included.

But anybody who is chronically ill and develops an acute problem certainly needs nursing care, but under this new program it doesn't provide for it. So this is the reason that we have had to eliminate some of the services. For miners who are younger and have sick members of their families, insurance companies will pay for the visits, but of course, there is some stipulations on that, where before, we could meet and anyone who was needful and we did do preventive nursing, which did cut down hospitalization. We kept the patient in their home, tried to keep the home circle together so they would not have to go to nursing homes.

Senator KENNEDY. What has been the reduction in the range of services have you detected? How much has it been reduced in terms of visits to various people?

Ms. JORDAN. Three-fourths.

Senator KENNEDY. Three-fourths?

Ms. JORDAN. Three-fourths. There is no mistake. Because the ones I am really seeing, I wonder if they will even be covered.

Senator KENNEDY. What has that meant to them in terms of their health needs?

Ms. JORDAN. Well, it is a real hardship. For instance, if you have a patient with both legs amputated, he is a bilateral amputee, or a woman or man, and medicare can go in and teach insulin therapy or take care of the limbs to a certain extent. Then, when they reach a maximum rehabilitation they have to discharge the patient, where I could move in and maybe go every 6 weeks to 2 months and draw a fasting blood sugar in the home. Now they have to be brought in by ambulance, pay their own ambulance fees.

Senator KENNEDY. What is the ambulance fee? Depends, obviously on where you are; it is still very expensive.

Ms. JORDAN. Anywhere from $18 to $50. They get their blood drawn work, you send it in. I also had a visiting service, who would be sure your people with congesive heart failure took their medication.

Senator KENNEDY. Are there any people who would like to call you but do not call you because of, you feel, these additional charges?

Ms. JORDAN. Yes; I have been very privileged and I am thankful that I have worked in this area, because coal miners are genuine and warm, and when you build up a relationship with them, if they do not feel they can afford a visit, they call in. So I am spending half the day on the phone, so they do not have to pay.

Senator KENNEDY. Does that make any sense to you?

Ms. JORDAN. No; it is like a doctor—you do not like to doctor on the phone. Well, how congested are they? And maybe I should make a visit. Oh, well, don't come until tomorrow.

Senator KENNEDY. Can you give us examples of people who call in, just the types calling in asking for advice when they should be—you should be able to treat them by going out and seeing them?

Ms. JORDAN. I can think of a family of three who are all ill. The mother has a brain degeneration, in general terms, she is a complete bed patient with tremors, she cannot walk, she cannot even feed herself, her speech of defective, and she is being cared for by two semi-invalid children in their late forties who don't come under full mining services. But I truthfully nurse the whole family when I go in, because I have to feed a neighbor or somebody takes them to a doctor. Right now they are not doctoring because they cannot afford their medications, they are both paraplegics. They try to take care of their mother, they have her to feed. And when I go in, it may amount to only a bath, but I have got all of them on doctor service. And because they do not have finances, they will call, rather than have you come.

Senator KENNEDY. You mentioned before the number of people that were involved in your program. How many did you have previously?

Ms. JORDAN. Five. Just on the program of coal miners and their families and the medicare program was transferred to.

Senator KENNEDY. How many do you have now?

Ms. JORDAN. Myself.

Senator KENNEDY. Just yourself? What has happened to the other four? They are not part of your services any more?

Ms. JORDAN. No. Our aide was transferred to the medicare program and our other nurses were temporarily laid off, but they have been called back they have got employment at other facilities.

Senator KENNEDY. But this service of preventive care, visiting care, is no longer available; is that correct? Or at a very reduced——

Ms. JORDAN. Very reduced.

Senator KENNEDY. It is available, but with the deductible, it has been minimized, much less utilized, is that correct?

Ms. JORDAN. Yes.

Senator KENNEDY. And is it your conclusion as a nurse that there is still the need there? One of the things we are trying to evaluate is overutilization. Do you find out that because of the deductibles the people are not using it that should be using it because of their deductible?

Ms. JORDAN. Some people have said that it was overused. But the need was so great that we couldn't cover everybody. The need is still there. When a patient goes to the hospital that has chronic illness, well, there are about 30 lung problems, and living in this industrial pool area, we find many lung problems. And when one of these patients has an acute problem that needs hospitalization, they come down to the hospital and the hospital closes its door. The need for nursing homes is great. But the rules concerning the operation of nursing homes are very rigid.

We have patients in the nineties who have children in their seventies. And when the children in the seventies die, what are we going to do with the patient? In the nursing homes and personal care homes—we have one that is excellent. She has 20 beds empty because she is not allowed to keep over 3 patients, because she is not a skilled facility. Not everybody needs a treatment in the sense of catheters and colostomy care, and yet they are very ill—and to keep the family—say, how much would it cost to take this family of three, separately, and place in different nursing homes, when a nurses evaluation, to go in, we would say you need family service for the bath and cleaning services. You need a nurse to evaluate and all this has been erased. Which is money savings, in my estimation.

Senator KENNEDY. I think you are right. We will go to Mr. Wriston.

Harley, any time you would like to ask any questions, obviously, you are welcome to ask any questions you would like to. Mr. Wriston, you are a coal miner, I understand. Is that correct?

Mr. WRISTON. Yes.

Senator KENNEDY. Are you an official in the local or union?

Mr. WRISTON. Yes, sir. I am president of my local and chairman of the Safety Committee, Health Committee.

Senator KENNEDY. Was your father a coal miner?

Mr. WRISTON. Yes, sir, he was and is still living. He is 76 years old and worked 41 years in the coal mines.

Senator KENNEDY. He has recently had a ruptured muscle in his stomach, as I understand.

Mr. WRISTON. Yes, sir. It has been about—back around July, right after the contract was signed, and what he thought he had, I guess, was an ulcer or a problem within his stomach, and it turned out to be a ruptured muscle in his stomach, I though maybe the input from his

situation might help you, the information he had on this particular case.

My father, like I said, is 76 years old, he has very little education, I would say he went to about the fourth or fifth grade, and he used to have this UMW system that we had prior to the new contract, and he has been a beneficiary from the Funds. He could take his card in and any problem he had, it was taken care of. Since this has turned around on us, this contract we got now, he went up on this problem he has got on his stomach, and he paid his $5, he is a retired miner and he has to pay a $5 deductible, and he thought it was taken care of. So about 2 months later, he got a statement from the Southern West Virginia Clinic saying that there was a balance due on his bill of $93.

And he went up to see them and they told him "You are going to have to take this and send it to medicare because the new policy, under the UMW plan is that Medicare has to pay their part first before the UMW will pay anything on it." So, like I said, my dad is 76 years old and doesn't have much education, and he was all confused. I came over on the weekend and he said "I don't understand what is going on. I used to just take my card up there and it was covered." So I said, "Well, it was a good thing when we had it like that dad, but you have got to go along with what we have got. You are going to have to send this form in the medicare."

Senator KENNEDY. May I ask you Doug, you mentioned just bringing your card in and resolving all the medical problems. Of course, that is what they do in Canada as well. Everyone has a card. You just bring the card on in, very similar to prior to this contract, and there is no paperwork. The Department of Health sends you a bulletin each year and tells you what they have spent to cover your medical expenses, just so the taxpayers know. And the people understand that, they know how their taxes are being spent. But that is the only paper work they get is the little bulletin that says we have spent X, Y or Z to cover your medical expenses. Now, one of the most costly aspects of our current system is the paper work on it. That is why I am interested in what your experience with the paperwork is, because that happens now. We have 2,800 different insurance policies with all different deductibiles, coinsurance, et cetera. And this is a problem, I understand, here now. Please just continue. As I understand, that happened before the contract. You just had a card, you presented it and that did it.

Mr. WRISTON. Yes, sir, that is the way it was with the UMW Health and Retirement Fund. It is two separate funds, by the way. The pension has nothing to do with the health part.

To continue with my story, to make it beneficial; my dad sent this form in to medicare and they sent back and said they would pay $57 of the $93. So my dad was confused. He thought he was going to get $57 from medicare to go spend the check. I said, "Dad, you cannot cash that check; you have got to take it to the clinic. That money belongs to the physicians and the clinic." So he said, "Well, OK." So he took it up to the clinic. He turned the check over: the medicare paid the $57 and they said there would be a balance of $x$ amount of dollars and that the United Mine Workers would pay for it. So he said OK, I am a retiree, they will take care of it. So they gave him a form to fill out for UMW. They said, "You take this form, fill it out, put down all the

parts that was administered through the office, the charge of the physician, the diagnosis, the X-rays, everything that they did to you." Like I say, he has had very little education. I don't know how they expect these old people that are in his condition to fill this stuff out.

Senator KENNEDY. If he was living alone, what do you think would have happened? If he was just like many other folks?

Mr. WRISTON. My goodness, Senator, I don't know, because he was all confused.

Senator KENNEDY. We talk about paperwork in our society and administrative overhead. What do you think it took, how many secretaries, people for filing and doing this and sending paperwork back—while in Canada, the administrative costs are about 2 percent to administer the program. You just have the thing come on in and bang, you get that card and the check goes out. This paperwork must be not only burdensome on the patient, but it is also going to be costly.

Go on.

Mr. WRISTON. Witnesses spoke before the administrative costs in these clinics. And I think that it is possible that is why they turned it over to the patient to handle this paperwork. Now, my dad made two trips to the clinic; one for medicare, one to finish filling out the papers from UMA. But that wasn't the end of it. He had to go from the clinic, he had to take the forms to the health and retirement office over on the other side of Beckley, W. Va.

Senator KENNEDY. Now, let me ask you, on another subject matter, on the preventive health care aspects. What has been your impression about the utilization of the preventive health care? Do you find less utilization of it now, after the contract?

Mr. WRISTON. Well, Senator, I would like to say something on that. We are United Mine Workers and we were out under a real serious contract. The biggest issue in the contract was this health care. We were told through the media, the newspapers, and so forth, that the UMW funds, the card itself, had been abused. And we were led to believe, and there has even been some miners that believe this theirselves because they might be fortunate enough not to have to go to the doctor, and there is a lot of confusion within the coalfields that people did abuse this card. Just because they had this privilege to go to the doctor and everything was taken care of by this card, it was abused and people would go and set for hours upon hours waiting to see a physician.

Now, I have got to be realistic—that probably happened, but in a real small percentage. That wasn't what caued the—you know, the—what you were explaining on those charts, is what really hurt the card, because medicare and the cost for it just skyrocketed. But there is a lot of people who believe that. And I don't believe it. As a man, I have got to say that it was, it probably was, like I say, a small percent did go and it was probably the elderly people that really did. You know when you get up in your years, your mind starts to fluctuate and you might think you need to go to a doctor. But, my goodness, they have suffered through life and they got up in those years. If they are abusing it a little bit, it doesn't matter to me.

Senator KENNEDY. I find most of the working people up my way are too busy working, the wives are either working or looking out after the children, to go down to the clinics and spend a lot of doctors' time.

As a matter of fact, we have found that in the establishment of our neighborhood health centers they have got to develop an outreach program to tell people about these programs so they will come in and use it. I do not question that there aren't some instances of utilization, but it is not the working people. But I am interested in your assessment. What has it meant—the general range of health benefits in your contract is excellent, at least in the relationship to an awful lot of other people.

Mr. WRISTON. No, sir, I would have to disagree with you.

Senator KENNEDY. Oh, you do? OK. Well, what we are interested in is in terms of the preventive aspects of it. This part has gone down, is that correct?

Mr. WRISTON. Yes, sir. I openly, in my local, I openly opposed the contract for the various reasons of the health care, but especially the real danger in accepting the contract we had under this health care plan was that it would definitely eliminate preventive care in our medical system. And that is really what has happened. It might give you a little bit of information as far as myself. I am a working miner. But a pensioner, people who are retired, like the man said before, is on a different income. They are on a fixed income. And I am supposed to be working every day, but the condition of the coal market right now, we only work maybe 1 or 2 days a week at our mine.

It has been a particular case that I can remember. The lady spoke about the coal miners having a lot of pride. I have pride, but I think it is important that we get information to people like yourself and Mr. Staggers to try to help the American people, not just the people of West Virginia. I think what you are doing is a wonderful thing. I support you 100 percent.

But as much as I hate to sit up here and talk before people, there is a case come up in my own family. I have a boy that is 14 and two girls; one is 6, one is 2. The girl that is 6 years old has a problem with her tonsils. And with just the least bit of cold, she gets infected tonsils. And it was on—we get paid on Friday and this case came, it was around Tuesday. My wife said, "Tina has got an infected throat; she is starting to run a little bit of fever. You think we should take her to the doctor?" Well, it is sort of like embarassing, but I have to say, I was flat broke. I told her, "Well, I guess we could go borrow the money from mother and dad, but why don't we wait a couple of days until I get the paycheck and if her condition either improves, then we will forget about it. If it gets worse, then we will take her to the doctor." We were flirting with a serious situation, because it is not a decision on whether to go or not, its the little girl's health. And we took a chance on it. It ended up it worked out OK. because by Friday she was running a little bit of a fever and we took her on in, they gave her a prescription and she got all right.

But the danger in this health plan that we have and the contract is that preventive care was eliminated there. I did not take that little girl there. What if it had been complicated, maybe congestion would have been in her lungs and it developed into a serious type of pneumonia or something. It could have been real costly to me. It would have been costly to the insurance company that is provided through my company. But if it was serious enough, it could have been real costly; it could have been her life.

That is the real danger of what we are facing in the United Mine Workers is preventive care. The lady there works as a nurse and the people that have to go to these doctors, to the clinics if they don't have the $7.50, they are not going to go. If they cannot borrow it, they are not going to go. So, like I say, people are flirting with a pretty serious situation, and I don't like it, but I have got to live with it.

Senator KENNEDY. Mr. Wriston, it is not just the mine workers. That same story that you told exists for working people up in Boston, Springfield, New Bedford, and Fall River. The exact same kind of situation that you have described here. About listening to children cry in the night and wondering if that child s $25 sick or $50 sick, because that is what it costs in the major city hospitals, municipal hospitals in this country. It isn't just a mine workers' problem, it isn't just a farmers' problem, it isn't just the problem of the people that live in Appalachia or live in these mining communities. It is a problem all over this country. Exactly the same.

What you see is, where you have a strong union trying to bargain on this with companies. The fact is, you have got other unions trying to do the same kind of thing. And there are all kinds of gaps. There are all kinds of areas which are missed—we are just a nonsystem. Maybe people are going to be a part of a particular union that is able to get a somewhat better kind of agreement. But what we are talking about is the whole range of people. It should not have to depend on the question of whether they belong to a particular local or a particular kind of union. It seems you find out, as in your situation, you find out the limitations, even in small unions or smaller groups of working people that do not have the large kind of financial background to develop the total kind of system. That is why we need a national kind of system. Because many of the local units just have not got the resources to try and deal with the kinds of problems that you are talking about. But that does not make it any less wrong. We are going to hear that exact same story again and again. We have heard it before.

In our program we have the range—the essential range—of in-hospital services and outpatient services. This would be the minimum program, with essential services, that would be available to every man, woman, and child in this country. That is what they have in Canada and in most of the other industrial societies. They have different types of systems in Great Britain. They pay the hospital and they pay the doctors. We are not asking that. Canada does not have it. There is a range of services that you have outlined here in terms of preventive health services.

Then there is the question of—if you are talking about these kinds of percentages—how the cost is going to be shared between the companies or the insurance companies and the individual. Employers provide that range of services in a mandated program. If they can get the same range of services on that card, then the management can go on out and buy that range of services somewhere else, and you get excessive sources. As far as the individual goes, he is going to have all of these services included on the card. And it is not going to make any differences whether you live in West Virginia or Massachusetts, it is going to have that range of services on the card. That is what we want to try to include. But, you are not going to have the kind of problem where people are going to have to make that kind of choice

or decision. I am strongly against the deductibles and the coinsurance. I think that they cause the kind of reaction that we have heard here today. Even if it costs a dollar, just take the number of elderly people in the room that are living on fixed incomes and cannot afford that extra dollar to get the prescription drugs they need, and it is so.

May we go to Mr. Walker and his son.

## STATEMENT OF RAYMOND WALKER AND RONALD WALKER, DAYBROOK, W. VA.

Senator KENNEDY. Could you tell us, Mr. Walker, how long have you worked in the mines?

Mr. RAYMOND WALKER. Well, I am a retired coal miner. I have spent about 38 years in the coal mines. I had to retire before I became 65 years old and disabled and I have a good many problems. I have a lot of problems with health.

My son here and my wife, neither one of them are in very good health, but I worked as long as I could and the doctors told me I would have to quit. So I have to do a lot for myself.

The UMW has done an awful lot for me and my family and I would have to say they have done extra well because he has a lot of problems that had to be taken care of other than in West Virginia and this whole job has helped us a lot. I think it has been wonderful, so I do not know if there is any more I can say. I am glad they have done what they can do but I am glad that I am still living to tell these tales.

Senator KENNEDY. Now, you know Mrs. Jordan?

Mr. RAYMOND WALKER. Yes; I do.

Senator KENNEDY. Has that been important to you?

Mr. RAYMOND WALKER. Yes; it is. It is very important.

Senator KENNEDY. Tell us a little about it. Why is it important? What kind of services——

Mr. RAYMOND WALKER. She has been there many times. I expect if she had not come, I could not have got my breath. I have a breathing machine 3 or 4 times a day and I get up at night. She has been there when I couldn't get my breath at all. I had a couple of heart attacks and she was there when I had one heart attack—pretty bad, the last one I had—and she has helped out a lot.

Senator KENNEDY. May I ask you, Mrs. Jordan, do you remember visiting Mr. Walker? Can you tell us a little bit about the conditions there?

Mrs. JORDAN. Mr. Walker is very honest. He takes 120 units of insulin a day plus oral medication. He is the only one in his home who is able to get around. There was one time we went twice a day because Ronnie has a muscle disease and has not walked for the last few years and he also had an ilio-bladder where he passed his urine through the side and I guess a lot of bladder infections. We have gone twice a day, early in the morning, clear to Daybrook and give him an injection and at closing time we went back due to pressure in the family which the wife was not able to handle. She has had several mental breakdowns. So Mr. Walker, who is in very poor health, is the only one who can function. He lifts Ronnie. We have a lift that works in the home but not to the car.

Senator KENNEDY. Let me ask you, Do you visit Mr. Walker as frequently now as you did before?

Mrs. JORDAN. No; in fact, he has been discharged, but I was so worried when his wife had all those problems, so I went back in and now he is paying $5 for my visit. Preventive medicine has been eliminated.

Senator KENNEDY. Do you miss those visits?

Mr. RAYMOND WALKER. Yes; I do.

Senator KENNEDY. See, he would not qualify for Medicare because he has been taught to care for himself. What do you do when you have a calamity and all three of you are sometimes a bed patient? Can you tell us, is Mrs. Walker in good health?

Mr. RAYMOND WALKER. No, no, she was in the hospital in Wheeling twice this year on a nervous condition but a lot of trouble is she worries over the boy. It takes a lot of work to work with him. He has got no use of himself from the waist down. He helps himself as much as he can.

Senator KENNEDY. So there are just three members in your family unit?

Mr. RAYMOND WALKER. Yes, just three. Ronnie had surgery. They flew him to Ann Arbor and they went back to Arlington to a rehabilitation hospital and he never learned to walk. About 3 years after he had the surgery he had trouble with his other kidney.

Senator KENNEDY. And he doesn't walk?

Mr. RAYMOND WALKER. No; he hasn't walked for 13 years.

Senator KENNEDY. So you really miss them?

Mr. RONALD WALKER. Yes, sir.

Senator KENNEDY. All right. May we go to Mr. and Mrs. Quickle?

## STATEMENT OF MR. AND MRS. GRADEN QUICKLE, RACHEL, W. VA.

Senator KENNEDY. Could you tell us, Mr. Quickle, how old you are and where you live?

Mr. QUICKLE. Fifty-five years old and I live in Rachel and I am now a retired coal miner. I had to retire on account of a bad heart and I have a black lung.

Senator KENNEDY. You have a heart condition as well as a black lung; is that correct?

Mr. QUICKLE. Yes.

Senator KENNEDY. How long have you had the heart condition?

Mr. QUICKLE. First began taking a heart condition when I was 37 years old and it progressively got worse and worse so now the doctor tells me there is no way they can operate on my heart or do anything for it. I am just going to have to live with it.

Senator KENNEDY. Can you tell us how many children you have?

Mr. QUICKLE. I have five.

Senator KENNEDY. You have five children?

Mr. QUICKLE. Yes.

Senator KENNEDY. And what is your income?

Mr. QUICKLE. Well, right now, I am drawing black lung and miner's pension and social security.

Senator KENNEDY. What is your income—maybe you can tell us about that.

Mr. QUICKLE. Around $750 a month.

Senator KENNEDY. And you have five children? You have an adopted daughter; is that correct?

Mr. QUICKLE. Yes.

Senator KENNEDY. And do you know Doris Lee Jordan? She used to visit your home.

Mr. QUICKLE. Yes, sir.

Senator KENNEDY. And does she come as often now?

Mr. QUICKLE. Well, she doesn't come as often as she did until the contract came in—I don't know if that has made all the difference or not—but we sure miss it because it saved me having to spend money to go to town to get the shots and things I had to have.

Senator KENNEDY. You had to go to the hospital recently, did you not?

Mr. QUICKLE. Yes.

Senator KENNEDY. And do you have to pay anything?

Mr. QUICKLE. I had to pay the first $5 at the university up there.

Senator KENNEDY. And didn't you have to put up $124 up front?

Mr. QUICKLE. At the Fairmont General Hospital, yes, sir. They would not cover the hospital bills. I had to pay that.

Senator KENNEDY. And you miss those visits of Mrs. Jordan, I assume?

Mr. QUICKLE. Yes; I do.

Senator KENNEDY. Mrs. Quickle, can you tell us what those visits meant to you and what the loss of them has meant?

Mrs. QUICKLE. You know, Mrs. Jordan is a very good nurse and she would come and check him and see how his blood pressure was and everything. And she keeps up with his medicine and if he needs to go to the doctor then, you know, she always tells us. There are a lot of things that she does, such as talking to the doctor, because he is in and out of the hospital about every 2 months. Mrs. Jordan has been a big help to us and we don't draw very much money. I tell you when a coal miner is working—when my husband worked we had money, but now when you have just got so much coming in, that is all you can spend. You don't have any more to spend. We have to pay $5 each time we go to the doctor. Then we didn't have to pay.

We have to pay on the medicine and there is a lot of things that the miner's welfare doesn't take care of. We got a bill of $596. We don't have the money to pay that bill, so I think this contract they have now, it isn't as good. If he hadn't come under social security on a low income—he came on a miner's pension or loan of $275—where if he had been working in 1974, you would draw more. When you have only so much, you can't spend but what you do have.

Senator KENNEDY. Thank you. The point we see is the importance of home health services in any kind of a program. We see the impact of deductible in reducing the utilization of those services in a very important way for needy people and very real kinds of health needs.

It seems to me we have to recognize the importance of home health services and what these deductibles have meant in terms of reduction of legitimate kinds of health care needs, and I think that has been demonstrated very completely this morning. We want to underscore that particular factor.

Congressman Staggers, would you like to say anything?

Mr. STAGGERS. I would like to say I have taken a lot of notes and I think it is going to be very useful in going back to Congress. I would like to thank you and the panel for coming.

I might say that we are going on the site of the Capitol to hold the hearings on your bill next year. I have had a bill in for years but we have not been able to get it going, and I hired a specialist—you and your staff know Sharon Nelson—on this one particular subject. Of course she worked on our projects, too, in health care. But we are going to hold hearings on national health insurance and try to come to some conclusion within a year, and so we can work it out together and be helpful to the people of West Virginia. But for all America, I would say that Senator Kennedy and I have worked on many projects for the benefit of this Nation and many of these were heart, cancer, stroke, diabetes, mental health care, and mental health clinics that we have started all over America today.

We have worked together on these and we will continue as long as I am there, as I say, and next year we are going to put some emphasis on the national health insurance program.

Senator KENNEDY. I think that deserves a good round of applause.

[Applause.]

Senator KENNEDY. This will be one of the first major sets of hearings in the House of Representatives on this issue and it will be under Chairman Staggers, and that will be a major factor in drawing attention and importance to this issue. I just think that it is an enormously significant development. I never would have questioned the commitment of Harley Staggers, because as I mentioned, he worked on many matters.

But to get the attention and to deal with these is going to be a great asset to all of us who are concerned about this issue. So we are very grateful to our panel and we want to thank you all very much. Now we will just take a 2 or 3 minute recess before we have our second panel. Then we will open for comments. Thank you very much.

[Brief recess.]

Senator KENNEDY. We want to urge our friends here—to listen to these stories of human tragedy, and we will hear others this morning. I want to say to everyone here that you can go to any community in this country, a community in my State, Massachusetts, or a community in West Virginia or in Michigan and hear the same stories. They are exactly the same stories, and I think we can do it in different communities in West Virginia or New York or California—and we are going to—and it is just the heart-rending stories.

The spokesman for the head of the medical association has talked about how we have the best health care and health care system. And we have, for those of us at the top of the mountain. I have been able to receive it, personally. I am not going to talk any more about it, but I am going to give the assurance to people that the stories that you are getting are identical types of stories of our friends all over the country. And that is the question—whether we are going to be able to try to do something for all our people.

This is our second panel; we have got Mrs. Mason—Mrs. Doris Mason—and she is from Berkeley Springs. We are glad to have you here.

Now, we are going to get into some of the serious problems that our panelists have had getting medical insurance coverage for illnesses

they have had to confront. That represents a whole different series of experiences. And we will find out about different coverages in different parts of the country and that coverage dependent upon the employment situation.

I mentioned in my opening statement I cannot understand why employment ought to relate to whether you are going to be covered on health, but it does, in our society.

## STATEMENT OF DORIS MASON, BERKELEY SPRINGS, W. VA.

Senator KENNEDY. Could you tell us, Mrs. Mason, where you live and how long you have lived there?

Mrs. MASON. I live in Berkeley Springs, W. Va., in Morgan County, in the eastern panhandle of West Virginia, and I have lived there for almost 6 years now. How we came to be there was because I had a son who was born in California—Los Angeles—and he was born with a partially collapsed lung—one-third of the lower lobe was collapsed due to birth defect. Due to the fact we had full coverage—we had 100-percent coverage, 80-percent coverage on medicine—he was able to receive 100-percent treatment. He lived almost the first full year of his life off and on oxygen and it is pretty scary when you have to take a baby to the hospital. That covered the first year of his life.

Senator KENNEDY. You were a member of the Kaiser plan. That is a prepaid program that covers several millions of Americans, primarily in California and other Western States. It is a very successful program and a very good one. You were covered with that particular program, is that correct?

Mrs. MASON. Yes.

Senator KENNEDY. Then what happened? How much was the value of the cost of the medical needs of your child?

Mrs. MASON. Well, with a defective lung, he had a hole in his heart. It called for a pediatric cardiologist. We had totaled $50,000.

Senator KENNEDY. And that was covered?

Mrs. MASON. Yes; it was completely covered. Due to the fact of the Los Angeles air pollution we were forced to the wonderful West Virginia clean air, and the lungs recovered due to the clean air. He is now a very healthy, active boy going on 7 years old. So now we had to leave California, no job, no savings, no income. We came here to West Virginia and now we have no insurance. We have our own business. It is small. It is progressively growing, but no insurance, and I thought, "What would happen if my husband became disabled and I would somehow not be able to work?" I am able to work, but I am not right now. If we couldn't get insurance and we were faced with some kind of major hospital bill—and it got me to thinking about the seriousness of health insurance, and I am in full support of that program. I am in constant awareness of the needs of the people.

Senator KENNEDY. Let me ask you, if I could, Mrs. Mason: Your husband now is self-employed, is that correct?

Mrs. MASON. Yes.

Senator KENNEDY. And he has a small business?

Mrs. MASON. Yes.

Senator KENNEDY. And he makes—approximately what is your income?

Mrs. MASON. I would say under $10,000 a year because we are just getting started.

Senator KENNEDY. Just getting started. And recently did your daughter have an accident?

Mrs. MASON. Yes; she had a very tragic accident. She got her big toe mangled in a tractor and she was admitted to the hospital and we did not have any hospitalization.

Senator KENNEDY. You do not have any hospitalization medical insurance?

Mrs. MASON. No, and we have a hospital that is very kind and they will take people who cannot pay and they don't ask you how much you have got when you go in, and they don't turn away people.

Senator KENNEDY. Why don't you tell us the name of that hospital?

Mrs. MASON. It is Morgan County Memorial Hospital and for the excellent care of her we weren't even talked to about money. The doctor didn't even talk to us about the money until the day we left the hospital and we walked out of there.

The doctor did a marvelous job—it was very serious. The day we left we said we would pay so much per month. When you are in a new business and you have to buy expensive equipment, sometimes payments are hard to make. We are still paying on it.

Senator KENNEDY. It is 3 years later and you are still making payments on that?

Mrs. MASON. Yes.

Senator KENNEDY. Your husband was employed—with a job that had excellent coverage—and it is really just because you moved and changed jobs that you are without coverage, right? On one hand, when you are on one job you are covered completely. You have now moved, and your husband is self-employed, with just a small business getting moving and going. Just because you moved you are not covered. Health insurance coverage really has not got anything to do with whether you moved, for your health, from where you worked—I mean, it should not have—and yet it does, in terms of our system and society. After 3 years, as I understand, you are still paying. Often you pay only $10 a month.

Is that right?

Mrs. MASON. Yes, sir.

Senator KENNEDY. The bill came to over almost $1,000 for just a hospital stay of 7 days?

Mrs. MASON. Yes, sir.

Senator KENNEDY. OK. Well, it seems to me that the health insurance ought to go to the person, not to the job. That is what the point of the program ought to be because it goes to the person, deals with people. That is what we are talking about.

Mrs. MASON. Senator, I would like to thank you for two things—for coming to West Virginia, and second of all, you made a very important point. You mentioned "people," and I feel that you feel that people are important, and in so many places they mention numbers, and we are not numbers. We are people. We have feelings, we are very emotional and we hurt when we are sick, so I thank you for looking at us as people.

Senator KENNEDY. I firmly believe that is what people in our society would like to do. Politicians have fallen all over themselves in

trying to get out in front of proposition 13. So many of them forget about the human aspect, of the needs of people, and those needs have not changed. In many instances they have grown more serious, and it is good we remind them of it. I appreciate your comment.

Could we hear from the Metzes now, Mr. and Mrs. Dale Metz, from Shinnston, W. Va.

## STATEMENT OF MR. AND MRS. DALE METZ, SHINNSTON, W. VA.

Senator KENNEDY. Mr. Metz, how old are you?

Mr. METZ. I am 36.

Senator KENNEDY. And Mrs. Metz is——

Mr. METZ. Thirty-nine.

Senator KENNEDY. And as I understand it, Mrs. Metz, you had some surgery this year?

Mr. METZ. Yes; she had a mastectomy a year ago and now it's in her bones—the cancer.

Senator KENNEDY. And have you been to the hospital, or she has been in the hospital several times, is that right?

Mr. METZ. Yes; she has been in the hospital about 4 weeks last year and she has been in 8 weeks this year and she has been having radium. They can't give her any chemotherapy because it is in the bone marrow.

Senator KENNEDY. Now, what kind of work are you in, Mr. Metz?

Mr. METZ. I am an engineer.

Senator KENNEDY. And what kind of income do you have?

Mr. METZ. Well, until lately I used to make anywhere from $20,000 to $30,000 a year.

Senator KENNEDY. And how many children do you have?

Mr. METZ. We have four.

Senator KENNEDY. Are you unemployed now?

Mr. METZ. Yes; I have only worked 4 months this year. Construction work is really bad.

Senator KENNEDY. You served in Vietnam?

Mr. METZ. Yes; I served over 13 months.

Senator KENNEDY. And you were wounded there, as I understand?

Mr. METZ. Yes; I have fought with the Veterans' Administration since 1969 for disability and can't get anything.

Senator KENNEDY. When you were in the hospital, how much of it was paid by your health insurance?

Mr. METZ. Well, our insurance is $375 for one quarter. The insurance pays $30 a day for a room in the hospital. The cheapest room my wife was in was $97.

Senator KENNEDY. So, even when you have the insurance it is very partial, is that correct?

Mr. METZ. Yes.

Senator KENNEDY. This is an important point that the medical association leaders—how so many people are covered. But the fact of the matter is—in the instances where there is some coverage—it is not complete, as in your situation.

Mr. METZ. Yes; I have cashed in my life insurance, borrowed $10,000 from banks and loan companies. I have sold my two cars and

truck. I have sold part of my furniture. And this could happen to anybody.

Senator KENNEDY. So you have cashed in your life insurance, is that correct? And you have sold your car?

Mr. METZ. Yes; I only have one car left.

Senator KENNEDY. What did you have—two cars?

Mr. METZ. Two cars and a truck.

Senator KENNEDY. And so when you are unemployed, perhaps when you need the insurance most, you do not have it. Does your daughter need money on dental expenses?

Mr. METZ. Yes; she had had braces on. I took her to the hospital. I had been unemployed for 3 months prior and I had to pay for it myself. The hospital bill for 1 day was $481.

Senator KENNEDY. As I understand it, Mr. Metz, you are trying to sell your house?

Mr. METZ. Yes; I am.

Senator KENNEDY. Why are you doing this?

Mr. METZ. Oh, I owe the Clarksburg Hospital quite a few thousand dollars and I owe around $10,000, and I have got to get them paid off so I can take my wife to Boston.

Senator KENNEDY. So, as I understand, you have been a member of the Armed Forces, you were wounded, you served your country, you are a member of the union and interested in jobs but because of the employment situation only able to work part of the time. You have high insurance premiums and you are expected to carry them when you are unemployed. Your wife is sick and, I understand, has this cancer and you are going to have a continuing responsibility to try to pay the bills. You have sold your cars. You are prepared to sell your house to pay off the medical bills in the first instance and you are prepared to use whatever kind of savings to try and offset the future medical bills. And even if you go back to work, the kind of health insurance program that the union has only pays for a part of the hospitalization or medical bills.

Do I understand correctly your situation?

Mr. METZ. The most they will pay is 80 percent for a doctor and—but the hospital they will give them $30 a day for a room and they will pay——

Senator KENNEDY. That is if you are working, is that correct?

Mr. METZ. Yes.

Senator KENNEDY. But if you are not working, you still, in order to keep it up—even to get that kind of coverage—you have got to pay premiums and you have got to pay when you haven't got the money coming in.

Mr. METZ. Yes; I have to pay $90 a month.

Senator KENNEDY. The time that people need it the most is the time that it is cut off? What is this? And what does this mean in terms of anxiety to you and your family and Mrs. Metz? What does this continuing kind of burden mean to you? Doesn't it—isn't it wearing and troublesome to you?

Mr. METZ. Yes; it is.

Senator KENNEDY. You don't see that on charts. You don't see that on figures. You don't measure that on numbers or arrows and lines going up and down but it is right there.

Mr. METZ. Yes; it is.

Senator KENNEDY. You worry whether or not you are going to be able to provide for your wife and for your family.

Well, could we move to Ms. Terry Prevola.

We would like to welcome Senator Randolph here and you know the Senate rules—they do not permit either approval or disapproval—but, I think we can bend them a little this morning, and I am sure the record would show you have been warmly greeted. We have learned a lot from your people here and they have been very helpful to us. We want you, as Congressman Staggers says, to join in at any time and ask any questions. We want you to be fully involved.

Senator RANDOLPH. May I take 30 seconds?

Senator KENNEDY. You may take a whole minute—as long as you want.

Senator RANDOLPH. Mr. Metz and I were in Martinsburg yesterday. I think you know we have a veterans' facility there and we are now in "phase 2" of the construction program. It will be one of the eight largest in the United States of America. We began in a very small way there in 1942 and 1943. We were developing the airport at Martinsburg and flying stretcher cases in from the Pacific and the Atlantic arenas. Then the hospital was known as the Newton Baker Hospital, named for the Secretary of War. The program, as it moves forward into "phase 2," and ultimately to "phase 3," will call for the expenditure of $76 million. The program is to help the veterans injured in the line of service for their country. Although I do not wish to make this a big point, I believe, Senator Kennedy, that we should look very carefully at the medical and hospital program of the Veterans' Administration.

I do not wish to cast a negative vote here for, as you know, I am for a national health insurance program. However, a successful program, as the Veterans' Administration program for hospital and health care, must be carried forward. It should not come under the umbrella and be lost.

Senator KENNEDY. You are absolutely correct, and we have no intention of doing that. I think the veterans' programs have worked well, and we have got many programs outside the system that are not included. We want to make sure that they be so included.

Senator RANDOLPH. I agree. We want to welcome you and your health insurance staff.

Senator KENNEDY. We have worked on this.

If we could move on to Terry Prevola——

## STATEMENT OF TERRY PREVOLA, MORGANTOWN, W. VA.

Senator KENNEDY. As I understand, you are separated and divorced from your husband. What kind of a job did your husband have?

Ms. PREVOLA. He is a steel executive.

Senator KENNEDY. And when you were married you had good hospitalization?

Ms. PREVOLA. Yes; a fine group coverage.

Senator KENNEDY. As I understand it, you had good coverage when your husband was employed as a steel executive and you were divorced from your husband a year ago. You went to work and 3 days after going to work, you were hospitalized; is that correct?

Ms. PREVOLA. Yes; 3 days after I started to work I was told in the hospital that a biopsy showed that I had cancer.

Senator KENNEDY. And were you covered with health insurance in your new employment?

Ms. PREVOLA. Yes; but it didn't take effect for 30 days.

Senator KENNEDY. You mean, even though you were working before the insurance takes effect, there was a lapse period of 30 days. Is that correct?

Ms. PREVOLA. Yes.

Senator KENNEDY. That happens in the United States? And then what happened—you had to have some surgery as I understand it?

Ms. PREVOLA. Yes; I went into a local hospital and had surgery. Unfortunately, the techniques used had been discredited. I had to go into another hospital and have the services repeated, so essentially, it cost me twice the amount of money that it should have.

Senator KENNEDY. How much money did you have to pay out of your own pocket, approximately?

Ms. PREVOLA. I am still paying for that. I don't know. I added it up in the beginning. It was in the vicinity of $6,000. I don't know the total on that.

Senator KENNEDY. It is about $6,000 and you are still paying, is that correct?

Ms. PREVOLA. Yes.

Senator KENNEDY. So you were covered by an excellent program, your family status changed and you went to work in another job. You would have been covered in your other program but you have that 30-day lapse period in which the medical necessity arose. You ended up with approximately a $6,000 bill. That has nothing to do with your job. Your job and your employment siutation and your marital situation—what has that got to do with your health problems? It does not seem to me it should, but it does in this case. And you have $6,000, approximately, of medical bills which you would not have had if you were still being covered by the coverage that your husband had earlier, or covered by the program where you worked after you were separated; is that correct?

Ms. PREVOLA. Yes; I think that there are many women put in this position, too. Women with children, who for various reasons are divorced and have no financial security whatsoever.

Senator KENNEDY. Well, you are absolutely right. In Detroit the other day we had a mother who had been separated, divorced from her husband and had their four children living with her. It was granted in the settlement that the children were to go with the mother. Then the mother needed some medical attention. She did not have the coverage which she had when she was married. Whatever little savings she had were wiped out and she faced the tragedy of seeing her children go back to live with the husband, when she wanted them and she was entitled to them. That was one heartrending situation that we saw.

Then we had a family in Canada—exactly the same situation—husband working, good coverage, they had separated, she had three children and she became ill, and still the children stayed with her. She pointed out if she had had additional medical expenses she would not have been able to afford it, but she was able to afford it and she was able to keep the children with her and it did not cost her anything else. So

this story is a similar story that we are hearing in other communities. You are still paying off that obligation now?

Ms. PREVOLA. Yes; I will be for a couple more years.

Senator KENNEDY. All right.

Mr. and Mrs. Bursee——

## STATEMENT OF MR. AND MRS. CHARLES BURSEE, WARWOOD, W. VA.

Senator KENNEDY. Would you tell us how old you are and where you live.

Mr. BURSEE. I am 50 years old. I live in Wheeling, W. Va.

Senator KENNEDY. And I understand that your first wife suffered kidney failure in 1974, is that correct?

Mr. BURSEE. That is right. Her trouble started prior to that, back in 1973, and we were on dialysis treatment at Presbyterian Hospital in Pittsburgh. Until we got the kidney machine at home, we were making two or three trips a week for dialysis treatment and I was told these treatments were $340 for 8 hours. And that is not medication, prescriptions, transportation, none of that.

Then we evenutally got the machine at home and we had to order supplies. We had to have purification tanks in basement to purify the water. The tanks cost us $165 for 3 months. Our medical supplies we had to order, $900 of which we would split and pay $200 for 3 months supplies.

Senator KENNEDY. Now, didn't you have some coverage?

Mr. BURSEE. We had Blue Cross-Blue Shield and Hartford Connecticut out of Hartford, which was supposed to pick up 80 percent of the leftovers the Blue Cross did not pay. And she also had medicare.

Senator KENNEDY. And you ended up with a series of bills. You had paper sacks full of bills?

Mr. BURSEE. Yes; shopping bags full of papers. When she would be sleeping, I would see if they were duplicates or different bills and tried to match them up.

Senator KENNEDY. So, you have had some insurance, pretty reasonable insurance, and you had outstanding medical bills. About how much; can you tell us?

Mr. BURSEE. Well, when she died in 1976 in—in February—the creditors started closing in and they sent threatening letters to attach my wages. Had they not done this, the children and I could have survived.

Senator KENNEDY. That is, after your wife had died, the creditors are knocking at your door. This is what is happening in community after community in the United States of America, and we are tolerating it. I don't know what it takes to shake the Members of Congress on this. This is happening. It is just unreal. Why don't you just continue please.

Mr. BURSEE. We have an agency up there and I went to them to try to get some help and they advised me, after seeing the bills I had, to get an attorney and file bankruptcy. I did that. Bankruptcy was filed and a lawyer had sent to all these creditors to submit a final bill. And the IBM computer machines that did the billing had been broken down for about 1 year, as I was told, and they were behind in their

billings. So, at the time of the bankruptcy the billings were only up to 1974, at which time they totaled $18,000 "something" and it had been submitted that my total amount was somewhere near $40,000.

Senator KENNEDY. $40,000.

Mr. BURSEE. And there is just no way——

Senator KENNEDY. This is after you are covered with Blue Cross, medicare, and a policy of Phoenix Mutual. In spite of your own best efforts, your wife dies and you have to go in bankruptcy to pay off the legacy of bills. You have how many children?

Mr. BURSEE. I have two children at home. And I had a tremendous telephone bill.

Any time something would go haywire with the machine or her I had to call long distance to Pittsburgh. I had to call for supplies—to Miami for artificial kidneys, or Denver for equipment and parts of the machine—and I had tremendous telephone bills on top of that. And there was times we couldn't meet the telephone bills. At one time the only help I got was through the church. They paid one large telephone bill I had and they knew we were short on groceries and they sent a basket of groceries.

Senator KENNEDY. This tells something about how much our society can really tolerate. We have not measured the anxiety—your anxiety about the well-being of your wife and the obvious concern that you have in trying to look after two small children.

After your wife dies you are faced with approximately 40,000 dollars' worth of medical bills with the creditors asking for you to sell your home. It just seems to me to be a completely intolerable situation and completely unacceptable.

Mr. Shellhammer.

## STATEMENT OF CHARLES SHELLHAMMER, CLARKSBURG, W. VA.

Senator KENNEDY. As I understand it, you were hurt?

Mr. SHELLHAMMER. I was hurt.

Senator KENNEDY. Could you tell us what happened?

Mr. SHELLHAMMER. Well, I had been a loader. When I started to move a truck which I loaded my foot slipped and went under the wheel. Of course, I didn't pay much attention to it. I reported it to the office. At that time I was a diabetic and gangrene set in and I lost my leg.

Senator KENNEDY. You crushed your toe and gangrene set in and you lost your leg. You are a diabetic and the metabolic factor is if you have this kind of injury or sickness it can result in this kind of a condition, as I understand.

Mr. SHELLHAMMER. Right.

Senator KENNEDY. And you lost your leg?

Mr. SHELLHAMMER. Right.

Senator KENNEDY. Now, what—tell us—continue now—did you receive some bills?

Mr. SHELLHAMMER. Well, workmen's compensation took care of that.

Senator KENNEDY. How many times were you hospitalized?

Mr. SHELLHAMMER. I have been hospitalized about three times. I was in again in 1974 for a hernia operation which my insurance paid

part, but I paid the rest, which I think was around $300, and the doctor—we owed him around $300 which I paid off in monthly payments. And then I was over at Morgantown for 1 week. I got on medicare then and my insurance I had at the factory took care of that. Of course, I have had a lot of trouble with my daughter. She has been in and out of the hospital since she has been here.

Senator KENNEDY. What was that about? What illness or sickness did she have that hospitalized her?

Mr. SHELLHAMMER. They had to operate on her when she was 8 days old and she was in the hospital for 6 weeks. I think she was home for about 4 weeks. She went back in the hospital for pneumonia and she was in there for 12 more days. Of course, she has been in and out and then I had to pay all that money out of my own pocket.

Senator KENNEDY. Why—didn't the insurance cover that?

Mr. SHELLHAMMER. They would not give any health insurance on it. They said she was too much of a risk.

Senator KENNEDY. What do you mean?

Mr. SHELLHAMMER. They wouldn't give it to me, and where I worked they did not have family plans back in 1969 or 1970. They took a family plan out which I paid all my family plan and half my plan. And I got her on the insurance then, but up until then I paid.

Senator KENNEDY. Does it seem strange to you that at a time when you needed insurance you go and try to get it and you cannot get it? That is what happened to you. They won't sell it to you.

Mr. SHELLHAMMER. Right. Then in May she has congestive heart failure and in July she had the same thing. Of course, the insurance picked up approximately half of the bill, but the other half—I was faced with it.

Senator KENNEDY. During this period of time what were your medical bills, do you remember, approximately?

Mr. SHELLHAMMER. Oh, gee. From 1960 to to 1969 I paid around $10,000, maybe $11,000.

Senator KENNEDY. What about from 1969 on?

Mr. SHELLHAMMER. Well, I don't know, just 2 months there——

Senator KENNEDY. All right. Well, now, what did you—what kind of income did you have during that period of time?

Mr. SHELLHAMMER. Well, I made $4,200 that year she was born, but I was just working part time.

Senator KENNEDY. So, as I understand it, you were making about $4,200 a year, you had about 10 or 11 thousand dollars' worth of medical bills during this period of time from 1960 through 1969; about $2,000 worth of medical bills a year on $4,200; is that correct?

Mr. SHELLHAMMER. That's right.

Senator KENNEDY. Well, how did you make "a go" of it?

Mr. SHELLHAMMER. I paid off what I could; I paid so much until I got them paid.

Senator KENNEDY. Are you still paying?

Mr. SHELLHAMMER. No, I am not paying. I paid all of them.

Senator KENNEDY. You had some recent hospitalization?

Mr. SHELLHAMMER. Yes, sir. I lost my eyesight.

Senator KENNEDY. And how was that paid for?

Mr. SHELLHAMMER. Medicare and my insurance.

Senator KENNEDY. And they paid what amount?

Mr. SHELLHAMMER. Well, whatever medicare approved they paid 80 percent of that, and my insurance made up the difference of it. It is covered as an outpatient.

Senator RANDOLPH. I would like to ask a question: Mr. Shellhammer, do you have medicaid?

Mr. SHELLHAMMER. No, sir. I went up at welfare and tried to get some help on my medicine and they told me that I made too much money. I did get a medicaid card for her backdated to May 1. What they have paid, I do not know. I have not heard, but they will not give me one. They say I owe too much money.

Senator RANDOLPH. Under the present Government rules and regulations of the program, the Federal Government cannot assist you because of the amount of money you are making, is that correct?

Mr. SHELLHAMMER. That is right.

Senator RANDOLPH. Are you blind in both eyes or one eye?

Mr. SHELLHAMMER. One eye is partly gone. The other is hemorrhaging in the back from diabetes. I have been going to Morgantown for a year now. I made a trip up to Johns Hopkins last month. I got back to Morgantown the 7th of October from there. I will know whether I have to go back to Johns Hopkins and have surgery.

Senator RANDOLPH. I do not want to divert from the subject matter but we do have programs in which the blind can be productive citizens. I do not mean that you are not productive, but last year there were 3,870 blind men and women who were operating facilities in Federal, State, and local industries. Have you ever heard of that program?

Mr. SHELLHAMMER. No, sir; I haven't.

Senator RANDOLPH. I want you to give us the opportunity to tell you about it. Those persons earned approximately $10,000 apiece last year and sold more than $131 million of items—foodstuffs, newspapers, and other items.

Mr. SHELLHAMMER. Well, the Lions Club has helped me on my eyes.

Senator RANDOLPH. Well, the Lions Club has a major program for sight conservation. I will follow through. You must qualify and become one of those being helped. We will contact you. It is a very important and proven program with which I am personally familiar.

Mr. SHELLHAMMER. Thank you.

Senator KENNEDY. I understand you still have some debt, is that correct?

Mr. SHELLHAMMER. Yes, sir, I do.

Senator KENNEDY. How much do you still have?

Mr. SHELLHAMMER. Well, right now, where she was in the hospital in May and July and I had a back debt of $1,200 or $1,400, some to the doctor.

Senator KENNEDY. How are you going to pay that off?

Mr. SHELLHAMMER. Well, they have back-dated the medicaid card for her, but we don't know what it paid on it.

Senator KENNEDY. But you are still going to owe some? You are going to do the best you can?

Mr. SHELLHAMMER Well, I will have to set up whatever I can pay a month on it—if I have to owe anything on it.

Senator KENNEDY. Mrs. Taylor.

## STATEMENT OF MR. AND MRS. TOM TAYLOR, SHINNSTON, W. VA.

Senator KENNEDY. As I understand, you have an 8-year-old son with some significant problems.

Mr. TAYLOR. He has a 50-percent hearing loss in 1 ear. It has been an ongoing situation. The first year it was 30-percent hearing loss and he received some medical attention. It became more and when we couldn't afford to keep up with—after we had the medication we didn't continue our visits because the pain situation was taken care of—when he wasn't suffering from pain with the fluid building any more. The schools ran a screening test. They sent a paper the following year and now he has a 50-percent hearing loss. So, it is an ongoing thing which gets worse—it is growing worse.

Senator KENNEDY. You learned about it when he was in an early grade, is that right?

Mr. TAYLOR. Yes; he was in the first grade.

Senator KENNEDY. And he was tested for it, is that correct?

Mr. TAYLOR. Yes; through the school.

Senator KENNEDY. Now, have you been able to take him to the doctor and get the kind of treatment that he needs?

Mr. TAYLOR. We have taken him from time to time, but then we would fall behind on the expenses that had come up and he was not able to continue.

Senator KENNEDY. What does your husband do?

Mrs. TAYLOR. He is a meatcutter, but in the years past he has been from one job to another. Right now his work is stable, but we have some medical bills from the first part of our marriage and we can't afford to make any more.

Senator KENNEDY. So because of that, because of the employment possibilities of your husband, effectively, your child is going without the kind of medical attention that you would like to give him, is that correct?

Mrs. TAYLOR. Yes; that's correct.

Senator KENNEDY. Does that make any sense to you—in our society—does that make any sense to you?

Mrs. TAYLOR. No, sir.

Senator KENNEDY. Well, it is certainly not fair to the child when we are talking about human beings and the individual. When we have a child that is in need of these kinds of services, why should the employment situation of the father determine the care that the child gets? This does not make any sense. And it does not make any sense for every other industrial society except the United States. And I think you have another child, too, is that correct?

Mrs. TAYLOR. Yes; I have three children. Eric is a very good student, it doesn't seem to have affected his schoolwork, but from time to time the fluid will build up and he will have an awful lot of pain. Even when he doesn't have the attacks, it seems like his system is so rundown that—a child will usually want to continue the things that he enjoys—and he is so rundown. He said he wanted to quit Cub Scouts because he was too tired.

Senator KENNEDY. Did he have some surgery?

Mrs. TAYLOR. The youngest child had a birth defect when he was born. It was where the umbilical cord connected into the intestine for

him to feed while I was carrying him. It didn't close off as it did at first, and they had to remove the umbilical cord and tie it off, and his heart stopped. I had surgery at that time, too, which it worked out all right, but the expenses came to about $500.

Senator KENNEDY. And how are those paid for?

Mrs. TAYLOR. They are still not paid for. We haven't had any insurance at any time.

Senator KENNEDY. And even though he is a meatcutter?

Mrs. TAYLOR. Well, from one job to another sometimes is different, and like with a pregnancy, if you are pregnant when the job change is made, they won't cover it.

Senator KENNEDY. If you are pregnant and you want to go in and get an insurance policy, you have to pay in for 10 months before you are able to qualify for a maternity benefit?

Mrs. TAYLOR. That is right.

Senator KENNEDY. So, it is here where we find out what happens with an expectant mother. We find out what happens to a family who gets a divorce and what happens to their children who are in need, let alone what has happened to your family with these outstanding needs.

Could we talk to Jennings Randolph?

Senator RANDOLPH. Thank you, Ted. You helped us in the passage of our amendments to the Rehabilitation Act. The President must sign, or I shall say, he has until tonight to sign that legislation, and he has assured me that he will sign it.

But, in connection with these amendments—your son, you said, had 30-percent hearing deficiency in one ear and 50 percent in the other?

Mrs. TAYLOR. No; the following year when he was tested again that 30-percent hearing loss had come to a 50-percent hearing loss. It is worsened in the 1 year.

Senator RANDOLPH. Well, I do not want to go into details, but under the amendments that I mentioned we have provided legislation from the Handicapped Subcommittee to address the issue. With you working in the Health Subcommittee, we will contact you directly through the Director of the Subcommittee on the Handicapped.

We have ways to help you and your son who has hearing problems.

Senator KENNEDY. Mr. Clevinger.

## STATEMENT OF MR. AND MRS. BOBBY CLEVINGER, JANE LEW, W. VA.

Senator KENNEDY. Could you tell us how old you are and how old your wife is and what your income is?

Mr. CLEVINGER. I am 44, my wife is 45, and my income is $195.26 every 2 weeks. I make $390 a month.

Senator KENNEDY. And you have children?

Mr. CLEVINGER. Yes; I have a 3-year-old son back there.

Senator KENNEDY. And may I ask Mrs. Clevinger what kind of problems she has had?

Mrs. CLEVINGER. Well, I have multiple sclerosis.

Senator KENNEDY. You do not have any insurance at all?

Mrs. CLEVINGER. No; we don't have any. Because of my condition we can't get insurance.

Senator KENNEDY. Did I ask you where you work now? You used to have insurance when you worked for 7–11 in Parkersburg, but you do not have it now?

Mr. CLEVINGER. That's right. I moved to Weston due to her condition. We had to be someplace where some of her family was—somebody to stay with her or something of that matter—so we moved back to Weston, and there is no stores out there, so I had no job.

Senator KENNEDY. So now you have a job but you do not have any insurance?

Mr. CLEVINGER. No insurance. I can't get any.

Senator KENNEDY. Could you tell us, Mrs. Clevinger, what your health problems are?

Mrs. CLEVINGER. Well, I have M.S. I can hardly walk most of the time.

Senator KENNEDY. Multiple sclerosis?

Mrs. CLEVINGER. And I can't hardly walk and take care of my son. My nerves are bad. I have no coating on my nerves. My nerves are shot, period, and I fall around a lot. I have got bruises all over me. I have fallen—when I do fall, I have to wait until my husband comes home so he can help me up.

Senator KENNEDY. It is because of the effects of the disease that you fall down during the course of the day. You are unable to get up on your own volition; is that correct?

Mrs. CLEVINGER. Yes.

Senator KENNEDY. That is a result of the disease, as I understand?

Mrs. CLEVINGER. Yes.

Senator KENNEDY. And even in that climate you are still trying to take care of your 3-year-old son, is that right?

Mrs. CLEVINGER. Right.

Senator KENNEDY. How do you move around?

Mrs. CLEVINGER. I lean on furniture and the walls most of the time.

Senator KENNEDY. And you have to use the walls to buttress you or to help you move around?

Mrs. CLEVINGER. Right.

Senator KENNEDY. And do you take medication?

Mrs. CLEVINGER. Yes, I do, but we don't have the money to buy it right now.

Senator KENNEDY. What do you mean by that?

Mrs. CLEVINGER. Well, my husband doesn't make enough so we have got no money left. We can't get any help from welfare. I can't keep the medicine. It costs too much.

Senator KENNEDY. Let us review that. As I understand, Mr. Clevinger, because you earn $4,800 a year you have to spend $900 on medical care before you would be eligible for medicaid; is that correct?

Mr. CLEVINGER. No; I have to spend $898 every 6 months before we can get a medical card for her.

Senator KENNEDY. Why don't you spend that so you would be eligible?

Mr. CLEVINGER. Where am I going to get it? I would, if I had it.

Senator KENNEDY. So you cannot afford that amount of money in order to qualify?

Mr. CLEVINGER. That is right. I can't afford it.

Senator KENNEDY. And as a result of the fact that you can't afford it, she suffers from the effects of the illness and the disease?

Mr. CLEVINGER. Yes; she has one medicine that keeps her walking and I can't buy it. So, she has had to quit taking it.

Senator KENNEDY. So, if you had the resources, you would buy the medicine and she would be able to walk; is that right?

Mr. CLEVINGER. Yes.

Senator KENNEDY. But you can't afford it, so you cannot get the medicine, and she is at home leaning against the walls and trying to provide for her son?

Mr. CLEVINGER. She is supposed to take two pain pills a day and she only takes one.

Senator KENNEDY. This must be very expensive medicine.

Mrs. CLEVINGER. Yes, very——

Senator KENNEDY. What is it—$20 or $25 a hundred? And how many do you take?

Mrs. CLEVINGER. Six a day.

Senator KENNEDY. And the cost is $20 for a hundred?

Mrs. CLEVINGER. $22.50.

Senator KENNEDY. So we are only talking really——

Mr. CLEVINGER. It is $22.50 for 100 of the others.

Senator KENNEDY. Well, what are we talking about—the cost of the medication of the day?

Mr. CLEVINGER. Something like $90 a month.

Senator KENNEDY. So about $3 a day—$3 a day—would make the difference whether your wife would be able to function in your home and be able to walk around. Because you cannot afford what, in effect, is $3 a day, she lives as you describe, using the wall, and chairs, and table. If she does fall down, she has to wait until you come home, is that right, because you cannot afford the $3?

Mr. CLEVINGER. That's right.

Senator KENNEDY. Now let me just get into one other item.

In order to qualify for the medicaid, what would have to happen?

Mr. CLEVINGER. OK. In order to qualify—they say I make too much money—I would have to pay $900 on her in medical bills before we can get it. We didn't ask for anything for me or the son, just for her.

Senator KENNEDY. But if you spent that, how would you support your child?

Mr. CLEVINGER. That is just it—I couldn't.

Senator KENNEDY. And it is Catch 22. You cannot qualify—the restrictions that have been placed on you.

Mr. CLEVINGER. I have got to spend that $900 if she has to go to the hospital. I have to spend that money before they will pay the rest of it. I am not sure how it works.

Senator KENNEDY. Well, it really is a deplorable situation. In order to reach the Government program, it is impossible in terms of providing for the child and treating your wife. You are just in an impossible situation.

Senator RANDOLPH. Mr. and Mrs. Clevinger, you live between Weston and Clarksburg. Sometimes the intent of the Congress, in passing a piece of legislation, can be given flexibility, or be placed in a straitjacket.

Mr. CLEVINGER. Sure. I used to be a police officer. I know the law. You can use the law to help you. I know how it goes.

Senator RANDOLPH. We do know, Senator Kennedy and Representative Staggers, and as I listened to your case, there was absolutely no way that you could win. Yours is a "no win" situation.

Mr. CLEVINGER. I know it.

Senator KENNEDY. Every witness we have had in here has been a "no win" situation. In any one of the communities in Massachusetts, you hear the same tragedy. It is the situation in every community in this country, and that is the tragedy. We will hear the AMA saying, those were carefully selected witnesses down there. Well, maybe some day they will start reading the records, and in every community hear the same stories. If they spent a lot of time talking to people, they would realize it happens in every community of the country.

## STATEMENT OF LINDA JAVOSKY, MORGANTOWN, W. VA.

Senator KENNEDY. Mrs. Javosky, you will tell us how old you are?

Mrs. JAVOSKY. I am 31 years old. I have two children, a boy and a girl. The boy is 5 and the little girl is 4.

Senator KENNEDY. And you are divorced from your husband, is that correct?

Mrs. JAVOSKY. Yes, sir.

Senator KENNEDY. And would you describe where you were living and what happened in January 1977?

Mrs. JAVOSKY. January 16, 1977 our mobile home caught on fire and our children were in flames and trapped.

Senator KENNEDY. Do you want to repeat that? You were living in a mobile home and it caught fire? Would you tell us in your own words again?

Mrs. JAVOSKY. Yes; it was 7:30 in the morning and there was a fire in the mobile home and the children were in flames and trapped, though they woke us screaming.

Senator KENNEDY. And as a result of that fire, your children were burned?

Mrs. JAVOSKY. They were burned severely. Fifty percent of their bodies were burned and 80 percent of their burns were third degree.

Senator KENNEDY. And where the children treated?

Mrs. JAVOSKY. They took us to University Hospital here and prepared the children for a trip to the burn unit in Pittsburgh.

Senator KENNEDY. And how long were they in the hospital?

Mrs. JAVOSKY. We spent the next 7 months at the burn center.

Senator KENNEDY. Excuse me?

Mrs. JAVOSKY. The next 7 months.

Senator KENNEDY. And how do you manage those bills?

Mrs. JAVOSKY. Well, being as my home was destroyed, I really had nothing. I was able to claim residency in Pennsylvania and got help from the State.

Senator KENNEDY. And I understand the Crippled Children of West Virginia paid for the care of the children?

Mrs. JAVOSKY. No; this was after I came back to West Virginia that I applied for Crippled Children. I was trying to find a type of

coverage that would allow me to go back to work. I am a professional person and didn't want to throw away my own profession, too. But with being on welfare—about the only help there would be—I had to quit work.

Senator KENNEDY. Why don't we go into that. Now, as I understand, you are a beautician, is that correct?

Mrs. JAVOSKY. Yes, sir.

Senator KENNEDY. And you have opportunities for employment as a beautician?

Mrs. JAVOSKY. Yes.

Senator KENNEDY. Maybe you could tell us about your career opportunities. Could you tell us just a little about that?

Mrs. JAVOSKY. Yes; well, I have got 10 years experience behind me. I was a beautician—and I would say in other areas—here I would be rated as one of the top hairdressers. I had been involved in hair work for 8 years before I went to school and had really had higher hopes of going on to outstanding creative work. But this has limited my chance of further education. It is even hard to work at all.

Senator KENNEDY. Let me just go back a step. Your children still require medical attention, is that correct?

Mrs. JAVOSKY. Yes, sir.

Senator KENNEDY. And will for a period of time?

Mrs. JAVOSKY. When they tell me how much time, they are speaking of years. I will be responsible until the children are 18 or 21, when they have reached their full growth. I think the medical attention is going to be extreme.

Senator KENNEDY. And you are talking about several thousands of dollars, I would say? Am I correct, based upon what the bills will be?

Mrs. JAVOSKY. When we left Pittsburgh after 7 months of medical attention, we put several thousand dollars behind us alone.

Senator KENNEDY. So you are faced with serious medical bills to have your children treated—for care in the future, am I correct?

Mrs. JAVOSKY. Yes.

Senator KENNEDY. You qualify for the medicaid as long as you make a low income and you qualified for the Crippled Children's program, am I correct?

Mrs. JAVOSKY. That is correct.

Senator KENNEDY. And that Crippled Children's progam will provide for those children, am I correct?

Mrs. JAVOSKY. They will provide any medical attention they have to have from injuries they have received from this fire and any other medical things that you or I would face. It is just left in the air.

Senator KENNEDY. You make how much?

Mrs. JAVOSKY. I am allowed to make $817 a month. I make $430 or $460. Excuse me—I am getting help for the children which is roughly around—pretty close to—$400.

Senator KENNEDY. I believe you could make more money?

Mrs. JAVOSKY. Much more money, yes, if I were not limited.

Senator KENNEDY. So the point is, as I understand it from what you say, you have had job offers to make a great deal more money?

Mrs. JAVOSKY. Oh, yes, I have two or three different shops even in our area that notify me off and on all year long that want me to come there.

Senator KENNEDY. Why don't you take them?

Mrs. JAVOSKY. Then I would have no medical coverage.

Senator KENNEDY. You mean if you take the job and you increase your income, you lose the other kinds of coverage to look out after the children.

Mrs. JAVOSKY. Right.

Senator KENNEDY. So because of your concern about insuring they are going to be taken care of, you just cannot make the additional income in order to provide even better opportunity for them and for yourself and their standard of living, am I correct? What sort of sense does that make?

Mrs. JAVOSKY. Well, it is just a matter of what is the most important thing to you. Do you feel it is more important for your children to be taken care of or is your career more important? Is what you want to do in life more important, of course, than your children? So, whatever it takes, whether it is even work—maybe in the years to come—maybe in the next week, it may eliminate my work entirely—to give them what they need.

Senator KENNEDY. Let me aks you another question. Would you have to hold back—we have seen that you have to hold back in terms of making more money because you would lose the eligibility. Would you have to hold back on remarrying your husband?

Mrs. JAVOSKY. Well, yes, with $817 a month as a monthly income, what family could have two people working and stay under that bracket?

Senator KENNEDY. You mean you would like to remarry your husband?

Mrs. JAVOSKY. Well, with what these kids have to face in their life and what they have been through, I feel that any love that anyone can give to them—and they are very close to their father. They have had extreme medical attention. In Pittsburgh they give the children each 1 week to live—and on the 23d of February, it was the little girl's birthday. They give her 1 hour, and it went like that for 2 months. So with what we have got ahead, they do need their father.

Senator KENNEDY. But, I understand from what you have said, if you did remarry, that you would also lose the eligibility for coverage for the medical attention for your children.

Mrs. JAVOSKY. Definitely.

Senator KENNEDY. So at the time your children need their father—you would like to remarry—you are in a situation that you say you cannot because you lose the medical attention for your children. We have a situation that says you cannot make more even though you are qualified to make more in order to provide additional kinds of opportunity for the children. You cannot remarry because you lose the eligibility for the medical coverage for your children.

What possible sense does that make in our society? Does that make any sense at all to you?

Mrs. JAVOSKY. Not only that, Senator, but with all the medical—we are into seven different clinics right now with both of the children—and there are certain things that Crippled Children's does not pay. We have recently had some new problems arise with our little boy. He had to have some psychiatric help and right away Crippled

Children's has notified us to say that I needed to be in the sessions with Robby in order to really deal with physical things the way they wanted to, and to help him as well as at home, so I would be up on what they were doing and how they are handling it. Immediately Crippled Children's has notified us to say they would pay for the evaluation to the psychiatrist but that we would be responsible from there on. So I have been eliminating the course entirely because of the expense ahead. I have got very much difficulty or very much need for medical attention myself, and I cannot possibly even think about it. I have got high blood pressure. In the different areas in the hospital when things were presented, I almost had heart attacks right there. But I cannot doctor my blood pressure. I cannot doctor the lung trouble that I have—allergies, many things. I cannot even think about it.

Senator RANDOLPH. Linda, I think we need to clarify a point.

Mrs. JAVOSKY. Yes, sir.

Senator RANDOLPH. Are you receiving any State or Federal aid for these children?

Mrs. JAVOSKY. That is a private charity.

Senator RANDOLPH. Are you receiving those funds from private sources?

Mrs. JAVOSKY. No; SSI. The kids get SSI. It is social security. It is a benefit they get from all of the medical expenses that we have. It is an added income when I am off work or being with a limited income. There is no way to be prepared. Like next week, if we are in the hospital and I am out of work, that is just lost wage with no one to say, "Well, we will make that next week." There is no way to make it up. This is—with SSI, it is supposed to help.

Senator RANDOLPH. Mr. Chairman, I don't want to push the point, but that is a private program for crippled children, and the record must show that. You are trapped. That is exactly where you find yourself, for not having money to do something.

Mrs. JAVOSKY. I have talked to the Shriners. I have checked every angle of help that could benefit, and with the Shriners—they wanted to take over—but they wanted to take the kids to Kent without me, and I couldn't let the kids go. They were 2 and 3. I couldn't just let them go on their own.

Senator KENNEDY. I want to thank you very much, Mrs. Javosky, but in the time that we have available—you have been enormously patient—just for the last 10 minutes I would like to ask members of our audience if they have any comments. I think we have a brief list here, and I will call on those names.

I want to thank the Reverend Canon for running the public address system. He donated his material and his time and we are enormously grateful for the donation of all this equipment and the time he has taken to move around for all our witnesses up here. We are grateful.

I want to make a point that we will not be able to get through all of these witnesses, but I will ask them just to each take a minute and make a comment, and any of the ones we don't call on—I would like to ask them if they would take a minute, when they go home, and write to us. We will keep this record open and try and include in the formal part of the Senate record and I will get through them in a

personal way. If there are some friends of yours—your wife or husband—couldn't be down here and has a particular point of view or comment, write to us. We will keep the record open for 10 days. Take the time over the weekend and get it in the mail by the first of the week.

We will start down here. I will take the top 10. I will ask them to limit their comments, if they would, to a minute.

Sam Folio.

Mr. FOLIO. Mr. Chairman, Senator, Congressman, distinguished panel people, I teach at West Virginia University, health education department. I am chairman of the health region six and we welcome you to our region. I am glad you have decided to come to this region to listen to the things we have heard all along, and I did want to voice our anxiety, as you have been experiencing throughout the country. In our region we have picked out health education as a major focus and we will ask that you give that consideration, and I will be sending some additional information.

Senator KENNEDY. You can come right up here and talk to one of the staff here.

Richard Wideryuski.

Mr. WIDERYUSKI. I was curious to know, if this bill was passed, the health care bill and that type of thing, if there will be any provisions made to help people, such as the witnesses, to take care of the bills that they have run up before, so sort of like a grandfather type of thing, a certain number of years before the bill was passed?

Senator KENNEDY. Sir, to be very frank about it, we have not given that a thought. In terms of looking back, in terms of accumulation—really the legislation looks forward, but we ought to take a look and see if we can find some way of looking back. The legislation is trying to look at gradually phasing in over a 9-year period—over a prospective period of time. But clearly, we ought to take a look at the existing problems. There is one thing that is clear, and that is, when it is fully implemented, you will never hear another case like you have heard this morning. That is one thing I can give you an assurance of.

Lena Barton.

Ms. BARTON. I am glad to be here this morning. I have one case I would like to refer you to. I work as a senior companion, and this medical bill you are trying to pass is wonderful. This lady is very badly crippled with arthritis. She needs medication all of the time. But due to her low income, she takes what she has, then she doesn't have money to get her next medication until her next check comes in. Under her circumsances—she is a widow and she lives alone—she can't afford insurance. I think this insurance thing, or whatever, could help the elderly. They have worked hard, raised families, and they are deserving of what is coming to them. And we are glad to welcome you to West Virginia and I think I like to see you drink our West Virginia coffee.

Senator KENNEDY. Thank you very much.

Mr. Harry Harrison.

Mr. HARRISON. I would like to speak a word about welfare systems. In the State of West Virginia I have experienced a case where in—or in the beginning of the winter they were investigating to see how much income you have, then they raised the price of food stamps

again—which amounts to about $18—and you keep that on all winter. Then in the spring they cut it. I would like to see this system changed and I would like for you to carry a message to Washington that those who vote against a good bill for the elderly people, as far as I am concerned, they are out. And if the President of the United States—if there is a bill passed and he vetoes it, as far as I am concerned, he is fired.

Senator KENNEDY. Harry, you will excuse me if I don't deliver that message. I will let Jennings deliver that. I will give you 10 seconds.

Senator RANDOLPH. There are many men and women over the age of 65 in West Virginia. Only nine States have a higher percentage of persons over that age, so when he speaks, I expect he speaks for more than himself. In the black-lung legislation, we go back and take care of the benefits. I think we have to check it very carefully because we do have the black-lung law where the benefits for the widows and orphan children were adjusted. This is a subject to check into very carefully.

Senator KENNEDY. Well, we will look for your help on it.

Patty Tolle, Helen Mason, and Joyce Whiting.

Mrs. TOLLE. Patty Tolle, and I work for the West Virginia Community on Aging. One problem we feel is being faced here in West Virginia, and throughout the country, is the lack of coverage through Federal programs and through private insurance for more in-home supportive services and for preventive health care services for the elderly as well as for all other low-income consumers throughout the State. Right now services are lacking under medicare and there is not coverage for services, homemaker services, and services that are needed to keep people in the homes.

I have a personal example: I have a grandmother who, right now, is in the nursing home, supported under the welfare program. She could be taken care of in my parents' home if only they had day care, that someone could have cared for her between 8 and 5. Because of that, thousands and thousands of State money is going into nursing home care.

Senator KENNEDY. It would be less expensive on the taxpayers today that way and, secondly, it would be a much more human way to treat people. They have that in Canada. Thank you very much, Patty.

Joyce Whiting.

Ms. WHITING. Yes, sir. I am here to speak on behalf of Marion County senior citizens. I think so many areas concerned with our seniors have been presented today, and in regard to health insurance itself, if, unfortunately, it does not take place—if it does not happen for us—we honestly believe that we should have liberalized guidelines in regard to medicare recipients. We are concerned that physicians are not required to accept medicaid assignments from our seniors, and closer monitoring is needed.

Senator KENNEDY. What percentage do take in medicaid?

Ms. WHITING. In certain parts of Florida, it is 31 percent.

Senator KENNEDY. What is it around here?

Ms. WHITING. Unfortunately, I can't tell you. The areas that we seem to find most difficult in our area is, unfortunately, the area of people who have incomes just too high to qualify for any of the Department of Welfare assistance. Those are the people that need to have

this added care, whether it is by health or by liberalizing the guidelines, as far as medicaid goes.

Senator KENNEDY. Well, if you could drop me a note on it, I would like to hear. We have a good list here and we would like to hear from you.

We will take this gentleman here who has raised his hand and then until the last person has a chance to speak. We have a transcriber here. I am going to ask that the rest remain here with my staff assistant until the last person has a chance to speak. We have a transcriber here. It will be made a part of the record. Everyone in this room who wants to be a part of this record will have the opportunity to do so. After this, I am going to make a brief comment and Senator Randolph also. We are going to have order in here and the committee is going to remain in session until everyone in this room who wants to speak can speak. We will hear everybody's story. Anybody who has to leave may leave.

Sir——

UNIDENTIFIED MAN. What I would like to do is—I have spoken to you before, Senator Kennedy, and I want to comment on this national health care program. It is a very good item, but I am always suspicious of too much federalization. I want to commend you on the 2 percent. I believe it is a very, very good thing for all of us, whether he is a service station man or whether he is a coal miner or whoever he is, to cover that whole program. I thank you very much for the whole program, that is, taking into scope all the citizens of the whole country. I would like to mention another thing about cases that we have. I am thankful it covers them all, but there is one thing we missed, and that is the youth of our country, and I am going to bring one thing up. Let us see if we can get in the prevention part for these youth, the youth of the country. They have the whole world before them. No one has touched this. I know that. Let us take those youth into consideration and see if we can do something about our youth.

Senator KENNEDY. First of all, I would like to thank our witnesses for speaking very candidly and openly. It is never easy to speak about one's illness. I think we have a normal tendency to work these out within our families and we are reluctant to speak publicly. Since people have spoken frankly, I want to indicate to all of our witnesses that because they have, I am hopeful that we in the Congress can take some positive action to deal with it. It is a deplorable situation in our society.

I have personally seen the very best in health care. None of us are interested in running down our system. We have the very best for those who can afford it. I have been able to receive it. I was 7 months in the hospital in Boston after my back was broken. The medical bill was extraordinary and it was covered in full. My father was sick for 7 years and we were able to get the best medical help because we were able to pay, and my son, who suffered from cancer, got the best care because we were able to afford it.

I want to give the assurances of our friends here that as long as I am in the U.S. Senate, as long as I have a voice and a vote, it is going to be for a health care system that provides health care, good quality health care, as a matter of right, and not the dehumanization, the anxiety, the stress, the tragedies that we have heard this morning per-

petrated on these individuals and their children and their loved ones. It is unacceptable in our society.

I am hopeful we can take this record and make an impression on the Members of the Congress of the United States. Anyone who takes the time to read this record could not be but convinced about what the needs are and what we ought to do in the Congress of the United States.

I am enormously grateful for your patience and I would like to ask Mr. Staggers if he would like to make a comment.

Mr. STAGGERS. Yes; Senator Kennedy, I want to thank you for coming to Monongalia County, W. Va., to have this hearing. I know you could be in New York City or St. Louis or Los Angeles, or any of the large cities of America, and have a much larger audience, and I am sure you would hear the same stories. You are in the center of West Virginia where the very heartbeat of people is real.

A lot of people had many generations grow up in this area. You have heard their story, and I am sure that it is the real story of the real America. Everything you can do will be helpful.

My committee would be willing to hold joint hearings with yours on this very legislation next year. I think we can probably work out something that would be helpful. I am perturbed about the senior citizens, too, because most of them are on fixed incomes and they are the ones who cannot afford it.

Certainly, in a great and powerful Nation as we are in, we can have the compassion, and certainly the interest, to try to see that they are taken care of. And also to those who are crippled and disabled—to get help for them.

I thank you.

Senator RANDOLPH. I am one of those seniors. I am 76. We have a new jurisdiction in our Environment on Public Works Committee—a new assignment a year and a half ago—jurisdiction over what we call endangered species. I understand that subject very well. This has been a great hearing.

Senator KENNEDY. We will have a 2- or 3-minute recess to permit our witnesses to be excused and then we will come back into order and until the last person in this room gets a chance to speak, this hearing will not be adjourned. So we will begin by following the list that has been signed here and they will start down the list and include all.

[Brief recess.]

Mr. FROH (subcommittee staff member continued the questioning). There are people from the audience who would like to testify. You come to the microphone and, if you would, please give us your name and spell your name for us.

Ms. DAVIS. My name is Olymphia Davis. I have a problem similar to the Mrs. Taylor that had multiple sclerosis. She stated that every 6 months that they would have her fill out applications.

Mr. FROH. In other words, every 6-month period you file your application and they go by your monthly income, and according to your monthly income, they give you an amount?

Ms. DAVIS. My monthly income is $224 a month. My "spend down" is set up for $175. That means if I am eligible after filing an application, then I must start "spend down" and accumulate $175 on my own then.

Mr. FROH. Before you are eligible?

Ms. DAVIS. Right. If it takes 2 to 3 months to do that, you have lost time from getting your card. You have got 3 months to use a medicaid card which they give you. At the end of the 3 months they take that card away and you go back and apply from scratch—a new application—and become eligible again. Then you go back on the "spend down" as you did the 6 months before. This goes on every 6 months. I have terminal cancer. I go to the University quite a bit. I had a medicare card because I am on disability. Medicare would cover 80 percent of my bills in the hospital in Morgantown. It will not cover prescriptions. My prescriptions are very high. I had one prescription that I had taken at home three time a day. It runs $38 a month. With my income I cannot take that much money out of $224 to buy this one drug. That is just one of the drugs. So this is my problem. I need a fulltime medicaid card in order to go to the drugstore and get my drugs.

Mr. FROH. What is your annual cost for your out-of-hospital prescription drugs, Ms. Davis?

Ms. DAVIS. Well, approximately $50 a month, not counting pain pills.

Mr. FROH. So that would be $600 yearly?

Ms. DAVIS. Yes.

Mr. FROH. And does—is that covered by the medicaid program here in West Virginia once you "spend down"?

Ms. DAVIS. They will pay for this drug after my "spend down" for the balance of 6 months. There it is starting all over again every 6 months, the same old thing.

Mr. FROH. Are you having difficulties finding physicians to accept the card?

Ms. DAVIS. No; I go to the University because I have cancer and that is the only place I can go. Everything there—I use my medicaid card—80 percent of that is paid. But when it comes to the drugs, that is my big problem. The drugs have to come from the drugstore.

Mr. FROH. We have testimony that you would like incorporated into the formal record, in addition to this testimony; is that correct?

Ms. DAVIS. I have an envelope with different information and literature from the Welfare Department showing how this "spend down" works.

Mr. FROH. Are there other things you would like to share?

Ms. DAVIS. Well, my biggest problem now is prescriptions, cancer drugs.

Mr. FROH. Thank you very much.

Ms. DAVIS. And I thank you.

Mr. FROH. Mr. Phillips.

Mr. PHILLIPS. My name is Allen Phillips. They were talking about when you go to a doctor around here anywhere—any doctor I know of anyhow—it is $15—and you pay the $15 right now. You don't wait. And then you take your receipt that they give you to medicare, over to the Social Security Office, and what do they do? They write it down and send it in and maybe you would get $10 back, or maybe $13 back, but you don't get any more. Like that check I sent to the Welfare Office and got it back. For a $7.50 bill they gave me 40 cents back. That is the kind of business we got. Now, you know we just cannot live like that. We have got to have help from somewhere. And

I really appreciate Senator Kennedy's thought for the people around here.

Mr. FROH. Well, thank you. And I will certainly pass that on to the Senator.

Mr. MCDANIEL. Leonard McDaniel. My story started in 1973. I was employed by the newspaper and by working fell and broke my left leg. I was placed in the hospital for surgery and released by a doctor to go back to work in a walking cast. Well, my leg became swollen up to where they had to remove the cast and the doctor told me to stay home for 2 months and keep my leg elevated. Well, with the help of the minister we were placed on welfare. I have never got any compensation and I have only had a job with that newspaper. So, when my leg did get better I was stuck with no job, I hung around.

Finally, I got on with the State Department of Highways hauling junked vehicles throughout the State. Working for them I fell and bent the pin they put in the leg from the previous operation. I was placed back in the hospital and this time Compensation was supposed to take care of everything. And I was sent home for another 2 months—later the doctor discharged me after surgery to come back in 2 months. I got no compensation and we had nothing except what the neighbors brought in to us. And then in 2 months I went back and I was supposed to come back in 2 more. Still no compensation. So, 6 weeks later I went back and asked the doctor for the papers. He hadn't filled them out yet and Compensation said they couldn't pay until they got more information. Finally I got a letter from Compensation saying they would pay me $100 a week for every week I was off work until I was able to return to work for a job of equal pay.

Well, the doctor—I went to see him the next time and he said, "You are not taking your medicine. Your leg has swollen back up." And he hadn't prescribed me any medicine for 32 months. When I left his office that day his order was to keep your leg elevated and remain on crutches. So, I went home and got a letter from Compensation that they had received word from the doctor releasing me to go back to my previous occupation as long as I remained on crutches and kept my leg elevated.

So I called my boss and told him I was coming to work. He said, "You can't. The doctor hasn't signed that little form that you have to sign and since you are still on crutches—you can't drive a truck on crutches." So I didn't get back to work then. I went to the head of Compensation. They said they couldn't pay me because the doctor released me to go back to work. So, I was kind of left in limbo there.

Mr. FROH. Is there a Workmen's Compensation Appeals Board?

Mr. MCDANIEL. I have been through that, but the thing was, my house burned down in January and that left kind of a bind there. So, we were placed on welfare temporarily awaiting compensation and we were moved into housing under HUD. Our insurance from our house came and after we paid the house office off and everything, we were left with our furniture and money from our furniture. We had $10,000 left to rebuild our lives on. I couldn't draw unemployment. I was still on crutches. By having $10,000 I was no longer eligible for welfare. HUD, in turn, by its own welfare, was $35 a month. By adding $10,000 it went to $100 a month. So, I bought a truck and delivered

lumber and stuff on crutches. Well, I couldn't make any money doing that. It was hard on crutches.

Mr. FROH. Are you still doing that?

Mr. MCDANIEL. No, sir, I started cutting hair and anything I can do to make a dollar. So, I finally got a job with Region 6 Transit Bus after another doctor made a leg brace for me—which I now work for Region 6 Transit. I have been working with them since May.

Mr. FROH. You have had outstanding medical bills at this point?

Mr. MCDANIEL. Well, I was hospitalized 2 weeks ago and I have no insurance.

Mr. FROH. How are you paying for that hospital care?

Mr. MCDANIEL. I just got the bill yesterday—the day before—and I brought it with me today.

Mr. FROH. How much is that bill?

Mr. MCDANIEL. That bill is for $980.

Mr. FROH. And for how long of a stay was this in the hospital? How long were you in the hospital?

Mr. MCDANIEL. I believe not quite a full week. I went in on Sunday and stayed for 6 days.

Mr. FROH. How do you plan to meet that bill—the $900?

Mr. MCDANIEL. Well, I will just pay it. I last week got settlement from Compensation. It came through last week. Being off that year and everything I got $3,000, 5-percent disability, so that money was already spent before we got it.

Mr. FROH. You may not have much of that left.

Mr. MCDANIEL. Well, I had to move out of that housing project in Grafton because I couldn't pay the $100 a month rent. So we are living in a shell of a house.

Mr. FROH. How many children?

Mr. MCDANIEL. Four

Mr. FROH. How old?

Mr. MCDANIEL. Fifteen, 12, 11, and 8.

Mr. FROH. And your wife—has she seen a physician lately?

Mr. MCDANIEL. Not recently. One boy—the bill for him for bee stings is $300.

Mr. FROH. How much is that?

Mr. MCDANIEL. $300.

Mr. FROH. $300?

Mr. MCDANIEL. Yes.

Mr. FROH. Well, thank you very much. Would you like to add any other thoughts or comments?

Mr. MCDANIEL. No; that is it.

Mr. FROH. Well, it will be a part of the formal hearing record and we thank you.

Mr. TUCKER. William Tucker, from Morgantown, W. Va. My wife and I have been married 17 years this December. We have a daughter 16 years old, born with a hare-lip palate. She has gone through a period of 15 operations—no, 16 operations—and is getting to go through the 17th.

Mr. FROH. Approximately one a year?

Mr. TUCKER. One a year. In one period of 24 months she had 3. But this is a combination of the lip—the palate and the gum—plus on the

ears. And I want to say something. The lady that had the daughter or the son that had a hearing loss or the fluid build up in the ear—I am pretty sure that the simple Armstrong procedure can help that problem. This Armstrong procedure saved her hearing because the fluid had built up in the ear. It is a very terminal thing. If it allows to rupture the eardrum you only have 10-percent hearing. Another thing is I have a boy who is now 11. He was diagnosed with diabetes. And my daughter's bills are $33,000 to $34,000.

Mr. FROH. What kind of health insurance did you then have or do you now have?

Mr. TUCKER. All right. The first two operations were welfare—Crippled Children's Fund. The second was personal funds and some insurance. Back to Crippled Children's Fund—beg, borrow, whatever I could. I think I even have $1,000 left to go on her. I don't worry about paying off because they will get paid off. Another boy has diabetes. It is not sugar-related. It is almost as deadly as sugar. A few years ago these people never lived to see 17 years of age. You drink a glass of water and urinate 20 minutes later.

Mr. FROH. How old was he?

Mr. TUCKER. Three and a half. But he had a problem of infected tonsillitis for many years. The doctor beforehand had said there was nothing—they wouldn't touch the tonsils because they would outgrow it. Indirectly through my son's personal physician—we call on the telephone—and that doctor has said that the infected tonsils has infected his pituitary gland which controls his urine problem. We are fortunate that we never withheld his water because of permanent brain damage. However, his medication—we used to have to give it to him in shots form, which was expensive.

Mr. FROH. Insulin?

Mr. TUCKER. No, not insulin. It is a hormone around $4-something a month plus another $3 for the needles—very expensive. No problem, but in order to give him the medication it took five of us to hold him down because the pain was so severe. Then the medication came out called Diafed Nasal Spray—he had to take it every day between 7 and 9 times a day, which was a "hellish" time schedule. The price of this was $12.

Mr. FROH. $12 a bottle? And how many bottles?

Mr. TUCKER. Ten a month. However, I was able to finagle—believe me, I have turned into one of the best finaglers around to get the best price possible. I can get it at $7 a bottle. The second godsend on this problem came with a purely experimental medication. It takes one application—it is in the nose—and he does it himself. I have to meter it out. He no longer has to worry with running to the bathroom. He lives like a normal kid. The retail price is $41. The retail price—I was able to get it because I know a pharmacist. They were able to give it to me at a welfare rate of $30 a month. This is a lot of money between this and my daughter.

Mr. FROH. And how are you presently paying for drugs?

Mr. TUCKER. My wife has allergy problems of the very severe nature. I mean she has bronchitis. She has viral pneumonia of the bronchial tubes. She teaches school. She can't be in a room where there is smoking. I force her to go to work. She takes "dust" medicine. She can't be around where food is being cooked. She can't wash clothes except for once in a while. I do this.

Our medical—it is a State Equitable Insurance Co.—has helped immensely. But that leaves us with a big void of money to take care of. I have applied for welfare—Crippled Children's—my oldest daughter and my youngest son have come under that. The youngest boy has not been fully accepted with the rehabilitation department in West Virginia, but he soon will be. My oldest son—all my kids, all four of my kids—my oldest son is a borderline genius. He needs psychiatric attention, but I can't afford it. I have been able to work with him to try to get him to accept the fact that things aren't perfect in our household.

I had to work 3½ years to pay on these expenses. I have had two cars demolished. The second one burned up on me. I was fortunate to buy another car. I have seven small loans, roughly 42 percent interest—say something like 42.

My father had major surgery and we all had to go. We found out that he had TB spores all through his body. They found out he was a neutral man but because I had to work 3½ years I developed TB because I could only sleep between 4 or 5 hours a night.

Mr. FROH. Well, this was diagnosed 5 weeks ago. And fortunately the State will pay for most of the medication, but they will not pay for the penicillin or to help me control my senses as I go along. And in the meantime it causes me to lose money at my job because I am a cashier. The last couple weeks I have lost $50 a week, and I have to make it up out of my pocket. I am hoping that programs that come along will help other people. We have about crested the hill except for my wife's allergies.

We will give you every assistance we can.

Mr. TUCKER. Believe me, if anybody has a problem trying to get through some social agency—I worked my way through. It is hard. You stick with it and believe me, if somebody wants me to twist somebody's arm, I am there.

Mr. BRANGAN. David Brangan. I would like to speak for a moment about abortion. I don't know if the Senator has considered that as part of the health insurance program or not. Could you enlighten me on that?

Mr. FROH. We are still developing information on that.

Mr. BRANGAN. I want to go on record that I am opposed to any kind of abortion. My philosophy falls in line pretty much with the amendment that has been passed by Congress, and that is what I wanted to say.

Mr. FROH. That will become a part of the formal hearing record. Are there any other witnesses?

Mr. TUCKER. Because I can't work that second job, that puts a deficit of $250 to $580 that we cannot have, which would bring it back to a hardship level. But, because my wife is a teacher with a master's degree, I cannot get any public assistance other than the juvenile rehabilitation to take care of the extra bills we have. So we do not live "high on the hog." I have gone through the house and had it remodeled, but I have got two floors that don't have a pane of glass in them. I put plastic up in the winter and the screens in the summer.

Mr. FROH. Thank you very much.

[Whereupon, at 12:30 p.m., the subcommittee recessed to reconvene subject to the call of the Chair.]

# NATIONAL HEALTH INSURANCE, 1978

**TUESDAY, NOVEMBER 28, 1978**

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U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE COMMITTEE ON HUMAN RESOURCES,
*Chicago, Ill.*

The subcommittee met, pursuant to notice, at 9:15 a.m., at the Billy Caldwell American Legion Post No. 806, 6038 North Cicero Avenue, Chicago, Ill., Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senator Kennedy.

## OPENING STATEMENT BY SENATOR KENNEDY

Senator KENNEDY. We will come to order.

First of all, I want to express my warm appreciation on behalf of the Senate Health Committee to Commander Steinbrecher and the members of the Billy Caldwell Post for providing this very fine hall, and for the amount of cooperation and help we have received from them to hear the testimony that we will hear today. I am extremely grateful.

Mr. Steinbrecher will comment on the issue himself later on but we want to acknowledge our appreciation for their assistance.

Second, I would also like to extend a very warm word of welcome to our Canadian friends. I will introduce them in just a moment, but I want to thank them for taking their time out of their busy lives to join with us and come across the border and help in assisting their friends in the United States to understand better their health care system. They will talk frankly about their families and some of their own experiences over the period of the past year.

Canada, as I am sure they understand, has a very special relationship with the people of the United States. We share common traditions and history and values, and we welcome very much the opportunity to hear from them, both as a group and their willingness to come here to the United States and to talk with us here this morning.

I am enormously grateful, as the members of our Committee are. This has followed a rather interesting precedent of our hearings on health care. Earlier this year, we had Canadian families come to Washington and to share their experiences with us there.

In Detroit we heard from those that live just across the border and from families from the greater Detroit area. Now we hear from Canadians in Chicago and later in Denver and somewhat later in Los Angeles.

But we are very, very grateful. We have learned a great deal, I certainly have. I think the committee has. And we want to thank them for joining us.

Three weeks ago today, the citizens of Illinois, along with millions of Americans across the country, went to the polls. Since that time, analysts have been pouring over the results and have pronounced national health insurance a casualty of the election. I believe those analyses are wrong. The testimony we will hear today from Illinois families will effectively rebut those arguments. Health insurance is not dead—it cannot die while medical costs continue to escalate out of control it cannot die while parents all over America worry whether their child is $50 or $100 sick before seeking medical attention; it cannot die when the threat of financial ruin hangs over so many American families—poor, middle class, and upper middle class alike. It cannot die when our senior citizens are forced to pay more for their care today, even after adjusted for inflation, than they did before medicare was passed.

It cannot die because every American—every man and woman in this country—knows the fear of illness. Everyone in this room today has felt it—for yourself or for your loved ones. In America that fear has two parts: First is the fear of the illness itself, second is the fear of not being able to pay for the needed care or of not being able to afford the basic necessities of life after or while paying for care. How many Americans have lost their savings, their homes, their life insurance policies, in order to pay for care? And this in spite of having insurance; in spite of having a good job and a good income; and in the absence of an unusual medical problem. Common problems like strokes, heart attacks, intestinal ailments requiring surgery, can and do needlessly disrupt the economic lives of millions of Americans.

I might say at this point often we think about the particular medical bills the families have and will hear about them—about those associated with really catastrophic situations I think the testimony we will hear today of very sizable medical bills that are catastrophic in terms of the incomes or savings of those particular families, but the important factor is from the economic point of view is that those illnesses, those sicknesses, those ailments are basically the type of everyday ailments that are affecting millions of American families. They are really not that unusual. They are not that distant from the types of health care problems that affect the average family in this country. They are catastrophic but they are more often typical than unusual.

What we really do in this country, I believe, is penalize people for getting sick. We penalize them financially for something over which they have no control. They have trouble getting insurance. They have to pay more when they do get it. It is a peculiar kind of American Darwinism—survival of the wealthiest.

No other industrialized nation in the free world except South Africa penalizes its people for getting sick. All of them have universal, comprehensive national health insurance. None of those systems is perfect—they have real and serious problems. But not a single political leader, not a single political party, not a single respected commentator, would turn the clock back and substitute our system for theirs.

National health insurance must come to the United States. If it does not, there will be no way to control runaway health costs. The choice is not, as critics would have us believe, between doing nothing on the one hand and enacting a national health plan on the other.

I might just say that this particular chart over here that has been developed by the Congressional Budget Office shows that if we do nothing at all, if we do not come to grips with the health care issues that face this country today, we are going to spend $252 billions by 1981; whereas, if we adopt a national health insurance program with effective cost controls, we are spending actually less than if we are doing nothing at all because of the growth of inflation in our current system.

In our health care area, it is almost double what it is for consumer price index. I think that is what is reflected to some extent with this chart here that shows the growth of the percentage that is of gross national product in the United States over the period of recent years in health.

In 1968, we were spending 6.5 percent. In 1978, 8.8 percent. This is without any national health insurance. That is without any effective kind of cost controls.

Any of our friends that look at what the record of the Congress was last year when we were trying to come to grips with the issue of cost containment and cost controls know that even a program that set a 14 percent increase in hospital costs for the first year, 12 percent the second year lost in the Congress of the United States.

What we have seen are enormous growth projections in terms of health care costs by doing nothing at all.

The question is whether we are going to be able to get effective handle on those costs over the period of future years and deal with the issues of equity and fairness and compassion in our health care system.

So if we do not do anything, we will see the explosions of the cost. It need not be that way. We will hear from families in Illinois and their counterparts in Canada, and one of the interesting points on the issues of cost is what the contrast has been with Canada. They were spending 6.8 percent of GNP in Canada on health in 1968 when they implemented their final aspects of national health insurance, and now they are spending effectively 7.1 percent 10 years later with prospective budgeting and effective cost controls.

It is going to be fair to ask with that kind of cost controls what the people of Canada feel about that particular program. Whether it is a program of humaneness and compassion and decency, and whether Canadian people feel that it is effective in meeting the health care needs of their particular families because we hear a great deal about that issue, we want to hear from our friends in Canada on that.

We will move to our witnesses today. We are delighted to welcome our families from the Chicago area. We appreciate their joining with us.

First will be Mrs. Loretta Wilson, from Chicago, and Mr. and Mrs. Iain Troup, from Windsor, Ontario.

What I am going to do is ask some questions, first of Mrs. Wilson, and then we will go down and hear from our other families, Mr. and

Mrs. Louis Steinbrecher, from Chicago, and Mr. and Mrs. Gerald Clancy, from Windsor, Ontario; and then Mrs. Reifsterk, from Lena, Ill., and Mr. and Mrs. Gerard Beneteau, from Windsor, Ontario, and Mr. and Mrs. Kemo Biondi, from Chicago, Ill., and Mr. and Mrs. Archie Kinberg, from Hamilton, Ontario.

Then we will hear from Mr. and Mrs. Bjarnason, from Buffalo Grove, Ill., Mr. and Mrs. Agnew, from Windsor, Ontario; Mr. and Mrs. Moss, from Chicago, Ill., and Mr. and Mrs. Mieyette, from Manitoba, Canada.

We will start with Mr. Steinbrecher, from Chicago.

Mr. Steinbrecher, I believe you are 58 years old?

Mr. STEINBRECHER. Yes. I was born the same day as Stan Musial, November 21, 1920.

**STATEMENTS OF MR. AND MRS. ARCHIE KINBERG, HAMILTON, ONTARIO; BELLE BIONDI, CHICAGO, ILL.; MR. AND MRS. PAUL (GLORIA) MIEYETTE, WINNIPEG, MANITOBA, JOHN MOSS, CHICAGO, ILL.; MR. AND MRS. IAIN TROUP, WINDSOR, ONTARIO; LORETTA WILSON, CHICAGO, ILL.; MR. AND MRS. GERALD CLANCY, WINDSOR, ONTARIO; LOUIS STEINBRECHER, CHICAGO, ILL.; MR. AND MRS. GERARD BENETEAU, WINDSOR, ONTARIO; MARGARET REIFSTERK, CHICAGO, ILL.; MR. AND MRS. SAM AGNEW, WINDSOR, ONTARIO; AND MR. AND MRS. CHARLES (GERALDINE) BJARNASON, BUFFALO GROVE, ILL., A PANEL**

Mr. STEINBRECHER. I would preface my remarks with a thanks, a deep thanks for the staff of the Swedish Covenant Hospital because without them and their heroic actions, quick actions, their facilities, their patience and their love and their kindness, I would not be here. I would have died 4 years ago.

And also thanks to modern medicine, the medicine, that if it had happened about 10 years prior to that, they would have let me bleed to death. We are making progress in medicine.

I would also like to say these people at Swedish Covenant are of the highest caliber. They are kind, good, sincere, dedicated, and knowledgeable. I also want to express my thanks to the chaplains who gave me the spiritual strength to survive this ordeal. I never will forget it as long as I live.

I will say they are a victim of the system. I have asked one of our assistant directors what the problem was. He explained to me, but they are victims as well.

Senator KENNEDY. I think that is very true just as doctors are and as consumers are. That is why it is essential we deal with the total systems approach rather than just sort of Band Aid approach. I agree with that.

Let me just ask you some specific questions.

As I understand it, 4 years ago, with your illness, you were taken to the hospital and you were given a series of transfusions, is that correct?

Mr. STEINBRECHER. Yes: I was given 19 pints of blood.

Senator KENNEDY. You had surgery?

Mr. STEINBRECHER. Yes; it was really a rough situation. I had really practically everything in the book.

Senator KENNEDY. Collapsed lung, is that correct?

Mr. STEINBRECHER. I had the same as one of our Presidents had. I had a collapsed lung. I had a blood clot on my lung. I had 105° temperature. My blood pressure was 50/40.

Senator KENNEDY. You were a very sick man?

Mr. STEINBRECHER. Not only that, but I also developed an infection. And I was unable to work for about 2 or 3 months later. Then I became anemic. Thank God I pulled through.

Senator KENNEDY. You had some medical insurance?

Mr. STEINBRECHER. Yes. I had Blue Cross and Blue Shield.

Senator KENNEDY. What part of the medical bills were covered?

Mr. STEINBRECHER. Roughly costs totaled about $11,000, and out of that I was reimbursed $7,000, and then I had to go over to our savings and loan association and pull out about roughly $3,900, plus I had a few other payments in the following year.

Senator KENNEDY. So they covered a little better than half?

Mr. STEINBRECHER. Roughly about 60 percent. Thank God I was able to go to my savings. I feel sorry for the people who are unable to do this.

Senator KENNEDY. You have a daughter who, several years ago, fell off a sled and broke her elbow, is that correct?

Mr. STEINBRECHER. She tried to make a sled run out of a slide. She dislocated her elbow. She was in intensive care because they were afraid that the artery might be punctured or she might have a nerve that might be pinched and give her paralysis. She came out very fine.

Senator KENNEDY. She was covered by some of the insurance, but you had to pay some of that as well, did you not?

Mr. STEINBRECHER. It is like going to bed and having your feet stick out.

Senator KENNEDY. Do you remember how much approximately that was?

Mr. STEINBRECKER. Certainly. That was $2,300. She was in intensive care because of this condition.

Senator KENNEDY. The insurance paid part?

Mr. STEINBRECHER. Yes. They paid roughly about $1,600. I paid about $650 in all.

Senator KENNEDY. You were one of the people in our system who actually recovered with health insurance, probably a good program that exists today, and still you had those kinds of financial payments for your own health and for your child's health?

Mr. STEINBRECHER. Yes, sir.

Senator KENNEDY. Mr. Clancy, how old are you?

Mr. CLANCY. Fifty-one.

Senator KENNEDY. You are about the same age, about 6 years difference. You are a member of the Auto Workers, is that correct?

Mr. CLANCY. UAW.

Senator KENNEDY. You have diabetes?

Mr. CLANCY. Yes.

Senator KENNEDY. Has that ever required hospitalization?

Mr. CLANCY. On about four occasions. I was confined about 3 weeks to where I could leave the hospital.

Senator KENNEDY. You spent some time in the hospital for a chronic condition?

Mr. CLANCY. Yes; I have.

Senator KENNEDY. How long would you say you spent in the hospital?

Mr. CLANCY. Over the period of my life, at least 6 or 7 months.

Senator KENNEDY. And in 1977 did you not have a swimming pool accident?

Mr. CLANCY. Yes.

Senator KENNEDY. Would you tell us a little bit about that?

Mr. CLANCY. I was getting out of my pool and I fell back in and ripped my heel, which became infected. I was put in isolation for 3 weeks in the hospital, and for 6 months I was an outpatient and had to go in every week.

Senator KENNEDY. Now, at sometime Mrs. Clancy had some surgery, as I understand, as well?

Mr. CLANCY. She has had three major surgeries, kidney operations.

Senator KENNEDY. Over a period of recent years, last several years?

Mr. CLANCY. Yes.

Senator KENNEDY. You have children as I understand, five children?

Mr. CLANCY. That is right.

Senator KENNEDY. You have had your fair share of broken bones, I understand, with them.

Mr. CLANCY. Two boys were great football players. After the game, they were in the hospital every weekend.

Senator KENNEDY. So your children have been hospitalized. Do you have any idea about how many times?

Mr. CLANCY. Not that often.

Senator KENNEDY. A fair number of broken bones?

Mr. CLANCY. Yes.

Senator KENNEDY. How did you pay for yours? We heard now from Mr. Steinbrecher about his hospitalization and the amount going down to his savings account and taking out approximately $5,000 for his own hospital bill, and approximately $600 a few years ago for his children.

You have been in the hospital several times in the last few years. Your wife has had three major operations, and your children also have had broken bones.

Can you tell us how much you had to pay?

Mr. CLANCY. Nothing whatsoever. Nothing that was laid out of my own pocket.

Senator KENNEDY. Who paid for the program?

Mr. CLANCY. OHIP.

Senator KENNEDY. That is what?

Mr. CLANCY. Ontario Hospital Insurance plan.

Senator KENNEDY. Were you satisfied with both the medical treatment that you received——

Mr. CLANCY. I was in a semi-private room and we got the best of care and choice of doctors.

Senator KENNEDY. Did you have choice of doctors that you wanted?

Mr. CLANCY. Oh, yes.

Senator KENNEDY. Could you have gone to a different hospital if you had not been satisfied?

Mr. CLANCY. I could have.

Senator KENNEDY. But you were satisfied with both the hospital and the medical attention you received?

Mr. CLANCY. I figured I was given the best.

Senator KENNEDY. You felt that way, too, Mrs. Clancy?

Mrs. CLANCY. Yes.

Senator KENNEDY. You felt that way about your children as well?

Mr. CLANCY. Definitely. They did not want to leave a couple of times.

Senator KENNEDY. What has it meant to you to have a national health insurance as a parent?

Mr. CLANCEY. It means I never had a worry or apprehension of anything like coming home and finding one of the children hurt or the wife ill or I had to go in where it had to be a financial drain—it has never been a worry since we have been under this plan.

Senator KENNEDY. Do you have any reactions to that, Mr. Steinbrecher?

Mr. STEINBRECHER. Yes; I do.

Senator, I would like to say when I first started the Blue Cross and Blue Shield, the cost was $46 covering 3 months. Now, even though I am well, it costs me still $184.72 every 2 months. So that totals $1,108.32 even though I stay healthy, which is still a lot of money.

I would also like to say, too, that when my wife had her first child—Louis is 17 years old now—she paid $25 a room. When I had Anita, it was kept kind of stationary, 2½ years later, and then when we had one of the children in the hospital for tonsils, it climbed up to $73 a day.

When I was in, it was $96 a day. Now, I understand that you stay in the hospital, and I have a mother-in-law in the hospital now, and it will cost about $165 a day. So it has escalated much faster than the increase in my salary.

Senator KENNEDY. I would think that is true about everyone we are going to hear from this morning,

Do you think you speak for other members of the Post as well? You are Commander of the Post. Just from your own understanding and familiarity with the other members of the Post, are they affected in similar kinds of ways?

Mr. STEINBRECHER. About the only thing we have going for us is Veterans Hospitals. One of our members went to the Veterans Hospital and had open heart surgery. And the tab on that if he went to a regular hospital would have been $31,000.

Senator KENNEDY. Well, I think we see what can happen in two different situations, both in Windsor, Ontario, and Chicago, Ill., from families approximately the same age, basically the same relative income, and what happens is one system in Canada compared with what happens in the United States.

I want to say at this time we welcome our senior citizens who have joined us here today. Good morning. We are glad you are here. You are very welcome.

Mrs. Wilson, we are delighted to have you here. We appreciate your coming.

As I understand, you have been married for 23 years, is that correct?

Mrs. WILSON. That is correct.

Senator KENNEDY. Can you tell us what Mr. Wilson does?

Mrs. WILSON. Supervisor, Fort McMillan Blodell Co.

Senator KENNEDY. What kind of insurance policy do you have right now?

Mrs. WILSON. Right now we have Prudential Life. It is not major medical. It is 80 percent.

Senator KENNEDY. So it covers approximately 80 percent of your hospitalization, that is hospital bills, and a smaller percentage of the doctor's bills?

Mrs. WILSON. That is right.

Senator KENNEDY. Do you have children?

Mrs. WILSON. Yes. I have six children.

Senator KENNEDY. How many of them live at home?

Mrs. WILSON. Four.

Senator KENNEDY. Do you work?

Mrs. WILSON. Yes; I do.

Senator KENNEDY. Where do you work?

Mrs. WILSON. I work for Appollo Detective Agency.

Senator KENNEDY. How much do you make an hour?

Mrs. WILSON. Three dollars an hour.

Senator KENNEDY. Your husband works, is a supervisor, and you work as well. As I understand it, you have had some problems with your heart.

Could you describe those for us?

Mrs. WILSON. Yes. I had open heart surgery in 1973. Since then I have had seven operations and I have to have medicine constantly, so that is a pretty big bill. I have been in the hospital every year since 1970, twice a year. This is the first year that I have not gone to the hospital since 1970.

Senator KENNEDY. When you first had open heart surgery, did you have any insurance?

Mrs. WILSON. Yes. We had Blue Cross and Blue Shield which was canceled after the surgery after I came home.

Senator KENNEDY. Why was it canceled?

Mrs. WILSON. Because they say we went over the limit.

Senator KENNEDY. So they cancel it if you go over a certain limit?

Mrs. WILSON. That is what they told us.

Senator KENNEDY. In any event you were without insurance for awhile?

Mrs. WILSON. Right.

Senator KENNEDY. What kind of medical bills have all of these medical problems run up?

Mrs. WILSON. They have run me approximately about $45,000.

Senator KENNEDY. How much of the money do you owe, you and your family?

Mrs. WILSON. $19,539.95.

Senator KENNEDY. You owe that now?

Mrs. WILSON. Yes.

Senator KENNEDY. How are you going to pay those bills?

Mrs. WILSON. I don't know.

Senator KENNEDY. You tried to pay those?

Mrs. WILSON. I tried to pay some of the collection agencies that I get letters from, $10 or $15 a week, or a month, which they constantly

come in every day, because a lot of the bills have been turned over. The hospital bill itself was paid, but the way the hospital was set up, radiology, that is one bill because they have to be paid, and anesthesiologist, that is another bill, a separate bill, and the boctor's bill, that is another separate bill. Everything is broken up into separate bills.

Senator KENNEDY. But as I understand, your husband has got a good job; you are working; you have got 6 children at home; you have got serious heart problems; you owe $19,539, and you are still trying to pay that off, either a few dollars a week or a few dollars a month and still bring those children up, is that correct?

Mrs. WILSON. That is true.

Senator KENNEDY. Have you ever been turned away because you have not been able to pay?

Mrs. WILSON. Yes. I was turned away from Mercy Hospital. I had what they call an ovarian cyst. I was bleeding inside. I went to Mercy Hospital.

Senator KENNEDY. Is that not fairly common, that kind of illness? It is fairly common, as I understand it.

Mrs. WILSON. Yes. They told me they did not have any room, they would call the police to take me to County Hospital. That is where I had surgery for that.

Senator KENNEDY. How does it make you feel with that kind of medical bill still hanging over your head?

Mrs. WILSON. It is more or less a constant worry because we have not had a home too long, and with judgments—we have got a few judgments now that are coming in, and I do not know anything about the law, but I have been told by several people that they cannot put a lien against a home. We are barely eating half of the time with the collection agency knocking on our door. I do not make enough money to pay for my children to go to school, and my husband, well, he does the best he can. It is hard.

With winter weather coming on and high gas bills and everything, it is a lot of those people that will not get paid.

Senator KENNEDY. Mr. Troup, as I understand, you have had problems with your heart.

Could you tell us a little bit about the kind of problems?

Mr. TROUP. My trouble first started in 1960 with my first heart attack. There have been three subsequent heart attacks. Three years ago, June 12, 1975, I had three bypasses and an aneurysm repaired. Since 1960, I have been in the hospital 10 times. It cost me $60 for my heart operation.

Senator KENNEDY. Sixty dollars for your heart operation?

Mr. TROUP. I had to pay $60.

Senator KENNEDY. You had four surgeries?

Mr. TROUP. Four heart attacks, three bypasses, an aneurysm repaired in surgery.

Senator KENNEDY. How long were you in the hospital during those times?

Mr. TROUP. I was in 4 days for heart scan and workup, and I was 10 days for the operation.

Senator KENNEDY. What about heart attacks?

Mr. TROUP. I have had three previous heart attacks, in the hospital 3 weeks for most of them, 1 week for the last one because I was sup-

posed to go to London for a heart scan and I ended up in the hospital in Windsor with a heart attack at which they told me I had food poisoning because my EKG did not show any change from the previous heart attack. And when we had our heart scan, it showed occlusion had lodged in the dead part of the heart from the first heart attack. If it had not been lodged there, I would have been dead.

Senator KENNEDY. So you received medical treatment when you needed it. Were you satisfied with the medical treatment you received?

Mr. TROUP. It could not have been any better.

Senator KENNEDY. You feel that way?

Mr. TROUP. Certainly. And my whole family—nothing ever happens that you have to worry about.

Senator KENNEDY. How do most of your friends feel about it? Do they feel the same way?

Mr. TROUP. I have never heard anyone complain about it. The only complaints you ever hear are rising like everything else, there is a certain feeling that it is like in any system or plan, certain people abuse it, and it is detrimental to those who need it.

Senator KENNEDY. You certainly needed it, did you not?

Mr. TROUP. I certainly did.

Senator KENNEDY. We see here Mrs. Wilson with serious heart problems, operations that were necessary and the complications that came about from it. She is working and her husband is working. They have six children. They are facing close to $20,000 in debt with judgments coming in against the family. They are having an incredibly difficult time trying to make ends meet with the concern about winter coming and heating their home and providing food on the table. And Mr. Troup finds out that he has had heart attacks, three different heart attacks, in the hospital for several weeks, heart surgery, open heart surgery, medication I imagine—you receive medication?

Mr. TROUP. Yes.

Senator KENNEDY. And his total bill was $60. You do not have any debt now?

Mr. TROUP. No.

Senator KENNEDY. You do not owe the system or the hospitals anything?

Mr. TROUP. No sir.

Senator KENNEDY. And well satisfied with the system. I think what it conveys, at least to me, is the question of the freedom of fear from illness and sickness.

Mrs. Wilson, I guess a day does not go by when you are not worried about these bills?

Mrs. WILSON. I worry about the bills and then, too, I worry about going back to the hospital. We could not possibly make it. My husband could not make it if I went back to the hospital and stayed any length of time. He has to get somebody to watch the kids and pay somebody if I stay in the hospital.

Mr. TROUP. There is one point I would like to add. I do not want any misunderstanding. We pay premium for services, $38.80 a month.

Senator KENNEDY. What were you paying, Mr. Steinbrecher? They are paying $38.80 a month. I think you were paying $184 for 2 months. That is quite a difference in terms of the fee. And Mr. Steinbrecher is not getting full coverage. He is getting about 80 percent covered for the hospitalization, paying three time as much.

That is about the way I think it would work out mathematically.

We will hear now from Mrs. Reifsterk from Lena, Ill.

Mrs. Reifsterk, as I understand, you have a son Benjamin?

Mrs. REIFSTERK. Yes.

When Benjamin was about 3 weeks old, he was hospitalized in Freeport, Ill., with what was believed to have been pneumonia. The following day he went into severe congestive heart failure and was transferred by ambulance to a hospital in Madison, Wis. He was taken there because he needed immediate emergency medical care. Time was of the essence and the care he needed in terms of time and equipment was available in Madison.

At first, the doctors were able to stabilize Benjamin's condition with medication. Later he worsened.

When he was 7 weeks old, he underwent a series of cardiovascular open heart and lung surgeries. This was at 7 weeks. Against all odds, Benjamin survived the operations and we were ultimately able to take him back home to Lima. These operations were only temporary measures. Benjamin had a very rare condition. There is no corrective surgery at this point in time for our baby.

Later, last winter, in February, Benjamin was hospitalized again. This time with viral pneumonia. Hospitalized in Freeport. Because of his heart condition and because there is no corrective surgery, he has not had corrective surgery, he is also in some degree of heart failure, and this fluctuates from mild to severe depending on the circumstances, and because of his lung problems, any problems with pneumonia affect his heart and he was hospitalized first in Freeport and then sent by ambulance to Madison.

Just last month, he contacted bacterial pneumonia. This time he was transferred directly to Madison. He did not stop in Freeport on the way. After we got him home—and we were very grateful, of course, that we were able to take him home. And we have a private insurance plan, my husband is a carpenter, but not through any union. And when my husband does not work, he does not have company coverage. For that reason, we carry a private insurance policy so that he is always covered. We found out that the policy that we thought was a good policy turned out to be not so good. It is covering less than half the expenses. Today the expenses for Benjamin's hospitalizations run between $30,000 and $40,000.

This includes the doctors' fees and includes the hospital fees.

Our insurace will cut off any and all coverage at $100,000.

I know that we will reach this amount probably within the next couple of years. Every other insurance company has flatly refused to cover Benjamin. They are willing to cover him if they exclude his cardiac condition.

With his lung problems, something as simple for someone else as pneumonia becomes very, very dangerous in a child. So we started contracting agencies when we found out that our health insurance plan was not going to pay the complete coverage. We contacted Social Security because of the ads on television for children, if you know a family who has a child with a problem, tell them about supplemental security income. No; it does not exist in cases such as ours. The representative that I talked to from Social Security accused me of putting on an act over the telephone. He accused me of trying to cry and get

his sympathy and said flat out, "Look, lady, it is not going to work with me. You can cut out your act."

He found out that I am trained to teach school and told me that I was young, I was healthy, I should get a job. At the time that I contacted him, when feeding our baby, every 3 hours I would have to put a tube up through his nasal passages down to his stomach, and be very careful I got into the stomach and not the lungs, and would force formula, a very high protein, high calorie formula through this tube into his stomach. Because he was hospitalized so long and was so sick, he could not get his act together. He sucked because he had a pacifier, but he did not get the sequence of sucking, breathing and swallowing and, therefore, could not nipple his formula, could not nipple out of the bottle his formula.

I was doing this lavage feeding every 3 hours around the clock. Because of Benjamin's condition, when the formula gets to his stomach, it would come directly out, just spew forth. He had to be completely upright when I fed him. Therefore, the process took an hur.

So I only had two hours in between each feeding.

I have an aunt who is a nurse, and my mother is a nurse. I have a lot of very great friends, and everyone is afraid to take care of the child. There was absolutely no way on earth that I could have gone outside the home and gotten a job, and yet that is what this Social Security agent told me to do.

Senator KENNEDY. As I understand, you feed the child every 3 hours, 24 hours a day?

Mrs. REIFSTERK. Yes, right. It took until, I remember the day, the 29th of December last year was the first time Benjamin was able to nipple his minimum requirement which, at that time, was 14 or 15 ounces, which was not a lot. Most babies can sit down at one feeding and take that much fluid.

So then one of the financial advisers at this one clinic that we go to suggested that we contact the township supervisor, and they said that in Illinois the township receives moneys to help with medical expenses. When I contacted the township supervisor, he said he would have to check at the next meeting get back to me. He did. He said because Benjamin is not 65 years old and because he not indigent, he therefore is not eligible.

My husband did not want to me do it, but I contacted State aid. We were told that our income was too high. The State of Illinois, believe this or not, allows a family of four to earn $339 a month total. Any excess is declared surplus income. They maintain that any amount over the sum of $339 a month is surplus income and can be used to pay toward medical expenses. I think they are crazy. Food alone, food and utilities costs more than $339.

I brought with me something that I think is very interesting. This is when the State of Illinois told us that Benjamin—there is no way that they can help us—Benjamin received a letter, dated April 18, 1978, addressed to "Steinbrecher, Benjamin" from the Illinois Department of Public Aids stating—it is written in English and in Spanish—it tells Benjamin they are sorry that the Illinois Department of Public Aid will no longer pay for abortions performed on or after May 1, 1978. At this time, Benjamin was 7 months old. He really did not have

any need to find out about whether or not his abortions would be paid for.

I think it is strange that Illinois can afford to send these letters out. It has got to cost for the paper, the envelope, the postage. Not only that, I found out later that each and every person living in the county old people's home—these are 60, 70, 80, 90 and 100-year-old people in our county—everyone received the same letter. I am sure we have some senior citizens here today and I am sure that they would be interested in knowing that they cannot get abortions any more either.

It is really crazy.

Next, we contacted the division of services for crippled children, which has to do with birth defects. I have the pamphlet that explains all about crippled children. One of the things they cover is emergencies with cardiac treatment—except they do not cover emergencies with cardiac treatment. I got in touch with the representative of the 35th District, State of Illinois, House of Representatives, and I got in touch with him to see what he could do. He found out that this DSCC, first of all, is at least 50-percent federally funded. If they are getting money from the Federal Government, why will they not help? And he found out that other families had received help out of State.

Crippled children said we went to Wisconsin, not to Illinois. And because we went to Wisconsin, Benjamin is not eligible. I am sick and tired of these people acting as though Wisconsin—by the way, we live 8 miles from the border—they act as though Wisconsin is a foreign country, a Communist foreign country, instead of just a different pasture 8 miles up the road. They said we went out of State, therefore we would not be covered. Even though it says in the pamphlet that they put out that in emergency situations——

Senator KENNEDY. Just on this point, I understand you do not qualify from Wisconsin because you are an Illinois resident?

Mrs. REIFSTERK. It is a catch 22 situation. Illinois will not help us because we went to Wisconsin, and Wisconsin will not help us because we are in Illinois. I am so tired of Dr. List, worrying about his budget—Dr. List is head of crippled children—he has more concern for his budget than he does for real live children. I am prejudiced. I want to see my son live until he is 4 or 5 and, hopefully, there will be a cure for him. He is a darling child. I want that son to live. There are other families who have not gotten help too.

Our pediatrician back home has had very poor luck with the division of services for crippled children in the past. Their services seem to be—they are only on a very, very select basis. And then a lot of times only for research. If you do not fit into the very narrow limit that they decide you will have, then you just cannot get the help.

Right now we have got an insurance policy that will cut off at $100,000. They pay 85 percent sometimes.

The surgeon fortunately wrote us a letter and said he would accept our insurance payment, what the insurance paid as full coverage. He accepted that as full coverage.

The insurance company gets out of paying two ways. They say, first of all, an expense is not needed for the treatment, and in February there was expense with it under miscellaneous expense for hundreds of dollars. When I asked them what miscellaneous expense was, they said nothing of this was eligible. At this time, I want you to know he

was hospitalized with vital pneumonia. The hospital said, well, miscellaneous expense covers such things as oxygen, therapy, chest therapy, and the insurance company said this was a miscellaneous expense not covered, not needed for that particular illness.

That is one way the insurance company gets out of paying.

Senator KENNEDY. Let me ask you at this time your husband is working?

Mrs. REIFSTERK. Yes.

Senator KENNEDY. He earns approximately what?

Mrs. REIFSTERK. He made $18,000 last year. The year before, he made $3,000.

Senator KENNEDY. You try to have income average?

Mrs. REIFSTERK. I asked them if they considered income averaging. They said no, you take the last three paycheck stubs. And you could never have made anything all your life, and all of a sudden be employed—the way it works, you could be employed for 3 weeks, and you would have to take those 3 weeks stubs in. One is contingent upon the other. If you are not eligible for one program, you automatically are ineligible for any other program.

The Hills-Burton Act, for example, said that the hospital has to lower room costs, and they have to treat you. That is not true. The only way that the hospital will lower the room cost, if you are already on aid, State aid. If you are already on State aid, then you have a green medical card and you do not need anyone to lower the cost.

Senator KENNEDY. How is Benjamin now?

Mrs. REIFSTERK. Right now, he has never been better. He is 15 months old. He is small. He got down to 14 pounds last month and hospitalized with bacterial pneumonia. He is starting to walk. Everyone is amazed at how well he is doing. They said he might have to be 2 or 3 years old before he had the strength to walk. He has half a heart, no valves. His aorta and pulmonary arteries are reversed and enter at the same point in the heart.

Senator KENNEDY. You have how much in medical bills now?

Mrs. REIFSTERK. After insurance paid, we had $15,000 that we owed. We have received some help since that time, not from any organized group.

Senator KENNEDY. Local community people?

Mrs. REIFSTERK. Right.

One thing that really helped was the fact that the surgeon who did the open heart surgery said he would accept full payments.

Senator KENNEDY. You are looking down the road to when your insurance is going to run out in any event?

Mrs. REIFSTERK. I know it is going to run out.

Senator KENNEDY. And run into medical bills before that?

Mrs. REIFSTERK. Benjamin has been refused any and every kind of insurance.

There is one point that I notice a lot of placards here today and propaganda and people saying we have got good health coverage, and I want to say something to you people, and that is if you have not been in this situation, you have no right to judge. The problems that my family is facing right now and problems that other families are facing did not exist in the past, and even a few years ago when the public aid programs and supplemental security income programs were

written, a lot of these problems did not exist because then the children died. The children with these problems, the people with these problems, with heart problems, with bleeding ulcers, whatever, we did not have the medical costs because the people died.

Benjamin would have been dead 4 years ago. Four years ago, they did not have the surgeries that he did have. It is only recently that the children and adults, too, have been saved. Then it is because of our advanced medical technology. The problem is there is a fantastic price to pay. In the past, children who did survive were encouraged by the doctors—the parents were encouraged to put these children into State institutions. We were told at one point to give our son up. If we had placed Benjamin into a foster home, he would have been receiving assured immediate and guaranteed moneys regardless of the income of the foster family. They could have $100,000, $500,000 in a Swiss bank account, and all of Benjamin's expenses would have been paid. Plus he would have supplemental security income, SSI. The foster family would have had a medical green card through public aid assistance, and also moneys would have been guaranteed either for children in family services or mental health services—well, with Benjamin, it would not be mental health, but depending on disability, there are three to four agencies that would have funded this.

We do not choose to give our child up. We want our child in our own home and we want our child and do not want to give him up.

Had we given him up, the bills would have been paid.

Senator KENNEDY. Let me ask Mrs. Beneteau.

I understand that you have four children of your own, ages 1 to 5, and that you are expecting a fifth?

Mrs. BENETEAU. Yes; we call it our sixth because of our adopted child.

Senator KENNEDY. Wonderful.

As I understand it, 2 years ago, you had three normal healthy children, and you decided to adopt a disabled child?

Mr. BENETEAU. Yes; we did.

Senator KENNEDY. Why did you decide to adopt a disabled child?

Mrs. BENETEAU. We had normal children, and Gerry and I always said as soon as I got pregnant, if we were given an abnormal child, we would accept it with our whole heart. Since we had set our mind to it already, we thought we could give a child love, let us go get one, and he showed up in the paper, and he was "Today's Child"—do you have it in the States—where the adoption agency puts a hard to place child's picture in the paper with a write-up about it, and you apply for that child and adopt him. And that is what we did.

Senator KENNEDY. You felt it was important for healthy children to participate in caring for disabled child?

Mrs. BENETEAU. It has changed our attitude about handicaps. I used to be afraid of retarded people, really afraid of them. Now, I can walk up to any retarded person and treat them as normal people because they are people.

Senator KENNEDY. What was the disabled child's name?

Mrs. BENETEAU. Michael.

Senator KENNEDY. What is his problem?

Mrs. BENETEAU. He was born with a syndrome that in the fourth month of pregnancy, a soft spot and four divisions of the skull closed,

and he got a massive bone build up which was forcing his eyes out, but he did not develop a good nasal passage. He had almost cleft palate—not cleft, there is no hole. A high palate. His fingers did not separate and the toes did not separate, and the fingers are not formed. He can only bend his fingers from here [indicating]. It caused brain damage. He had two cranial surgeries under the Children's Aid Care. They took sections of bone out of his forehead to relieve pressure on the brain and his eyes.

Senator KENNEDY. Has he had operations since he has been in your family?

Mrs. BENETEAU. Since he had been with us, he has had four operations. Fingers seperated and some of his toes. That took two operations.

He had a dental procedure. They drilled holes in his teeth so they could wire his jaw. In July, he was operated on for 17½ hours to reshape his whole face from his top jaw to the back of his head. They just reshaped everything. They took four of his ribs and put them in here, brought features out, took away from the bulged eyes. They reshaped the skull and took his—gave his brain room to grow.

He has been much more alert since they have taken pressure off the brain.

Senator KENNEDY. Those were four operations?

Mrs. BENETEAU. One for the face was one operation. There were complications. He had to go back down on two other points, and it was a total of 17½ hours.

Senator KENNEDY. How have you been able to afford such extraordinary medical expenses?

Mrs. BENETEAU. We have not had to pay anything other than long distance telephone calls from Toronto to Windsor. When I go to Toronto, I stay in the nurses' quarters. The Rotary, they fund Crippled Children's Association in Toronto, and the Toronto Society for Crippled Children, they paid for my food, lodging, and my babysitters for the other children. They paid for my transportation, the train fare—if he has to go by plane, they pay for the plane, and they pay for taxis, buses. They pay for everything.

Senator KENNEDY. What about the operations?

Mrs. BENETEAU. Dr. Monroe accepts OHIP payment, not in full usually, but in our case he does. Then the hospital—they showed me the bill, and this bill was from July 4 to August 4, intensive care for 2 weeks, and there was a special room because he had tracheostomy, and he was in a special room where he had nurses care 24 hours a day, and there was always a nurse in that room. And they showed me the bill and it was over $10,000. We did not have to pay 1 penny.

So, for all his operations, we paid approximately $60 for telephone bills.

Senator KENNEDY. As I understand, in Canada you get some reimbursement from the Province just to take care of the child?

Mrs. BENETEAU. Michael blinded his eye in February and, shortly after that, they came out with this new pension, just in Ontario, that we get $150 a month for the care of our child so we do not have to put him in an institution. It eliminates an institution. It helps people adopt children without financial burden.

Senator KENNEDY. I think these two families perhaps demonstrate as clearly as could be demonstrated the essential issue of philosophy

and humanity which I think lies between the Canadian system with all of its difficulties and all of its complexities and all the problems that it faces, and the failure in the United States for us to deal effectively with our health care challenges.

On the one hand, you have a devoted mother trying to take care of a child, devoting hours of time and effort, energy and love in caring for that child. I am sure there is not a day that goes by, Mrs. Reifsterk, that you are not thinking when that insurance is going to end. You are burdened with the medical bills that have already accumulated. As a carpenter your husband's work is, to a large extent, dependent on general economic conditions. You are facing bureaucracy in local, State and Federal Government and finding all of the bureaucracy geared toward removing you from the child, and basically inhumane and indecent policy toward a mother and a child.

On the other hand, the basis of a policy in Canada is actually encouraging the caring and the loving of a child. We see a family reaching out and adopting a child to live with other children and giving the love and attention and affection to that child and removing the child from the institutional framework. They have a basic health care system which encourages a family, and a family unit, to bring the child out of the institution and to remove the pain and anguish of financial burden from the parents.

On the other hand, in our system—or nonsystem—we have extraordinary anguish in listening to Mrs. Reifsterk, about how she is attempting to deal with his financial problem.

It will say something about our society and our civilization in years down the road. I think it says something about it today, quite frankly, that over any period of the future about how long we can tolerate this kind of condition.

We will get all kinds of letters in the mail saying why did you carefully select those witnesses in Chicago? You can find this kind of situation in every community of this country, every community of this country. We have gone down to the hollows of West Virginia, and you hear the exact same story. You go into rural communities, you go into cities. You stay in Washington and you will hear the exact same stories, the names are different and the hospitals are different, but the same kind of personal anguish and the same kind of personal tragedy. It really is a deplorable situation and one that we ought to be addressing and coming to grips with.

Mrs. Beneteau, you had your hand up.

Mrs. BENETEAU. When you stress taking my son away from an institutional atmosphere, it was not a foster home—but he was 6 years old and he did not speak and he was not toilet trained. And she thought he would just be barely trainable. He goes to the rehabilitation center in Windsor, and he is speaking at the 6-age level in 2 years, and learning to read. He can pick up letters out of a magazine. He can communicate his feelings.

Before, you never knew when he was hungry, never knew if he was cold or tired because he did not express these feelings. Now, he is constantly complaining, to put it in a good way, he is a good child and he has learned a lot in 2 years.

Senator KENNEDY. Would you have been able to do this, adopt this child, if you had to pay for medical attention, given your family income?

Mrs. BENETEAU. If we had to pay for anything other than his clothing and his food, then it would have been totally impossible because then I would have felt guilty about doing so, taking so much away from my family. It would have put us in debt so far that we would have never seen clear. That is what we decided when we adopted. We told the agency that. We said we will take the emotional strain and give him love and the items which he needs, but we cannot pay for anything. We have not even paid for trivial amounts.

Senator KENNEDY. Mrs. Reifsterk, do you want to make any brief reaction to that, and then we will move on?

Mrs. BENETEAU. I wanted to say that our other children have been hospitalized as well. Every one of our children—well, right now, my 14-month-old is in the hospital right now in Windsor with bronchial asthma. He had an asthma attack 4 days ago and was given adrenalin and some other kind of asthma medication and was put in oxygen 48 hours.

When I go there, like I've been in so many times with stitches and things like that, people in emergency know me and they say, OK, what was the last date he was in, and they will pull out the file and type it up, and say go in that room or the doctor is in within 10 minutes. And he is upstairs within an hour.

Senator KENNEDY. You are well satisfied with the service?

Mrs. BENETEAU. In Toronto and in Windsor, although with the cutbacks I am disappointed that they are closing wards in Toronto Sick Children. It is such an important hospital.

Senator KENNEDY. Mrs. Reifsterk.

Mrs. REIFSTERK. There is one thing that I found fascinating when Mrs. Beneteau was talking, not only having the medical costs covered, but also help with babysitters, help with everything, except for phone calls. I was really unpleasantly surprised when we went to have our taxes figured for income taxes this past year to find out that the only eligible expense that we could deduct was mileage to and from doctors and to and from the hospital. We, as of July, had had over $100 in phone bills to doctors and to the hospitals. Now, that was just in July. He has been hospitalized since then.

Senator KENNEDY. If you went to lunch at a fancy restaurant, you could deduct that. Or if you want to see the Chicago Bears play, you could deduct that. If you go first-class air fare, you can deduct that.

Mrs. REIFSTERK. The expense of sitters, we could not deduct the food and lodging that it cost me to be there although it was important, the child needed me to be there. And since my husband is a carpenter, not only costs for him to be there when he had surgery, but we had a loss of income because when one is a carpenter and one does not work, one does not get paid.

None of that was eligible as a tax exemption either.

Senator KENNEDY. Mrs. Biondi, we would like to ask you a few questions.

How old is Mr. Biondi?

Mrs. BIONDI. Mr. Biondi is now 73.

Senator KENNEDY. He is a retired musician?

Mrs. BIONDI. He was at the time that he had his stroke 3 years ago.

Senator KENNEDY. As I understand, not long ago he was teaching music after he retired?

Mrs. BIONDI. That is correct.

Senator KENNEDY. In 1975 he was hospitalized and he was in a coma; is that correct?

Mrs. BIONDI. That is right.

Senator KENNEDY. Perhaps you could tell us what kind of facility was he transferred to for rehabilitation?

Mrs. BIONDI. I later learned that something called Utilization Committee considered it rather unnecessary for him to be transferred to rehabilitation. That is why we have had this misunderstanding and this problem.

But at the time he was flat on his back, unable to walk, and unable to talk. He was paralyzed on the right side and had been in a coma for 2 weeks. He was transferred to—instead of the nursing home which was originally recommended or they threatened actually, there was a threat to send him home in this condition, and I mean it was just something I could not even think about, he was sent to London Memorial Hospital, which was a small rehabilitation psychiatric center.

Senator KENNEDY. Who paid for the hospitalization at the hospital?

Mrs. BIONDI. I believe that was covered by his medicare. That was the only coverage that he had.

Senator KENNEDY. Then he went to rehabilitation therapy at Barkley Hospital?

Mrs. BIONDI. It is now Barkley. At that time it was London Memorial.

Senator KENNEDY. You applied for medicaid but you were rejected; is that correct?

Mrs. BIONDI. We applied, and immediately was rejected because of some of the things, suppositions on the part of the people reviewing it, that the lady next to me reviewed, which I will not go into now. But he was accepted for medicaid while there a patient at London, and we have sort of what they call green card covering that period while he was there.

Senator KENNEDY. Do you have any medical bills at the present time, outstanding bills from this particular occasion?

Mrs. BIONDI. From London Memorial Hospital?

Senator KENNEDY. Yes.

Mrs. BIONDI. They are claiming we owe them $11,000.

Senator KENNEDY. And how will you pay that bill?

Mrs. BIONDI. How will we pay that? We have no way of paying that. My husband, of course, is not able to work at all. I have had to give him complete care at home and have not been able to work. There is no income outside of his social security at home.

Senator KENNEDY. That is $250 a month?

Mrs. BIONDI. That is correct.

Senator KENNEDY. Is the hospital going to take you to court for the money?

Mrs. BIONDI. Yes; we are being sued by the hospital for the $11,000.

Senator KENNEDY. Mr. Kinberg, you live in Ontario?

Mr. KINBERG. That is correct.

Senator KENNEDY. You lived a good part of your life in the United States?

Mr. KINBERG. All my life up until 1973.

Senator KENNEDY. You are still a U.S. citizen?

Mr. KINBERG. That is correct.

Senator KENNEDY. As I understand it, in 1960 your former wife became ill while you were living in the United States?

Mr. KINBERG. She became ill prior to that, a good many years prior to that; around 1960 she became quite ill when she required hospitalization quite frequently.

Senator KENNEDY. What kind of insurance did you have?

Mr. KINBERG. I had Blue Cross and Blue Shield, and several other policies besides.

Senator KENNEDY. How much did you have to pay beyond what the Blue Cross and Blue Shield paid, do you remember now?

Mr. KINBERG. She was in the hospital so frequently that she stayed 21 days, medical payments expired, and then I was on my own after that. That went for doctor bills as well.

Senator KENNEDY. Do you know approximately the amount of money that you had to pay at that time that was not paid for by Blue Cross and Blue Shield?

Mr. KINBERG. I cannot exactly tell you how much. Down through the years it was quite a large amount.

Senator KENNEDY. Hundreds of dollars or thousands?

Mr. KINBERG. Up to date?

Senator KENNEDY. Yes.

Mr. KINBERG. I imagine over $50,000.

Senator KENNEDY. You subsequently moved to Hamilton?

Mr. KINBERG. That is correct.

Senator KENNEDY. Where you married your present wife?

Mr. KINBERG. That is correct.

Senator KENNEDY. You moved to Ontario; is that right?

Mr. KINBERG. That is correct.

Senator KENNEDY. Have you had experiences with the medical system there?

Mr. KINBERG. In Canada?

Senator KENNEDY. Yes.

Mr. KINBERG. Yes; I have. I think it was in the summer of 1975 I came down with a hemorrhage and I was hospitalized.

Senator KENNEDY. For how long?

Mr. KINBERG. Close to 2 weeks, I guess. I had two of the best surgeons there that were ready to operate on me, but they did not operate because we found another way to get by. The entire hospitalization and the doctors' expense did not cost me anything except I paid for a private room. I have a policy for a semiprivate room, but I chose a private room and I paid the difference.

Senator KENNEDY. Now, your wife had some difficulties in 1976, as I understand, she fell down?

Mr. KINBERG. Yes; my wife slipped on the ice on property where we live and she sustained a concussion of the skull.

Senator KENNEDY. How long was she in the hospital?

Mr. KINBERG. Three weeks. She was in the house about 3 months after that under the attention of a neurosurgeon.

Senator KENNEDY. Did she visit them?

Mr. KINBERG. She visited them.

Senator KENNEDY. Do you have to pay for health care, for her care in Canada?

Mr. KINBERG. No, sir, I do not.

Senator KENNEDY. What do you say to your friends here in the United States, having lived a good deal of your life in the United States, as well as living under the Canadian system; you have lived under both systems?

Mr. KINBERG. Yes; I have.

Senator KENNEDY. Do you draw any conclusions from that experience?

Mr. KINBERG. Well, I found that I get along very well here because I do not have to be burdened with the——

Senator KENNEDY. You are talking about Canada?

Mr. KINBERG. Yes. I do have to be burdened with the cost of medical bills which we would have sustained if we lived in the States. We did not pay for my wife's costs or mine. We did not pay for either one of those.

Senator KENNEDY. You are happy with the quality and the kind of attention you have received from doctors and nurses?

Mr. KINBERG. I think it is as good as you can expect anywhere.

Senator KENNEDY. Do you feel just as a consumer that you are getting as good in Canada as you are getting in the United States?

Mr. KINBERG. As good if not better.

Senator KENNEDY. I think with these people we see the differences, both with illness, medical bills that were attendant to those problems, and the very heavy burdens that the families continually face. We see the charges or legal problems that they are facing versus the Kinbergs who faced serious health bills when they lived in the United States. Now they live in Canada, and Mr. Kinberg and his wife find that they are not faced with those kinds of heavy financial burdens. They are well satisfied with the system. I think this has again underlined that point.

Mr. KINBERG. May I make a correction? Mrs. Kinberg never lived in the United States. She is a British subject.

Senator KENNEDY. The first Mrs. Kinberg.

Mr. KINBERG. That is right.

Senator KENNEDY. The record will show that.

Mrs. Bjarnason, we welcome you and would like to hear a little of your story.

As I understand—perhaps Mr. Bjarnason will answer—could you tell us what your business is and the approximate income?

Mr. BJARNASON. About $51,000 right now gross, the two of us.

Mrs. BJARNASON. For the last 2 years. It has not always been that way.

Senator KENNEDY. As I understand it, your son had pneumonia when he was 8 months old?

Mr. BJARNASON. Correct.

Senator KENNEDY. Perhaps you might describe what happened during that episode.

Mrs. BJARNASON. Well, he had acute pneumonia. When I went to pick him up, he was not breathing. I heard him cry, he was not breathing, and we rushed off into the bathroom with cold water, and he went into convulsions immediately. My husband called a doctor and I told him that he had to get this baby to the hospital or he would die. It

must have been about 11 o'clock at night. The doctor said there is n problem, put him in lukewarm water in the bathtub and he will b fine. We put him in lukewarm water in the bathtub, and I could fee the baby was getting hotter and hotter. I did not have time to tak his temperature. I screamed and I said, "Chuck, we have got to ge this baby to a hospital or he will die." We did not have a facility to take care of this.

My husband went to the phone again and called the doctor and said we have to get the child to a hospital. He said all right, I will meet you over at the hospital. We got the baby there, and his fever was 106.7. Immediately they put intravenous liquid into his veins and potassium which you lose when you have such a high fever. They put him in ice bags, oxygen tent. He was in convulsions for 3½ hours. That was almost 25 years ago, when penicillin and sulfa drugs were just being experimented with. The doctor did not really want to give him a shot because he did not know if it would kill him, and he was trying—I imagine he was hoping the child would come out of the convulsion. He did not. So, after 3 hours, he gave him a shot of penicillin, and evidently it did help, and the convulsion stopped and his fever went down.

During the time of this whole thing, we were waiting by the crib with our son, as they were doing all these things, and they gave him cold water and we could not have done all these things at home. And there was a nurse, and I will never forget, she was standing beside us and kept saying why doesn't the doctor give him that shot? And we were almost beside ourselves. We figured the doctor should have judgment. She was all upset because the doctor would not.

Do you think I could say one thing about some of our experiences as far as medical health in this country is concerned before we get into the details of the money?

In my own experience and my husband's experience, we have seen many, many doctors because, after our son was brain damaged after 3½ hours of 106.7 fever, he was brain damaged in the perception part of his brain, that made him hyperactive. Every time a thought comes to the brain, and an action has to follow, he was hyperactive child, a very strong, and from some of the doctors that we talked to, to try to find out what was wrong with our son, after we had spent thousands and thousands of dollars trying to find out what was wrong and trying to find out what to do for him, and where to get education for him, we spent many thousands of dollars. And finally we said we do not want to go on this way. We have to do something for this poor kid. Finally, when he was about 5 years old, and other kids were going to school, he said, what is the matter with me? Am I a dope? What's the matter with me? Why can I not go to school with the other kids?

It is like when something happens to a child and you do not have any resources and you do not have resources to develop their potential, it cuts inside your guts. You are so worn down from all of it. You can hardly operate yourself. You are trying to find facilities and nobody wants to help you. They want to get rid of the problem.

As far as the medical profession is concerned, after Bill was 4½ years old, we had testing done for him at the University of Minnesota and, at that time, his intelligence was in the normal range. But the doctor said to me, he said put him in an institution and forget

about him. His judgment will never be right. He will be off always. It was just a judgment on this child—your own child—just like that, put him in an institution.

I think along with our son Bill and our daughter Mary Jane, who has had a lot of problems with their colon and finally had to have the colon out, the problems in this country with medical care that we get, we pay for, we pay insurance, they get all loopholes they possibly can, the doctors do not look at you as a local entity. The look at you as they have a business that is going on. That is the feeling I have gotten. I do not know if anybody else has gotten that feeling or not. You are just a thing. You are not a person, human being.

When we were kids, we had a family doctor. He knew us and he knew our history. He knew our characteristics. He knew when we were sick or faking.

A doctor looks at you for 10 minutes and he makes a judgment of some kind. How can he possibly know all the complicated things involved in illness between psyche and physical and all that is involved in human being is one of my main complaints.

Another thing, they do not listen to what you tell them. You can see the child, and you know the child better than anybody, and they make us feel what is the matter with you people? What are you complaining about?

Senator KENNEDY. What kind of surgery did your daughter have?

Mrs. BJARNASON. Ileostomy back in 1975. The colon was completely rotten and had to be taken out, and the small intestine pulled through. We call it a change in plumbing operation.

Senator KENNEDY. You mentioned just earlier the burden that it has on the family, besides the financial burden. We lose track so often frequently of the emotional strain it has on the family. You mentioned this a little bit earlier. I think others have commented on it, perhaps not nearly enough. Could you just mention what it has meant to you in terms of your own kind of psychology, your own outlook about life.

Mrs. BJARNASON. At one time in my life we were told my son had to have controlled environment. You have to have a routine for him and you have to have special education. We really did not know what the problem was except what we read. We read as much as we could. We are not stupid people. We tried to take our responsibility to the best of our ability.

Anyway he could not get into State institutions because our income was middle income so we could not get any help. In order to get him into a State institution, my husband would either have to abandon us, destitute us, or I could have a nervous or emotional breakdown. Those were the two choices.

The other choice concerns special education. If we had $400 to $800 to $1,000 a month for his education and care.

Senator KENNEDY. It shows even with a very substantial income currently that there is still a very powerful and important emotional strain.

Mrs. BJARNASON. I almost became psychotic, watching that child morning, noon, and night. Nobody would know the wearing down. Yet I had come from a very strong sturdy God fearing home. People never gave up. That was the only thing that kept me going. The other thing that kept us going, I think I must say this, Mrs. Kennedy had

said that she was concerned about people like my husband, and I who did not have the money to get help with this child. Like with Rosemary, your mother could get maids and people who come in and help relieve that terrible tension. When you are with somebody 24 hours a day, you have to watch them all the time, you do not know what they are doing or capable of doing, especially when he was little, when he got older it changed just from groth, you could not believe it. Our other two children had all kinds of problems. I was out of my mind. You do not run a home and have a peaceful home when all of this is going on. And the doctors and everybody wanted their money before you got into the office. They wanted it in advance.

Senator KENNEDY. Do you have bills?

Mrs. BJARNASON. The last hospitalization my daughter had was just a month or two ago.

Senator KENNEDY. What have you paid out of your pocket over the years?

Mrs. BJARNASON. For Mary Jane, all the operations and hospitalizations when she had trouble with her colon, it took us 2 years, and the doctors were not telling us that——

Senator KENNEDY. What were you paying?

Mrs. BJARNASON. The total bills for her hospitalization was $31,958.35. Through my husband's insurance—well, the insurance company paid $17,607.94 of that amount. We paid $14,350.40. That does not include the followup doctor visits, the medications.

We also had a problem with our son. He was in special education.

Senator KENNEDY. With that amount of income now, you are still facing serious financial——

Mrs. BJARNASON. We have no savings. We are lucky we are even able to have good health ourselves. These things are so far beyond what the ordinary person can take.

My contention is, I wish in the medical profession, they could get back to medicine to look to people with compassion and find out just how to help this person get well rather than looking at someone and worrying about money that this person can ever have. [Applause.]

Because with my experiences, I feel this way. I think our whole society has to help on this. It is too much. We are not irresponsible people. We are not trying to get things for nothing. We are trying to take care. I think we have done a very good job, I have to say that for ourselves, in spite of everything that happened.

My son became the most wonderful young fellow in spite of the handicaps. He has sometimes more sense than a lot of people running around today.

Senator KENNEDY. Mr. Agnew, how many children do you have?

Mr. AGNEW. I have six daughters.

Senator KENNEDY. In 1971, as I understand it, you were found to have high blood pressure?

Mr. AGNEW. Yes; it started out that way. Subsequently they found I had a growth on a kidney which was malignant. They removed the kidney after the third operation. After that, cobalt treatments. About a year late, a bowel problem started and they were giving me too much cobalt. I had six bowel operations.

Senator KENNEDY. You had six bowel operations, is that right?

Mr. AGNEW. Three kidney operations and six bowel operations and one testicle removed. My hospital stay was 212 days during that period of time. And just for the hospital itself, it cost $47,488 at current rates. For 10 operations, a round figure of $60,000, plus office calls, $108,287. Out of that, it cost me personally $5.

Senator KENNEDY. $5?

Mr. AGNEW. $5.

Senator KENNEDY. With these families, we are talking about basically upper middle income people that have had a series of contacts with the medical care system, they would have to be considered to be upper middle income families in our own society. In the United States they face serious financial strain. We have from a family that today has an income of $50,000 and no savings and is contrasted with a family that lives in Canada and has had a series of operations and virtually free from financial pressures, let alone emotional strains from financing.

I would be interested in any of our friends from Canada since we just heard from Mrs. Bjarnason about the strain that it has been on her, and we have heard from others as well about the emotional strain of financing obligations.

Is this a factor in your own families? Do you feel in a sense free from fear of financial strain? Is this a factor in terms of your own lives and the type of quality of life that you have?

You could not put a dollar and cents sign on it. I just would be interested.

Mr. AGNEW. You get a feeling, Senator, like I do, get a feeling that, well, anything happens, you do take sick and you are given the best care, and it is not going to cost you. I am not going to lose my house. If I had to pay for what I went through, I would have lost my house, my car, just everything I own. I would have to probably come home from the hospital and die.

Senator KENNEDY. Mrs. Beneteau.

Mrs. BENETEAU. If we had to pay for Michael's expenses, my Michael would still look the way he did, and Michael still would not have his fingers separated. I really believe that it has done a world of good for him.

Mr. TROUP. I would like to add there is a built-in security when you have a medical plan, that it takes away that burden of any disaster falling on your family.

Senator KENNEDY. Do you feel you are getting a dollar's value for the dollars you were spending in terms of taxes?

We hear a lot about the tax revolt here. I am just wondering whether you feel you are getting dollar's value for what you are paying for in terms of your health area. I do not know what your political affiliations are, but I would just be interested as a consumer whether you feel—we have not heard from the people in the back row—what about Mrs. Agnew?

Mrs. AGNEW. I really feel that you always pay for what you get. It is a lot, not compared to what the people are paying for over here, because we do not have that big payment.

I am a diabetic and, who knows, you never know when you are going to end up in a hospital. And I have been very fortunate. There might be a day when I am going to need it.

Senator KENNEDY. You are prepared to at least feel that what you are paying out now is well worthwhile to cover you in the future?

Mrs. AGNEW. Yes; it is far better to pay a little bit this way than having to pay a large amount over a period of time.

Senator KENNEDY. Would the others agree with that, our Canadian friends agree with that?

[The Canadian panel nodded affirmatively.]

Mrs. KINBERG. We have no fear of being ill or suddenly being taken ill because we know fully we are going to be cared for if we are hospitalized and no payments will be made and medications as well. In that sense, we have no sense of fear.

Senator KENNEDY. Is there not a lot of bureaucracy though? Do you feel the doctor is giving you good treatment?

Mr. KINBERG. Yes.

Mrs. KINBERG. I have had several homes visits, doctors that come to my home to visit me in the household, and some people say that they never have. And you can always go to your family doctor any time you want and it does not cost you anything at all. It is exactly the same. No payments whatsoever.

Mr. KINBERG. There is no bureaucracy as far as choosing your own doctor. You can choose whoever you like, the best if you want to. But it does not cost you one nickel more.

Senator KENNEDY. You have a choice of both doctors and a choice of hospitals?

Mr. KINBERG. Yes; you have a choice of where you can buy your medication.

Senator KENNEDY. That choice is up to the consumer?

Mr. KINBERG. I would like to tell you about a daughter who is in trouble in the United States. She lives in Jacksonville, N.J., and she had two operations for spinal tumor back in 1963 and one in 1972. The last operation paralyzed her from the waist down. It has put her in a wheelchair. She got to the point within the last year or two where she could not move at all. She had to be moved around and she was at a stage where she had no control of her natural functions.

It seemed to me she could not go back to the doctor who operated on her, she was operated in Columbia Presbyterian Hospital, New York City, Neurological Institute. And it cost quite a bit of money over and above what her insurance put out.

Senator KENNEDY. That is what we have been hearing. That is the usual circumstances.

Mr. KINBERG. In order to save herself, she had to have an operation, and there was no one to operate on her in her condition, and they had to call for a surgeon from Austria who operated on her by laser beam. There are only two surgeons who did this kind of operation. One was in Israel and one was in Austria. She is still paralyzed, and she is in no better condition than she was after turning her back and forth like a baby every half hour, so she does not get pneumonia. Now, she has to go to rehabilitation center, and the officials there in the hospital told her they would have to requisition about half of her property, that is the house and whatever bank accounts they have, and probably garnish half of his income.

Senator KENNEDY. Let us now hear from the final witnesses here on this panel, Mr. and Mrs. Moss, from Chicago, Ill.

Mr. Moss. She is not here this morning. She is home with the child.

I am 32 years old. I must say in the beginning that hearing the heart-rending testimony of my fellow panel members, our situation is fairly inconsequential. At least at the moment. But maybe the piece that we can add to the health insurance puzzle is the costs of fairly routine health care through surgery and other means here in the Chicago area.

Senator KENNEDY. Perhaps you could tell us. I know you are a graduate student and your wife is a graduate student.

Mr. Moss. We were both public school teachers in the Chicago area and decided to go to graduate school here in the Chicago area at a major university. We were going to support ourselves through savings, part-time work, and careful planning. The university did offer a family plan, that is last year when we began, at a cost of $550 a year, not a small amount but an amount that we could afford. And so we decided to start a family.

Last year, in 1978, the university announced that it would be discontinuing the family health plan as of that October. My wife, at that moment, was 6 months pregnant. We looked around to see what was available. The university did offer, through the Blue Cross and Blue Shield, an individual health plan for a family at a rate of $150 a month or basically $1,800 a year, which was beyond our possible expenditures as we had planned. We were, in a sense, stuck in that situation, and other individual health plans were similarly expensive and not suitable to what we could do.

What we were capable of doing was to at least sign up for the family plan through October 1 of this year, that is through the quarter this summer, so that, at least, did cover the birth. The baby was born in August, a normal birth, and everything turned out fine. We were faced with a decision, being in graduate school with a reduced standard of living and making some sacrifices to be there, what we should do for health insurance since it was no longer available.

Since the baby seemed to be in perfect health after birth in August, it was coming October 1 and we decided since we anticipated having jobs in June that we would try to make do until June, this coming June.

Unfortunately, on October 5, 4 days after the insurance expired, we did discover a lump in the baby girl's groin, which did require a hernia operation. Again this was fairly standard, a routine type of operation. It took half an hour surgery in the hospital on an outpatient basis. The cost of that for which we were not insured was roughly $1,000. As I say, in comparison with some of the other testimony, that perhaps is not large, but from our standpoint it was exceedingly large.

Senator KENNEDY. You would have been covered for the hernia operation under the other program?

Mr. Moss. Which unfortunately had been canceled 4 days before.

Senator KENNEDY. Four days before?

Mr. Moss. The university said last week when it canceled, it was due to rising cost and also due to lack of interest, other student members there.

Senator KENNEDY. That is a point that should not be lost. Rising costs are going to be hitting the middle income with reduced coverages. Your income is $12,000, and you are going to see reduction in the range of services or higher premiums which are going to put it out of range

of someone like yourself. This was with a fairly routine type of operation, as you pointed out, as I understand?

Mr. Moss. Very definitely so. The bill from the surgeon, he did reduce that in view of our limited finances, but the hospital did not, however. We were particularly interested in the use of the operating room for half an hour, a routine operation, $375. The anesthesiologist also received over $300 for a child who weighed about 9 pounds, 3 ounces.

Senator KENNEDY. Have you found any other insurance?

Mr. Moss. We have not. We are actively looking for some at the moment.

Senator KENNEDY. In the meantime, you do not have any coverage for your daughter, is that right?

Mr. Moss. No; we do not.

Senator KENNEDY. Mrs. Mieyette, could you tell us how old you are?

Mrs. MIEYETTE. I am 24.

Senator KENNEDY. What is your income?

Mrs. MIEYETTE. I am not employed.

Senator KENNEDY. Your husband?

Mrs. MIEYETTE. My husband makes between $12,000 and $14,000.

Senator KENNEDY. We are talking about two young couples, effectively the same age, same family income.

As I understand, your second child, Melinda, was born 3 weeks ago?

Mrs. MIEYETTE. A month ago.

Senator KENNEDY. Normal birth?

Mrs. MIEYETTE. She was born breeched.

Senator KENNEDY. Maybe you could say what does that mean?

Mrs. MIEYETTE. She came feet first.

Senator KENNEDY. Bring the microphone up closer.

She had pneumonia, as I understand it?

Mrs. MIEYETTE. Yes; at birth, the fluid was in her lungs and we had to put her in intensive care.

Senator KENNEDY. For how long was she in intensive care?

Mrs. MIEYETTE. For 8 days.

Senator KENNEDY. How was that paid for?

Mrs. MIEYETTE. That was medicare.

Senator KENNEDY. Health plan paid everything?

Mrs. MIEYETTE. That is right.

Senator KENNEDY. Should a herina operation had been required, it would have paid for that?

Mrs. MIEYETTE. That is right.

Senator KENNEDY. You also have a hemophiliat child, too?

Mrs. MIEYETTE. Yes; 7 years old.

Senator KENNEDY. Seven years old, hemophiliat child, who is covered?

Mrs. MIEYETTE. Yes.

Senator KENNEDY. We see in this instance where two young families, just getting started in their own lives and together, with virtually identical income, the first child here with the Mosses and the second child with the Mieyettes having complications, which were basically minor complications. We have heard earlier during the course of the hearing about the significant and major problems that affect families. Here is a minor one, but one that has very, very powerful impact on the lives of these young people, certainly in the United States as contrasted to young people in Canada.

I do not know, Mr. Moss, whether you would make any comment just about the issue of being free from the fear, how it feels to be without any kind of medical insurance for your child. Does that have any value to you?

Mr. Moss. It feels very uncomfortable to say the least. When we were both employed as schoolteachers, we were under health insurance. But as graduate students, holding part-time jobs, the part-time employment usually does not offer health insurance, so we feel very exposed.

Senator KENNEDY. Again I want to thank our panelists this morning. I think one of the real things that has come through other than the basic kinds of medical tragedies which have been commented on during our hearing has been the fact that our Canadian friends have felt really free from the fear of financial ruin. I think I could say that without any exception from our friends here from Canada. They have all commented on that in varying degrees.

That is something difficult to put a dollar and cents value on. It is something extremely important to all of you.

I think this says something about our society and about the country that we live in. It is something that I think we have to give attention to. Hopefully, we in the Congress will give attention to it.

We talk about the fear of missiles in the Soviet Union, and they are not unimportant. They are important. It is important that we have a strong national defense. We want to make our people free from the fear of foreign invasion and foreign conquest. How appropriate that thought is at least in this center, in the American Legion Hall, but also as a humane society we ought to be freeing our people from the fear of devastation, from wiping out a lifetime of savings, and the fear that a mother has in looking in the child's eye and knowing her insurance is going to expire in $x$ period of time, and is going to be faced with the intolerable situation about how she is going to deal with insuring that the child will receive humane and loving care, the extra burdens that a mother faces when she is trying to deal with local, State, and Federal bureaucracy in our own country.

As contrasted with a young family with four well, happy children, and the parents' willingness to share their love and affection and to give something to another child so that it would not have to be institutionalized. What a humane atmosphere and humane policy that really is.

That underpinning is missing in the United States.

Make no mistake about it. I am certainly hopeful that we can deal with it. The Canadian system is a universal program. It is universal in terms of its reaching all the people in Canada. It is comprehensive in terms of talking about hospital needs as well as visiting hospitals with physicians. It is comprehensive and it is universal. It is a quality program, listening to the testimony of the people that testified here today.

The choice of going to the physicians that they want to and being able to go to the hospitals that they want to, and they feel they are getting good attention and humane attention.

As a bottom line, it is a program that has costs under some reasonable control, certainly far more effective control than we have in the United States. No one denies they are not important pressures and that expenses are rising in Canada as well.

The interesting point of view is that the Canadians feel that they are getting the doctor's value for the dollar expended from their taxes; what they are investing in terms of meeting their health needs today as well as further down the road is well invested. I think I can say that without contradiction. As a program, this deals with all the provinces in all parts of Canada, and they are able to get effective cost controls on it.

They have gone from effectively 6.5 percent of their gross national product to effectively 7.1 percent in a period of 10 years. Ours is escalating out of control. Just think of all the implications it is going to have for middle income and others in our society.

As we have stressed here, it is beyond the dollars and cents description of the program. It is basically a humane system, not without imperfections, not without complexities, not without problems, but basically a humane system, and how well articulated that was here this morning. So I welcome hearing our witnesses. We are enormously grateful to them, our friends here in the United States as well as in Canada.

I want to thank you very much for your willingness to share this message with us this morning. We want to give the American friends here the full commitment of my own that we are going to work in Congress and in the Senate of the United States—I am—I am hopeful others will, and I am hopeful that those that could listen to our friends in Canada and listen to the tragedies which have befallen our associates, fellow citizens here in the United States, will let their Members of Congress know their views about this.

We are going to keep this national health insurance issue on the front burner of domestic priorities, and we want to hear from our fellow citizens. I hope they will communicate with their Congressmen and Senators on it.

We want to thank you all very much.

We have two more witnesses. We will just recess for about 2 or 3 minutes while we get our witnesses up here and then we will conclude with our final two witnesses.

Thank you.

[Short recess.]

Senator KENNEDY. I will ask Dr. David Fox, who is president of the Illinois State Medical Society, and Dr. Linda Rae Murray, president of Cook County Housestaff Association, to come forward.

Dr. Murray, we will start with you.

## STATEMENT OF LINDA RAE MURRAY, M.D., PRESIDENT, COOK COUNTY HOUSESTAFF ASSOCIATION

Dr. MURRAY. I want to add my compliments to the people that testified this morning before I read my statement. Certainly from my experience, both before I came and since practicing medicine, has shown that kind of occurrence goes on every day.

The 500 housestaff who worked at Cook County Hospital are in an excellent position to see American medicine at its best and its worst. The members of our union daily toil on the front lines of health care. Together with other health workers across the Nation, we are trying to grapple with the massive problem facing American medicine.

The debate surrounding governmental guarantees for decent health care has been ongoing since the Great Depression. It is a disturbing fact that today, in 1978, the United States remains the only industrialized Nation where the Government has not guaranteed the right of its people to decent and adequate health care. President Carter's 10-point program is a reversal of his campaign promise and an insult to all Americans. Those leaders who have had the courage to break with the President on this question should be congratulated. The inability to solve the "crisis" in American medicine has its roots in the reluctance of our leaders to enact the type of legislation that will guarantee health care as a right for all of our people.

The state of health care services in the Nation is well documented. It is often described as a nonsystem, a chaotic operation that sort of works, except for a few unfortunate groups. Our present problems are not simply the result of poor planning and chaos. They are primarily the result of the guiding force in American medicine—a fee for a service system designed to maximize profits. This fact may explain why, according to a Harris poll, the number of Americans with "a great deal of confidence in the people in charge of running medicine" has declined from 73 percent in 1966 to 43 percent in 1977.

It is easy to understand why people approach the health system with so many fears. The fear of financial ruin is real as these hearings so clearly show. The Congressional Budget Office has estimated that at least 7 million families will spend over 15 percent of their income on out-of-pocket medical expenses this year alone. Health costs account for 8.6 percent of our gross national product, almost twice the percentage of 25 years ago.

However, millions more Americans fear being denied access to medical care simply because they cannot afford it or it is not available. The hospitals in Chicago carefully screen prospective patients to see if they can pay the bill. If you cannot prove your ability to pay, then you are turned away. Cook County Hospital has always served those sections of our population who are denied access to medical services because of the color of their skin or the size of their wallets. Every citizen in this area knows that the doors of our institution are always open to anyone who needs our services.

Because we are a public hospital, other important and, to some, startling facts became apparent. Public hospitals are forced to deal with the sickest population and the most difficult medical problems; the kinds of things private institutions do not want to be bothered with. It is not surprising then that public institutions house some of the most sophisticated special care units. County's burn, trauma, and neonatal units are the best in the area. The private sector has proven itself incapable of adequately meeting the need for primary care medical services. Ambulatory care is considered a money-losing proposition. Cook County Hospital sees more people in its emergency rooms and out-patient clinics in 1 month than many institutions see in an entire year. We desperately need a system of neighborhood clinics with backup hospital facilities for all of our citizens.

Every year the numbers of Americans who cannot afford health care increases, and so does the need for publicly owned hospitals and clinics. People with insurance and other means to pay are coming to county

hospital in larger and larger numbers. They put up with inferior physical facilities and equipment because they know the scalpels of our surgeons cut to save lives, not to turn a buck. They know our laboratories do not fake results of pregnancy tests in order to make a quick profit on abortions. We do not hand out Librium and Valiums like candy to keep the coffers of the pharmaceutical industry full. Parents do not have to choose between food and medicine for their children.

The private sector has failed to address the fact that 15,000 workers are killed on the job each year, and another 100,000 die of work-related diseases. The word is spreading through the factories of Chicago that county hospital has an occupational and environmental medicine department dedicated to improving the health and safety of workers.

We cannot expect an old-fashioned health system with horse-and-buggy approaches, disease-orientated fee-for-service practices to have an impact on the growing cancer deaths. Especially when we realize the 80 to 90 percent of all cancer is occupationally or environmentally related. All of us need to have the skills and resources of modern medical science directed toward programs designed to promote health and prevent disease.

Despite the fact that they are chronically understaffed and poorly financed, the public hospitals have for decades been doing the "impossible" tasks of medicine remarkably well. Public hospitals and clinics properly renovated and supported represent the foundations on which to build a health system designated to address the needs of our people. The private sector based on fee for service has given us skyrocketing costs—fueled by public dollars—in return for shrinking.

The failures of American medicine are clear. Life expectancy for Americans is lower than comparably industrialized nations. Infant mortality for white Americans is a staggering 14.8 deaths per 1,000 live births. For nonwhites, the infant mortality figures are almost twice as high. The United States ranks 15th behind such nations as Sweden, Japan, France, and the United Kingdom in infant mortality. Maternal death rates also show us trailing many other nations. Deaths from accidents, suicides, and homicide occur at twice the rate of the United Kingdom. By every recognized measure, our country's performance falls far below other nations. Always our citizens of color fare worse than white Americans.

American medicine has never worked for peoples of color, or for the poor. We have allowed the mad pursuit of the dollar to bring us to a state where no one can afford health care. American medicine in its present form will soon cease to work for the vast majority of Americans. It is truly folly to continue to throw our tax money to a system that each year is able to care for a smaller and smaller number of our citizens.

The American people are tired of being ripped off. That is the real message behind proposition 13. There is a danger in proposition 13; a danger of simplistic solutions which cut spending and critical programs necessary to our society. The challenge presented by proposition 13 is not so easily overcome. We cannot afford to cut taxes at the expense of our schools, our communities, our health. All we ask is a fair return for our tax dollar. The American people will gladly support a program that guarantees decent health care because it is painfully clear that the present system is not working. We have seen

that the piecemeal solution of the past 50 years has failed. More and more of our public money are disappearing into a private system over which we have no control.

There is no doubt that many, perhaps the majority, of physicians in this country will continue to fight to protect their income and privilege. But the numbers of doctors and other health workers who are critical of our present system grows every day. Many of us realize that drastic changes are necessary if we want to be able to practice medicine in a humane way. After being battered and financially drained by the fee-for-service system, millions of Americans are drawing the obvious conclusions.

As a young doctor training in both curative and preventive medicine, I have carefully studied the problems and proposed solutions. As a black woman, I am enraged by the inequalities and racism which characterizes our present system of health care. As a parent, I live with the fear that if this madness continues, the health of all of our children is in jeopardy. Any rational solution to the problems of providing health care must:

Provide universal coverage for all of our people;

Provide comprehensive coverage, including occupational and environmental health, mental health, preventive medicine, as well as curative medicine;

Be planned and controlled, not simply financed, by the public sector [applause];

Concentrate resources to correct problems in underserved areas caused by maldistribution and racism; and

Be financed by a progressive tax that places the burden on those who can afford it. Special corporate taxes must be levied to help pay for occupationally and environmentally related disease.

In my opinion, the only way to guarantee that health care becomes a right and does not remain a privilege is by the establishment of a National Health Service.

[Applause.]

Senator KENNEDY. Thank you very much.

I will ask Dr. Fox, who is president of the Illinois State Medical Society, to make what comments he would.

## STATEMENT OF DAVID S. FOX, M.D., PRESIDENT, ILLINOIS STATE MEDICAL SOCIETY

Dr. Fox. Mr. Chairman, I am David Fox, president of the Illinois State Medical Society.

The society is pleased to participate in hearings in given testimony on national health insurance. Like you, I have been deeply moved by the testimony which we all heard this morning from people from Canada and the United States.

I would have to take some exceptions to the remarks made by the previous speaker, but I do not believe that this is the proper forum.

I must say the medical society is deeply concerned that the Canadian national health insurance system has been touted in previous hearings of this committee as a model for a national health insurance in this country. Highlighting a few examples of the Canadian system's success, while ignoring its deficiencies, is deception. Sold to the public

as an improved insurance program, national health insurance actually is a Government takeover of medical care.

In Canada, that has resulted in cutbacks in necessary hospital admissions; cutbacks in the quality of hospital facilities and equipment; and cutbacks in teaching and research.

In theory, the Canadians have unlimited financial access to medical services. In fact, the services are rationed and no longer are up to U.S. standards.

Mr. Chairman, I realize that I have made serious charges. I have some authority for these charges. My authority is Raymond Robillard, M.D. Dr. Robillard is a practicing neurologist in Montreal, Canada. He has been trained in the United States, in England, and in Canada.

In 1967, he founded and was elected president of the Quebec Federation of Medical Specialties, the bargaining agent for Quebec Province's 6,000 specialists. He was chief negotiator for physicians when the welfare plan, Canada's equivalent to medicaid, was established in 1966.

He was physicians' negotiator when the national health insurance system was established in 1970.

Since 1969, he has been a member of the Quebec Health Insurance Board, the fiscal intermediary in Quebec for the national health insurance system.

Mr. Chairman, on three separate occasions—in Washington, Detroit, and Chicago—we have heard a number of Canadian citizens who have nothing but good to say about the Canadian national health service. We have not heard one person in rebuttal.

Dr. Robillard, with credentials which I identified a few moments ago, is here today, and, as the president of the Illinois State Medical Society, I would request that you allow Dr. Robillard to give the testimony in my place.

Senator KENNEDY. Fine. Dr. Robillard, would you come up, please.

He is speaking for the Illinois Medical Society?

Dr. Fox. That is correct.

[The prepared statement of Dr. Fox follows:]

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Statement

of the

Illinois State Medical Society

before the

Subcommittee on Health and Scientific Research
Committee on Human Resources
United States Senate

on

National Health Insurance

by

David S. Fox, M.D.

November 28, 1978

Mr. Chairman and Members of the Committee:

I am David S. Fox, M.D., president of the Illinois State Medical Society. The Medical Society is pleased to participate in these hearings on national health insurance.

In recent years, the debate over national health insurance has shifted focus, moving from the question of need to "point-counterpoint" assessments of a particular plan's merits. Proponents of national health insurance have adroitly moved to the second step without adequately addressing the basic question: Should this country have national health insurance at all?

The Illinois State Medical Society does not believe that a defensible case has been made to justify scrapping our present health care system in favor of national health insurance and its accompanying federal controls. The ISMS is opposed to any federally-mandated, compulsory national health insurance plan.

This country now has the finest health care in the world. I realize, Mr. Chairman, that you have strongly disputed that contention. Nonetheless, I believe a thorough analysis of our medical achievements clearly indicates that the high ranking is well deserved. Significant changes have been made, and continue to occur, in the health care system. Technological advances are unparalleled....the number of physicians and allied personnel is constantly increasing....and access to high quality care is becoming a reality for all segments of the population. The list of accomplishments, changes and refinements is formidable, and demonstrates the system's ability to respond to this country's health care needs.

Proponents of national health insurance conveniently equate more health care with better health. Simply stated, more is not necessarily better. The nation's health is determined by numerous factors, many of them socio-economic.

For example, poverty breeds poor nutrition and many lifestyle traits which have a detrimental effect on health. The federal government should focus on eradicating the cause of the problem, not treating the symptoms.

Despite its successes, the health care system does have some shortcomings. The major criticisms involve the continuing rise in cost and inadequate protection against the costs associated with catastrophic illness. The ISMS believes these problems can be solved without dismantling the system and creating an astronomically expensive national health insurance plan that will jeopardize the quality of care.

According to the Consumer Price Index for the first six months of this year, the price of medical care services has increased at a rate of 8.1 percent ....while the annualized inflation rate for all products and services stands at 8.3 percent. Granted, health care is grabbing a larger portion of the Gross National Product, but consider the reasons why:

- The average age of our population is rising, with the percentage of those over age 65 increasing at a rate of 2.3 percent annually compared to .8 percent for the entire population. The aged require--and are receiving--a greater amount of health care than the younger segments of the population.
- Health care services are being expanded to previously unserved and underserved segments of the population. A 1978 study by the Robert Wood Johnson Foundation and the University of Chicago's Center for Health Administration Studies indicated that 76 percent of Americans had at least one physician-patient contact in 1976. For blacks, the figure was 74 percent, a marked increase from the 49 percent in 1963.
- Wages and salaries of hospital employees--which account for 57.3 percent of hospital costs--have nearly doubled since 1974.
- A technological explosion in medicine, admittedly, is expensive but greatly enhances the quality of care.

Effective steps already are underway to check the cost spiral within the hospital industry which accounts for a major portion of health expenditures. The Voluntary Effort--directed nationally by the American Medical Association, American Hospital Association and Federation of American Hospitals--currently is exceeding its goal of a two percent reduction in the rate of hospital expenditure increases for 1978 and 1979. During the first six months of this year, the Voluntary Effort succeeded in reducing the annualized national rate to 12.9 percent. In Illinois, the Voluntary Effort--directed by the ISMS and Illinois Hospital Association--has bettered the national figures. Our rate of increase has dropped to 11.5 percent, placing us among the anti-inflation leaders.

We are confident that our success will continue. Hospitals in Illinois are participating in shared services programs and other activities to check costs. In addition, health planning activities coupled with implementation of recently-enacted prospective rate review legislation hopefully will have a marked impact.

The Voluntary Effort is succeeding despite the general inflationary trend that affects all segments of the economy. We are concerned that the national health insurance proposal being discussed today would significantly increase government expenditures....dramatically fuel general inflation....and cause health costs to soar. Unlike the Voluntary Effort, this proposal is not consistent with the President's voluntary anti-inflation campaign.

Claims that national health insurance would hold the line on costs are patently absurd. The misconception that care is "free" could stimulate widespread overuse of the system. In that situation, the only way to control costs is by rationing. I do not believe that the public will tolerate government rationing of health care.

The costs of enlarging an already bloated federal bureaucracy to administer such a large-scale program would compound the government's problems in attempting

to balance the national budget. Even more disturbing is the government's undistinguished record in providing personal services.

The HEW budget now is the third largest in the world, trailing only the U.S. and Soviet Union. As you are well aware, the HEW Inspector General has revealed that the budget contains some $7 billion in waste.

The cost problems associated with national health insurance have surfaced in other countries. For example, in Australia, health costs have increased sevenfold in the last decade, compared to threefold in the U.S. This recently prompted the Australian government to draw back sharply on its commitment to the national health insurance program.

Reports of previous hearings by this Committee indicate that considerable attention has been focused on Canada's national health system. Like Australia, Canada has encountered major cost problems. Since 1974, the government has set a "cap" on hospital budgets that falls below the inflation factor. This year, hospitals were granted a 4.5 percent increase against an inflationary factor of approximately 7 percent. In addition, there have been cutbacks in the critical areas of medical education and research. It appears, that the Canadian system is sacrificing the future to cope with the present.

The ISMS strongly believes that all citizens should have access to good health care. HEW statistics indicate that 24 million people have no health insurance protection....and that another 18 million have inadequate coverage. Assuming these figures are accurate, 178 million Americans--or 81 percent--have adequate health insurance. Adequate coverage can be extended to the remaining 19 percent through available private insurance and an extension of existing government programs. National health insurance is not required to solve this problem.

Another major concern is protection against the costs of catastrophic illness. Often overlooked is the fact that catastrophic insurance is widely available, inexpensive and already covers 60 percent of the population. A large

portion of the remainder may be without this coverage simply because they are unaware of its availability or importance. A concerted public education program is needed. The addition of optional catastrophic coverage to basic health insurance policies is a solution.

In summary, the deficiencies of the health care system can be remedied without taking a national health insurance program that will accelerate inflation, raise taxes and, we believe, jeopardize the quality of care.

Dr. ROBILLARD. Mr. Chairman, thank you for this opportunity.

Senator KENNEDY. Perhaps you would give us your name and address.

## STATEMENT OF RAYMOND ROBILLARD, M.D., MONTREAL NEUROLOGICAL INSTITUTE

Dr. ROBILLARD. Raymond Robillard, Montreal Neurological Institute.

I want to make the point, Mr. Chairman, that I do not represent here the Illinois Medical Association. I represent nobody but myself.

I trained in Boston 3 years and returned to Montreal, professor of medicine in neurology. It was quite by accident that I entered the world of medical economics when I saw the trends in Canada. I was 10 years in that field and then decided to go back to medicine where I think I belong.

The Canadian model has been cited to the American public, I gather, as a plan to be copied or at least to be implemented in parts in the United States. It has been touted as a success, a complete success.

I would like to make two areas of comment.

The first one is that as an insurance plan, there is no doubt that the Canadian system is a success. It is a compulsory system. Everybody in society contributes to the cost, employers in increasing fashion, and there is also a very important amount of public moneys going into the system. This has allowed us to give every citizen in Canada—quote, unquote—free access to all types of medical services. We are grateful for this happening.

We would not like to go back to the state of affairs that presided over our destinies before this.

However, the position I took at the onset as a practicing physician, and that I take today again as a practicing physician, and believe me with no ax to grind, the position is that a compulsory state directed and controlled insurance plan cannot remain an insurance plan and has not remained an insurance plan in Canada.

It has become, Mr. Chairman, a complete, or in the process of becoming complete, takeover of the actual dispensation of medical care in Canada.

I will give you as one example of this trend the fact that physicians in Quebec have been told publicly 3 months ago that in June 1979 they will become salaried civil servants working for the state.

That is nationalized medicine. [Applause.]

Two things have happened in Canada because of this inevitable Government takeover of the dispensation of medical services under the guise of presenting a better insurance plan. There have been difficulties with planification and difficulties with financing. The difficulties with planification have been numerous. I will only give you a few examples.

Medical manpower was felt to be insufficient to run this plan in Canada. Immigration was hopped up considerably and output of medical schools was doubled several years ago. Medical ancillary personnel was processed by teaching universities and high schools. We have no arrived at one physician per 400 of population, which is the highest figure next to Israel. At this point, the Government made a

sudden turnabout and cut down completely on immigration of physicians in Canada, which I thank, sir, is a bad thing because people coming to us had special talents.

Second, paramedical technicians have been formed in huge numbers at the same time as hospital beds are being closed. I will get back to that later. That means these people will be out of work. The hospital beds have been closed.

The lady from Ontario alluded to this briefly this morning. But, at the same time, the medical profession has been denied the possibility of growing on an ambulatory side.

Community clinics have been set up at the same time as general practitioners were coming into the field in large numbers, and community clinics and general practitioners have entered in competition, needlessly providing the same services at the same areas.

Government planification has pushed physicians outside of large cities where no money is given by planification agents for equipment to allow these specialized physicians to practice their specialty.

Preventive medicine has been pushed as being a solution for the future, although lab stains and surgical stains and laboratory methods for preventive medicine have been denied in outpatient departments. I could go on with this.

Budgetwise, costs have been contained in Canada. There is no doubt that we in Canada over the past 10 years have kept the increase in the cost of health services to around 7 percent of the gross national product. So this is a success. But there has been a price for this. Our medicine is the same as America. We have trained in the United States, nearly all of us, like Johns Hopkins, Boston, Chicago, or anywhere else in the States. Our equipment is the same. Our nurses are paid the same amount, et cetera. The cost is the same.

So, necessarily, if you are going to cut down on budgeting, something has to give. There has been increase in inflation in Canada over the past 10 years on an average of 8 to 9 percent per annum. The hospital budgets have been fixed at 4.5. The result is that hospitals have had to cut beds, active beds, and any administrator honest enough in the city of Montreal will tell you that he is waiting for summer in order to have a pretext and excuse to close beds.

Furthermore, the Government planifers have cut beds, acute beds, by 20 percent, transforming acute beds to chronic beds. We are not admitting patients in hospitals except very dire emergency patients.

We are not admitting certain medical cases that need to be investigated in hospitals according to American medicine principles, and I daresay, and I will say it very loud, that this is the best medicine in the world. I did not train here for nothing nor did all my colleagues train here for nothing.

We have cut funds for research in teaching. We have cut beds. East of the island of Montreal, in the whole area, for half of the poorer people in the island of Montreal, there is not one CAT scan. All those in the west half have been paid for by private funds because the Government has not the money to buy a CAT scan. I am a neurologist and cannot do neurology without a CAT scan today. It is criminal. We have to do it because we do not have any.

So, in a nutshell, I have no advice to give to the United States. We are a small country, Mr. Chairman. We live right next door to you,

and we are a mouse next to an elephant. When the elephant moves, we turn, to be sure. We respect American medicine. We agree you have a problem and the same problem we have. But the plea I make in the name of medicine, my gratitude to the citizens of this country who paid my way in Boston when I was a resident, and also your family, sir, the plea I make is do not make the horrible mistake of destroying what you have and thinking that the only way to correct difficulties you are living in is by giving the whole thing to the state and the Government. I think that is the mistake we did.

I do not know what the solution is, but there must be another way than bigger Government and bigger involvement in Government, and Government taking over the third largest industry in the country.

Thank you, Senator. [Applause.]

Senator KENNEDY. We are glad to have your testimony. I might at this point put in the record "Universal Health Insurance in Canada, History, Problems, and Trends," by Eugene Vayda, M.D., Robert G. Evans, Ph.D., and William R. Mindell, M.P.H.

[The information referred to follows:]

# UNIVERSAL HEALTH INSURANCE IN CANADA: HISTORY, PROBLEMS, TRENDS

Eugene Vayda, M.D.[1]
Robert G. Evans, Ph.D.[2]
William R. Mindell, M.P.H.[3]

See particularly pp 10-11-12

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Reprint Requests to: Eugene Vayda, M.D.

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## A B S T R A C T

This paper describes the universal health insurance program in Canada and identifies the historical events and social values leading to its adoption. Universal hospital insurance was adopted in 1958, 10 years before medical insurance; as a result hospital based patterns of practice were solidified. For both hospital and medical care insurance cost sharing was the mechanism employed by the Federal Government to influence the provinces to adopt relatively uniform universal plans.

From 1951 to 1971 there were rapid rises in health care expenditures to 7.3% of the Gross National Product (GNP). Since 1971 the percent of GNP spent on health care decreased and stabilized at about 6.9%. In the U.S. the GNP share for health care is 8.6%. Hospital use also increased rapidly in Canada to 1970 but appears to have stabilized and decreased slightly in the 1970's. Physician incomes rose rapidly before 1971, but since then the increases have slowed and relative incomes of physicians have fallen.

Although the percent of GNP spent for health care has levelled, there are still substantial annual increases in expenditures which are paid for by government. As a result, cost containment has become a major federal and provincial goal. Most recently, greater taxing authority has been shifted from the Federal Government to the provinces where the authority for cost containment resides. The Lalonde Report, despite its focus on individual responsibility for

health, grew largely from concerns regarding escalating health care costs. In the long term, the provinces, to contain costs, are moving in the direction of regionalization, decentralization and greater co-ordination. In the short term, the provinces have limited hospital budgetary increases to percentages less than the rate of inflation, effectively reducing hospital budgets.

On balance cost constraints may be long overdue. Planning cannot proceed without finite fiscal limits. It does not appear that the health of Canadians will be adversely affected, nor essential benefits curtailed by present budgetary restrictions or reorganization.

The National Health Insurance controversy in the United States has waxed and waned during this century. Since U.S. Medicare was adopted in 1965 pressures for universal coverage have mounted, spurred largely by increases in health care costs. The universal health insurance controversy has struggled with if, what, when and how. Discussions have frequently included analyses of other countries and their health insurance plans. Generally, when the eastern European countries and England and Sweden are dismissed for political reasons, attention turns and returns to Canada.

To understand the "national" health insurance program in Canada some knowledge of geography, history and political structure is required. Canada is a federation of 10 provinces and two northern territories covering an area of over 3.5 million square miles. Its 1971 population was almost 22 million, and over 75% lived in urban areas. Population density was 6 persons per square mile, about 10 in the provinces but only about .05 in the Territories.[1] Over 80% of the population live within 100 miles of the northern U.S. border. Canada contains two peoples with distinct cultures and populations, French and English, as well as native minority groups of Eskimo and Indians and immigrant groups from China, Japan, Europe, Asia and the Caribbean Islands. Cultural differences are supported and preserved resulting in what Porter has called "The Vertical Mosaic".[2] Canada has a

cultural system based on humanitarianism and investment in human capital, although in recent years these values have been stressed by the economic problems common to western civilization: inflation, unemployment and restricted economic growth.

1. The history of the development of Canadian universal health insurance

Government in Canada is by means of a parliamentary system based on the British model. Although Canada and the United States both have federal governments, Canada's is a relatively loose confederation of its 10 provinces and 2 territories, while the U.S. has a strong central government. The 50 states, generally, have less authority than the Canadian provinces. In many domains the provincial governments have greater power and authority than the Government of Canada. One such area is health. The British North America Act of 1867, which is the Canadian constitution, fixed responsibility for health care at the provincial level; the provinces were given exclusive powers to legislate in matters dealing with:

> "The establishment, maintenance and management of hospitals, asylums, charities and other eleemosynary institutions in and for the province, other than marine hospitals."

The federal authority was limited to residual areas and included quarantine, and health services for Indians, Inuit and aliens. Despite these limitations, the federal government, 111 years

after Confederation, now spends 10% of its total budget for health care; mainly as payments to the provinces to finance their provincial health care schemes. These payments give the federal government considerable leverage in determining how health care dollars are spent but no control over the amounts spent. The federal government also influences the direction of medical research because it finances most medical and health care research in Canada.[3]

Universal health insurance in Canada was first proposed in 1919. Over the next two and one half decades industry sponsored health care plans and voluntary medical and hospital service prepayment plans were developed, but by 1945, there were still numerous gaps in coverage - both in numbers of people covered and in benefits for the insured.

Following the depression and the second world war, a Federal-Provincial Conference was convened in 1945 to develop programs of social reform which had been delayed by the economic deprivations of the depression and the war. The Federal-Provincial Conference on Post War Reconstruction proposed universal health insurance with federal-provincial cost sharing. The Conference also produced a model draft health care bill for the provinces which provided for health regions, pre-selection of family physicians who would be responsible for patient "lists" and paid by capitation. They would also be paid additional sums to serve as medical health officers providing preventive services. Pro-

vincial administration was to be under the direction of a commission representing both consumers and the professions. Regional medical officers would be appointed to supervise the distribution and quality of services which would be based, wherever possible, on health centres.[3,4,5]

Despite favourable public opinion and the approval of key professional groups, the 1945 health insurance proposals were not enacted. Health, as defined in Sections 91 and 92 of the British North America Act, is a provincial responsibility and the new proposals were regarded as threats to provincial autonomy. However, planning and hospital construction grants were made available and the concept of federal-provincial cost sharing for health services was accepted in principle. By 1955, five of the ten provinces had universal hospital insurance plans which rescued their hospitals financially and proved popular politically. The five provinces pressed the federal government to honour its 1945 hospital insurance cost sharing offer. In 1958 the Hospital and Diagnostic Services Act was enacted; by 1961 it had been adopted by all the provinces.

This major social benefit led to some of the present financial problems. Services were insured and eligible for 50% federal cost sharing only when carried out in the hospital. There were no incentives to provide services in less expensive sites. As a result, many procedures that could have been done on an out patient basis were provided in the hospital and

hospital based patterns of practice were solidified.

Hospital construction which began before universal insurance continued after its enactment. Bed availability is associated with bed use. Whether provinces have four or seven acute care hospital beds per 1000, their occupancy rates remain about 80%. Between 1961 and 1971 hospital beds in Canada increased twice as rapidly as population growth (33% vs 18%), but bed occupancy remained at about 80%. By 1971, Canada had 23% more beds than the U.S. and used 30% more hospital bed days.

Universal hospital insurance in Canada provided payment to hospitals, but did not mandate an organizational framework to deal with problems of efficiency or duplication of services. The historical relationships between physicians and hospitals were also not disturbed.

Universal medical care insurance was adopted 10 years after hospital insurance. By then a hospital intensive system was well established. The Medical Care Act of 1968, like the Hospital and Diagnostic Services Act which preceded it, was an instrument of social benefit, because it removed financial barriers to medical services. However, the Act allowed federal provincial cost sharing only for services provided by physicians. As well, the Medical Care Act, like the Hospital Act, authorized payment for services but failed to mandate reorganization, although reorganization had been recommended by the 1964 Royal

Commission on Health Services which proposed universal medical insurance.[6]

That same Royal Commission, in addition to recommending universal medical care insurance, also predicted a shortage of physicians and other health professionals and recommended increases in the output of existing medical and health professional schools and the development of new schools. These recommendations were adopted and medical school output increased 70% over the next ten years. However, the projections on which the Royal Commission based its recommendations were not realized. Population grew less than expected, emmigration of Canadian physicians decreased and immigration of non-Canadian physicians increased sharply. The Royal Commission projections were based on 1961 utilization patterns and failed to anticipate changes in technology and productivity. The physician to population ratio fell to 1:600 from 1:850 as the stock of physicians rose; other health professional groups also increased. However, by 1973 nursing personnel and physicians still made up about 78% of all health care workers.[7]

The number of physicians is one of the factors associated with the volume of health care services. More surgeons are correlated with higher discretionary surgical rates[8] and more physicians with an increased volume of medical services, just as more hospital beds are associated with greater bed use. In the short term, insurance

may also be associated with increased utilization. In Nova Scotia, universal medical insurance increased coverage from 63% to more than 95% of the population; that province's elective surgery rate rose 25% in the first post insurance year although beds and surgeons increased only 4%.[9]

To qualify for federal-provincial cost sharing for hospital and medical services the provinces had to meet certain terms of reference:

1) Universal coverage on uniform terms and conditions (95% of the population, without exclusions, had to be covered within two years of provincial adoption of the plan).
2) Portability of benefits from province to province.
3) Insurance of all medically necessary services.
4) A publically administered non-profit program.

Federal provincial cost sharing was developed as a stimulus to the provinces to adopt universal health insurance programs. As well, it served as a means of income redistribution between the wealthier and poorer provinces. For hospital services each province is paid 25% of its actual per capita costs plus 25% of the national average per capita cost multiplied by the province's population. For medical insurance each province receives 50% of the average national per capita medical care expenditure multiplied by its population. As a result, the wealthier provinces which spend more receive less than 50% of their costs and the poorer provinces

which spend less receive more than 50% of their costs. The differentials are especially apparent for medical care cost sharing. In 1973-74 Ontario received 49.4% of its hospital costs and 44.8% of its medical care costs. At the other end of the spectrum, Newfoundland received 57.6% of its hospital and 81.5% of its medical care costs.[10] The federal contributions are drawn from general tax revenues; the provinces use premiums, special taxes and general tax revenues.

For the hospital act, public administration was mandated from the start, but medical insurance allowed a brief transition period during which private health insurance companies continued to operate. At present private health insurance plays no part in the universal plan; it covers only supplemental benefits.

Initially, most provinces had separate medical care and hospital commissions which were quasi public agencies, separate from government. In recent years, many provincial hospital and medical care commissions have merged and come under direct control of their provincial ministries of health.

As a result of the universal program virtually every Canadian has comprehensive medical and hospital insurance. There are no deductibles or co-insurance fees. Hospitals are paid on the basis of negotiated budgets. Physicians are paid on a fee for service basis with negotiated fee schedules, not usual and customary charges. In 1974 over 90% of Canadian physicians were "opted into" the provincial Plans. Although there are

provincial differences and exceptions, generally "opted into" means that the physician accepts some percentage of the negotiated fee as full payment, does not extra bill and is paid directly by the provincial government and not by the patient.[10] The universal insurance program has enjoyed considerable consume. popularity. It is, however, an insurance program which pays bills, not a National Health Care Program.

2. Canadian health care expenditure and some U.S. comparisons

Increased expenditures, additional health manpower and facilities and universal insurance have reduced regional and socio-economic disparities in the use of health care services.[11] However, the health benefits are not as readily apparent. A newborn male in 1931 had a life expectancy of 60 years; by 1971 this had risen to almost 70 years. On the other hand, a 40 year old male had a life expectancy of 72 years in 1931 and 73 years in 1971. Thus, contrary to common belief, people are not living longer; rather, more are surviving the first year of life. Infant mortality rates have decreased substantially in the last 40 years, but much of the improvement in infant mortality can be attributed to better living conditions (food, housing sanitation) as well as to more health care. Canada has a world ranking of eighth in composite mortality rates. However, England and Wales which spends a third as much as Canada ranks sixth. On the other hand, the United States which spends about 20% more than Canada ranks twentieth.[12]

In the analysis of health care expenditures in Canada, and their comparison with U.S. experiences, the year 1971 marked a significant watershed. For the previous two decades health expenditures in both countries were rising rapidly, both in absolute terms and as a percentage of G.N.P. U.S. spending rose from $78.35 per capita and 4.6% of G.N.P. in 1950, to $141.63 and 5.2% in 1960, and $368.25 and 7.6% in 1971. Canadian data in the 1950s are less complete, but showed a growth in the less inclusive Personal Health Care component from 3.5% of personal income in 1953 to 4.9% in 1960. In 1960 a broader based health expenditure measure made up 5.5% of G.N.P. ($118.01 per capita) and by 1971 this had risen to 7.3% of G.N.P. ($318.90 per capita). U.S. and Canadian cost increases were thus roughly parallel, with Canada's costs advancing somewhat more rapidly during the 1950s and the U.S. speeding up in the 1960s. Comparisons of per capita health care expenditures across countries are not very meaningful unless carefully adjusted for different price levels and monetary exchange rates, but the share of G.N.P. ratios suggest that by 1971 both countries were devoting approximately equal shares of their national resources to health care.

Since 1971 breaks in trend have occurred on both sides of the border, with the sharpest break in Canada. There, the increases in nominal G.N.P. resulting from the inflation of the early 1970s were not fully reflected in health spending,

which drifted off to 7.1% of G.N.P. in 1972, dropped sharply to 6.7%, 6.6%, and increased to 6.9% in 1975. Estimates for 1976 are not yet available but are not expected to be very different. In the U.S. expenditure levels as a share of G.N.P. stabilized in the 7.7% - 7.8% range, but did not actually drop, then took off in fiscal 1975 (July 1, 1974-June 30, 1975) and in 1976 to 8.6%. At present, then, health care is taking up a much larger share of G.N.P. in the U.S. than in Canada. The present discrepancy of over 20%, in share of G.N.P. was reflected in per capita spending of $499 in Canada in 1975 compared with approximately $599 in the U.S.[13,14], although per capita spending is harder to compare because of fluctuations in the rate of exchange and the rate of inflation. The difference in percent of G.N.P. is the largest in the historical record, at least for the past quarter century, and suggests that Canadian policies of cost control in the health care sector are showing more success than those in the U.S.

Corresponding to these broad aggregate movements over the past quarter-century were major changes in health care financing. The Canadian universal hospital insurance program was put in place province by province in the late fifties, and was associated with a sharp jump in hospital spending between 1958 and 1961. In the late 1960s the universal Medicare program provided similar comprehensive coverage for physician services, and a corresponding increase in relative expenditure occured between 1969 and 1971.

In the U.S. hospital and medical coverage (non-comprehensive) for the aged and/or impecunious in the mid-sixties is often perceived as having been associated with significant expenditure increases. Relatively tight price controls between August 1971 and April 1974 under the Economic Stabilization Program appear to have contributed to the U.S. flattening and subsequent 1975 rebound, while in Canada direct public responsibility for (almost) all hospital and medical expenditures since 1971 has encouraged much more rigorous budgetary control. These two categories of health expenditure dominate the totals in Canada (hospitals 49.6% and physicians 16.6% in 1975), and are almost as significant in the U.S. (39.2% for hospitals, 18.2% for physicians). Thus the forces driving total health spending can be traced primarily to these two sectors.

Hospitals

Perhaps the most interesting aspect of hospitalization experience in Canada is what did not happen. During the period of introduction of universal hospital insurance, little or no significant utilization response is demonstrated. Admissions and patient-days (adult and child) per capita in general and allied special hospitals increased slowly and steadily throughout the 1950s and 1960s, but no trend-break is observable in the late 1950s. Patient days (per thousand population) rose between one and two percent per year to 1971, from about 1529

to 1955, to 1639 in 1960, 1778 in 1965, and 1898 in 1971. Since then, utilization has actually begun to drop slightly for the first time.[15] Admissions per 1000 show a similar pattern, 132.8 in 1955, to 144.4, 152.2, and 164.9 in 1971. Admission rates rose somewhat more rapidly after universal medical insurance was introduced, and have been static since, rather than falling. Thus, the decrease in hospital days used has been due to small reductions in length of stay.

These statistics suggest that the principal impact of universal public insurance in Canada was on the unit cost of hospital care, not on levels of utilization. Further analysis shows that this was principally due to wage costs, primarily increases in manpower in the early 1960s and in relative wage levels of hospital workers in the late 1960s and the 1970s. Since 1971 hospital costs have been controlled by direct administrative limits on budgets and on availability of facilities, combined with powerful "moral sausion" to discourage excessive use of hospitals. In the U.S., by contrast, utilization of non-federal short-term general and other special hospitals has continued to climb since 1971. From 1973 to 1977 admissions increased 10.1%, while average length of stay fell 2.7%. Average daily census remained unchanged.[16] Utilization rates for short-term general hospitals in Canada (admissions or patient days per capita) are still above the U.S. but the rates are now converging with recent Canadian decreases.

These data do not include psychiatric or federal hospitals; the latter in particular play a much larger role in the U.S. system than in Canada. Increases in short-term general hospital utilization in the U.S. appear to be led by bed construction, up 10.8% from 1971 to 1976, despite a drop in occupancy rates from 76.7% to 74.4%. However, recent small increases in bed availability in Canada do not appear to have been associated with additional utilization.

Physicians' Services

The rapid increases in expenditures for physicians' services in the 1960s, averaging 12.0% per year from 1960 to 1971, combined both price and utilization effects. In the pre-Medicare period actual prices charged and collected were only loosely related to official fee schedules, such schedules often representing the hopes and objectives of physicians rather than their fulfilment. A combination of increasing affluence, changing attitudes toward medical care and expanding insurance coverage in this period enabled physicians to increase their gross and net billings per capita very rapidly, despite steady increases in physician supply per capita, so that from 1957 to 1971 the income status of physicians relative to the average worker rose about 3% per year for a total gain of 50.8%. Over the same period the physician stock per capita rose 28.7%.[17] It is of some interest to note, as well, that the relative income status of physicians rose somewhat faster

(25.1%) in the earlier period 1957-64 then the later period 1964-71 (20.5%) when the universal public medicare programs were established in all provinces but Saskatchewan (which had begun its plan in 1962). Thus the forces leading to expenditure increase predate medicare, and the net impact of the public programs is not wholly clear. In those provinces where the introduction of Medicare was associated with sharp increases in expenditures, we have no baseline evidence to determine how much was utilization and how much price increase. Since there is no evidence of a sudden shift upwards in physician workload, the principal impact was probably an increase in unit prices received by physicians (as well as some improvement in reporting of physician incomes for tax purposes). Certainly "free" care did not lead to physicians being overwhelmed by new demand.[17,18]

Since 1971, fee increases have been tightly restricted by provincial governments. From 1971-72 to 1976-77, average increases in fee schedules, Canada-wide, are computed by the Department of National Health and Welfare as 3.91% per year compared with 8.3% annual changes in the consumer price index. Physician incomes have not been wholly restricted by these low fee increases. From 1971-72 to 1975-77 the average billings per physician in Canada have been rising 1.5% per year faster than the fee schedule. Utilization per physician has increased most rapidly in provinces with low fee increases - 4% per year in Quebec where no fee increase was achieved in this period - and has not occured in provinces

with relatively large fee gains. Such an observation is consistent with target income behaviour by physicians; if income targets are not met through fee increases, more billings are generated in other ways. Nor has the income generation process been prevented by rapid increases in physician stock per capita, 3.9% per year from 1971-72 to 1975-76 (6.0% in Quebec). But despite these efforts the relative incomes of Canadian physicians after rising in the 1960s have clearly fallen since 1971.

As of 1975 the rate of immigration of foreign physicians has been sharply curtailed, so that continuing stability of physician expenditures in Canada will have to depend on stability of both physicians per capita and relative income levels of physicians. The former will in fact continue to creep up on the basis of current forecasts of graduating classes, and the latter would be very vulnerable to any "catch-up" efforts by physicians to regain the huge gains of the 1960s by negotiating large fee increases.

U.S. data does not, of course, permit detailed income or utilization analysis. Costs of physicians' services certainly rose more slowly over the period 1960-71, an average of only 9.5% per year, and from 1971 to 1974 these costs have moved more or less in line. In the U.S., however, the total cost increases since 1971 have been primarily price changes, while in Canada increases in numbers of physicians per capita seem to be more important. The U.S. medical care component of the consumer price index rose an average of 7.2% per year from 1971 to 1976, compared with the

Canadian figure of 3.9%, and even if all of the 1.5% annual increase in "utilization" per physician was really price change (as some of it was, due to, for example, shifts in billing behaviour), U.S. price increases would still be about 1.7% per year faster over the whole five year period. One would therefore expect U.S. physician incomes to have risen more rapidly in the 1970s, if data of equivalent reliability were available for comparison.

The variation in price behaviour thus seems considerably greater in Canada, with sharp increases in fees received producing large income gains for physicians in the 1960s and corresponding administrative cut-backs restraining incomes in the 1970s. U.S. physicians seem to have made slower gains in the 1960s but are continuing their upward march in the 1970s. In neither country are population increases a significant factor in health care costs, at least in the short run, though the large aged population in the future is of concern in both countries. Utilization increases in Canada prior to Universal Insurance and in the U.S. since Medicare for those 65 and older are hard to identify because available data does not permit one to observe the pattern or even total volume of services supplied. Utilization, however, is not demand, it can be initiated by the patient or by the provider, and post Medicare experience in Canada suggests that the latter is the more important component. Certainly there is no evidence that universal insurance triggered a massive response of patient-initiated demand, and in the hospital system it clearly did not.

In Canada taxes and premiums collected by federal and provincial governments finance the entire system.[10] Although percent of gross national product for health care services and percentage increases in per capita health care expenditures ar-. important, politicians are concerned with total dollar costs and dollar increases. Health care costs make up 10% of federal expenditures and 33% of Ontario spending, sums which must be raised by taxes or premiums. In 1965 the total cost of health care services was 3.3 billion dollars - in 1970, 6 billion dollars and in 1975 over 11 billion dollars. The magnitude of these expenditures and the rate of their increase has captured the attention and concern of the politicians. Health care in Canada has now moved into the political arena, and is there to stay.

3. Trends and Directions

The trends and directions are most easily discussed around three interrelated concepts: cost containment, Bill C-37 and the Lalonde Report, and they must be viewed from both the Federal and provincial levels.

Cost containment is the major issue. Regardless of whether the increases and the present levels of health care spending are justified, the entire bill is now being paid by government - roughly 50% by federal and 50% by provincial governments. In the United States only about 40% of the total health care bill

is now paid for by government. Of the two levels of government in Canada, the federal has been able to determine only the terms of reference but has had no control over the total amounts expended.

Because of this lack of federal control, and after earlier attempts to limit federal contributions without transfering additional taxing authority to the provinces, the federal government enacted Bill C-37* in 1977. This Bill will reduce direct federal contributions for health care to 25% and tie further direct federal increases to growth of the gross national product. At the same time, federal taxes will be decreased and the provinces will have the opportunity to increase their tax rates to balance the federal reductions. (This has been called Tax Room - the tax points vacated by the Federal Government can be levied by the provinces.) In subsequent years, the revenues to meet cost increases in excess of growth of the gross national product will have to be raised entirely by the provinces, not, as in previous years, jointly by the federal and provincial governments. In this way, cost control is being shifted to the provinces where the constitutional authority rests.

The 50/50 federal-provincial cost sharing arrangements made provision for adjusting provincial payments from the federal government so that the poorer provinces received more than 50%

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*Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977.

of their health care costs and the wealthier provinces received less. This feature has been retained to some degree in Bill C-37, as have the original terms of reference. On the other hand, the federal contribution is now largely independent of provincial health care costs and completely independent of cost increases. Provinces can no longer spend "50 cent health care dollars" since they will receive federal contributions and tax room credits which are far less dependent on their health care expenditures. As well, federal contributions for health care will no longer be earmarked for health; they will be lumped with federal funds for education, further increasing the competition for dollars at the provincial level. For 1977-78, the provinces may also receive additional per capita grants to develop potentially less costly services such as home and extended care. In 1977-78 the federal contributions plus the transfer of tax points will produce more money for the provinces than cost sharing would have. However, the long term trends seem clear. Health care costs will be met mainly by provincial rather than federal taxes. As a result, the major responsibility for raising the money for increased health care costs will shift to the provinces. Increases in federal contributions from year to year will be limited to increases in the gross national product and reductions in federal taxes (greater Tax Room). Lowered federal taxes can be reassessed by the provinces at the same, higher or lower levels. As a result of Bill C-37, the provinces will have greater flexibility and less book-keeping, but far greater responsibility and accountability.

Increased health care costs in one year can be dealt with in subsequent years in a number of ways:

1) Decreased benefits
2) Utilization or deterrant fees. Such fees when used in the past in Canada have deterred only price sensitive consumers and have not reduced costs.[19] Although the former Minister of National Health and Welfare, Marc Lalonde, has repeatedly spoken out against deterrant fees the possibility of use fees is still regularly considered.[20]
3) Higher taxes or increased health care premiums.
4) Increased spending for health care at the expense of other publically funded programs such as education, housing or environmental control.
5) Combinations of any of the above.

Increased taxes seem unlikely in the short term. The system will attempt to reduce costs by providing increases that are less than the rate of inflation, thus effectively reducing expenditures. New programs which have implications for higher costs (and most do initially) will be rejected unless they can be justified by reducing or terminating existing programs. With 90 cents of every health care dollar going to pay service costs, trade offs will be difficult if not impossible. Virtually no new hospital beds will be built and whenever possible politically, existing beds will be closed.

Pressure will be exerted to reduce the numbers of health professional graduates. Immigration of physicians has been stopped - except in those provinces which depend on foreign graduates to maintain present ratios. More and more government involvement in the control and management of health programs can be expected, if only by budgetary reductions. To date the budgetary limitations have been applied mainly to the institutional sector, but tighter negotiation of fee schedules has also slowed the rate of growth of physicians' incomes in recent years. There is now support in some provinces to replace fee for service payment to physicians by salary or capitation on an experimental basis.

The Lalonde Report, A New Perspective on the Health of Canadians[21] adds yet another dimension to cost containment. Part of the genesis of that Report was what was perceived as an unacceptable increase in health care costs. The Report identified the major causes of early and premature mortality as accidents, ischemic heart disease, lung cancer and suicide. It then described "The Health Field Concept", whereby health problems were separated into four components: Human Biology, Environment, Lifestyle and Health Care Organization. The principal underlying factors in the causes of early death were identified as self imposed risks or lifestyle and the environment, factors which could not be attacked by the medical model.

By questioning the "medical solution" for many health care problems, the Lalonde Report demonstrated an understanding that expenditures for personal health services contribute only small and decreasing marginal benefits to health. The Report is particularly important because in it the Federal government has gone on record to say that it understands that more doctors, more nurses, more hospitals and more dollars will, by themselves, have little or no effect on health status or health outcomes. Thus, there appears to be little justification for increased health care expenditures if they will not improve the health status of the Canadian population.

The concept of greater individual responsibility has great appeal but as yet, unproven benefit. It also runs the risk of penalizing the victim. As well, many of the major problems (environmental and occupational) can only be solved on a collective basis despite the Report's exhortation that they be confronted by individuals.

Bill C-37 and the Lalonde Report are Federal initiatives. At the provincial level cost containment has been achieved with budgetary constraints, reduced hospital construction and tightly negotiated fee schedules. The open-ended nature of fee for service payment has been balanced by physician service profiles, monitoring limitations on numbers of services which a physician can bill for and greater legal and investigative authority for regulatory bodies (the provincial Colleges of Physicians and Surgeons).

As well, the provinces have begun to employ organizational alternatives such as:

1) decentralization, primarily through regionalization, and

2) co-ordination and integration of related health and social services.

Decentralization

Virtually all the provinces and territories are divided into administrative regions by their respective health ministries. Services such as public health, mental health and many other community health and social services are delivered on a regional basis by provincial government branch offices. Control of public health has often been turned over to large municipalities, while the province retains responsibility for the administration of services in regions outside these municipalities. Several provinces are now actively attempting the decentralization of health planning and the control of delivery of personal health care services on a regional basis. The concept of a regionalized health system in the Canadian provinces is not new, but regionalization is being increasingly viewed as the vehicle to rationalize health care delivery. Health policy makers who support regionalization approaches argue that crucial decisions regarding the delivery of care should be made at the regional or community level, with emphasis on meeting the needs of geographic areas containing

100,000 or more people.[22] With cost containment redirecting services away from high cost institutions, "hard" decisions like the closing of a hospital or reduced resource allocation are more credibly attributed to a local community based board than to a more distant bureaucratic agency.

As a result, a number of provinces are currently attempting or considering regionalization schemes. Quebec, Ontario, Manitoba and Saskatchewan have established regional planning bodies, generally local boards consisting of consumer and provider representatives. Only Quebec has boards established for the entire province. Despite all the legislation,[23] reports[24] and administrative decisions, no province has yet relinquished to these local boards any significant fiscal control or executive authority over a region. However, proposals have been made in Manitoba[25] and Saskatchewan[26] to allow boards to control regional global budgets or major delivery programs in the future.

In 1971, Quebec established twelve regional councils for its ten health-social service regions (Montreal is one region with three councils). The councils have planning responsibilities for health and social services and are charged with eliminating duplication, promoting the amalgamation of common support services such as hospital laundries and recommending to the Minister of Social Affairs the preferred allocation of dollars among health and social services within their region.[22]

Ontario has opted for a more evolutionary approach to regional planning. This province has established District Health Councils

(DHC), each serving populations of 100,000 or more. A district is encouraged by the Ministry of Health to form a steering committee of local citizens. The steering committee, using general terms of reference and after consultation with providers and the public, recommends to the Ministry of Health whether or not a DHC should be formed and who the members should be. (No more than 50% can be health professionals.) The districts have boundaries which co-incide with regional or county governments or combinations of local government units.[27] Of the 31 potential regions in Ontario, 21 now have DHCs.[28] Ontario DHCs are advisory to the Ministry of Health on matters of budgetary control; as yet they have no fiscal responsibility.

Manitoba is divided into eight health districts, now referred to as District Systems. They should soon be responsible for public health, personal health care delivery and eventually social services, housing, education and recreation needs. Most programs are administered at the District level by the branch offices of the provincial Department of Health and Social Development. Programs included are community services (public health nursing, home care, services to the aged), community mental health, mental retardation and many social service programs. In each District System a local board will be established to be responsible for and co-ordinate the public services with medical, hospital and nursing home services. Ultimate fiscal control is contemplated, but not yet implemented. Since 1974, all personal care homes (nursing homes) built in rural

communities have been linked physically and administratively to their existing hospitals.[29]

Saskatchewan's regional system of community boards which dates back to the 1940s is now being revitalized. The system is predicated on a two-tiered arrangement in which each of the province's ten health regions is subdivided into districts. Each municipality in a district is represented on that district's Health Council and an allotted number of representatives from each district council are elected to the Regional Board of Health. Present legislation authorizes these Regional Boards of Health to undertake responsibility for a wide range of curative services; however, the Boards have not exercised this responsibility. Saskatchewan is currently reviewing the entire question of decentralization and public participation in health care. Although the exact role of the Regional Boards in the future has not been decided, the concept of public participation in general is likely to be strengthened.[30]

A study of one Saskatchewan Region[26] has recommended that the District Health Boards be composed of lay people who assume major responsibility for the administration of health programs, eventually including hospitals and nursing homes. The Regional Board would then serve largely in a support capacity to the district boards. The implications for eventual budgetary control by the Districts are apparent. Arrangements in this Region have been discussed as a possible model for a province wide system.

In general, regionalization in Canada is at an early stage. No single organizational structure has yet demonstrated its effectiveness in accomplishing regional objectives. Those provinces that have begun regionalization have done so on a trial and error basis without federal aid. As yet no cost control has resulted, although greater public concern has been generated.

In the United States regionalization is also not new. On a national scale, an early attempt was the Regional Medical Program in 1965. More recently, overall co-ordination has been attempted by establishing Health Systems Agencies (HSAs) across the country under P.L.93-641. Although such U.S. efforts are firmly grounded in national legislation, and well funded by Congress, Canada does have some natural regionalization advantages. First, its health care system is already significantly decentralized and tailored to 'regional' needs because essentially it consists of 10 separate provincial plans. Second, districts are being defined within existing health regions or other existing political subdivisions. Although the problems of regionalization in Canada should not be minimized, it is probably easier to use these political subdivisions than to define new boundaries as has been the pattern in the U.S. Third, and most significant, there is government control of all health funding.

Co-ordination and Integration

Besides decentralization, a major factor accounting for the interest in regionalized health boards has been the possibility

of better co-ordination of local health services. Co-ordination of services occurs at a variety of levels. For decades, hospitals in many provinces have worked through local hospital planning councils to avoid duplication by sharing common support services such as laundries or laboratories. On occasion, hospitals have co-ordinated their activities with local nursing homes or community clinics. Government provided services, such as public health nursing or voluntary services like home care, delivered by the Victorian Order of Nurses, may also be co-ordinated with hospitals or nursing homes.

Alberta, Manitoba, Quebec and the federal government have combined health and social services under single government departments. Such integration has also been proposed at the district level under single boards or councils. The concept has already been implemented in Quebec with its Regional Councils and has been recommended as the final stage of development for district councils in Manitoba,[25] Saskatchewan[26] and Ontario[27]. Alberta has been experimenting with two integrated regional service boards with combined responsibilities for personal health, public health and social services programs.[31] Bill C-37 may also play a role in integration, because it frees financing to fund planning and implementation of all programs.

On the service delivery level, Canada's limited experience with community health centres encourages similar integration. Provincial government supported centres are being operated in

British Columbia, Saskatchewan, Manitoba, Ontario and Quebec. Multi-disciplinary teams deliver a variety of services in these centres. However, with the exception of the integrated local community service centres of Quebec (CLSC) most of these efforts by the provinces are small in size and number and mainly experimental.

Program Expansion

Cost containment pressures are not necessarily negative. They can also be credited with encouraging program expansion in some areas. Provinces are increasing the number and scope of programs that provide lower cost alternatives to high cost acute institutional care. Long term care, especially home care, is being expanded in virtually all provinces. Saskatchewan is gradually implementing home care on a province-wide basis.[32] The community health centres, where they are being supported, deliver care through integrated teams which also stress health promotion and maintenance and disease prevention. In addition many provinces have launched major programs that concentrate on health promotion and maintenance and disease prevention for the entire population. These programs and others such as the 'preventive social services' program in Alberta are an attempt to identify and prevent or alleviate health and social problems at an early stage, to take pressure off the crisis care system.

While Bill C-37 fiscal arrangements will, it is hoped, encourage this trend by allowing federal dollars to support these alternative programs, many provinces had already begun prior to the new fiscal arrangements.

Cost containment potential, however important, is not the only factor governing health care program expansion by the provinces. Consumer pressure, political popularity and positive social objectives are other causes. Many provinces have recently implemented or are planning expansion of universal programs by increasing categorical benefits, often entirely at provincial expense. For instance, Saskatchewan and Manitoba, without cost sharing, introduced universal prescription drug programs and universal dental care for children.

Saskatchewan has also established a variety of categorical programs for the handicapped (hearing aids, wheel chairs, etc.), cancer patients, alcoholics and mental health promotion. Planning is now underway to provide additional provincial programs in areas such as vision care, chiropody, ambulance services, dentures and more services for the physically and mentally handicapped. These services are being covered despite the fact that Saskatchewan has been over budget in recent years and has had to rely on surplus revenues from previous years to finance some of its new programs.[32]

While Saskatchewan and Manitoba may be considered the leaders in the expansion of new universal programs, they are not unique. Since 1975, virtually all provinces have insured prescription drugs for senior citizens, with the province bearing the entire

cost of the program.[33] Nova Scotia and Quebec have recently established province wide children's dental plans and New Brunswick provides such services in underserviced areas. Provinces other than Saskatchewan are also increasing categorical benefits, particularly for the physically and mentally handicapped. There is considerable satisfaction with government funded programs and a demand for further expansion of benefits.

Obviously the picture is far from bleak. Many of the constaints are long overdue. Annual per-capita expenditures of $500 or more are probably sufficient. Planning is possible only when resources are fixed and limited. In all likelihood, insured benefits will be maintained and any spending constraints will not adversely affect the health of the Canadian people. On balance, universal health insurance in Canada has been a good thing. It is obviously here to stay. If we had to do it again, we'd still do it, although we might do it differently. As the Ontario Economic Council said in 1976, "In retrospect, it is apparent that a major error in the development of Ontario's health care system was the failure to rationalize - or even attempt to rationalize - the health care delivery system before public health insurance was introduced; at a minimum, it should have been concurrent with its introduction".[20]

The implications of universal insurance could not have been anticipated by those who enacted it. The program is funded by government which must raise the funds. Under Bill C-37, the

Federal role will be decreased and greater responsibility shifted to the provinces. The same government that taxes will have the authority to control costs. Public expectations may have to be reduced and professional perogatives confronted and limited. Without universal health insurance, Canada wouldn't have known what the problems were; the government would have had neither the authority nor the impetus to deal with the problems. There are dangers inherent in health care decisions which are predicated solely on financial considerations. On the other hand, governments now not only know what the total health care bill is, they also have to pay that bill and deal with the issues.

Perhaps, in Canada, universal insurance may yet prove to be the mechanism to rationalize the system. The stakes are high - no country has yet fundamentally changed its health care system after adopting universal health insurance. However, the economic realities of the 1970s coupled with a growing awareness of the limitations of uncontrolled increases in medical care may yet make rationalization possible in Canada.

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19. Beck, R.G. The Demand for Physicians' Services in Saskatchewan. Doctoral Dissertation, University of Alberta, 1971.

20. Ontario Economic Council. Health Issues and Alternatives, 1976. Ontario, 1976.

21. Lalonde, M.A. A New Perspective on the Health of Canadians. Ottawa, Information Canada, 1975.

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23. Quebec, An Act Respecting Health Services and Social Services (Bill 65)(1971); Manitoba, District Health and Social Services Act (1975).

24. Numerous studies by provincial and federal commissions have recommended the regionalization of health services during the last decade. For example, see A New Perspective on the Health of Canadians (federal): Report of the Task Force on Health Planning (Ontario), A New Direction for the Seventies (Nova Scotia) or White Paper on Health Policy (Manitoba).

25. Manitoba, Health Education and Social Policy Committee of the Cabinet, White Paper on Health Policy, July 1972.

26. Saskatchewan, Department of Health, Research and Planning Branch, "Prince Albert Community Health and Social Services Study", October 1975.

27. A Report of the Ontario Council of Health, "District Health Councils", 1975.

28. It is not clear what kind of a region Metropolitan Toronto, with over 2.4 million people, should be or how many councils it might have.

29. Information is based on the Manitoba submission on "Trends in the Provincial Health Care Systems of Canada" to the Canadian Health Administrator Study (work in progress).

30. Saskatchewan Department of Health, Policy Research and Management Services Branch, Briefing material prepared for the Saskatchewan Deputy Minister of Health for interview by reporters from the Financial Post.

31. Government of Alberta, Alberta Habitat Demonstration Projects, May 1976.

32. Saskatchewan, Department of Health, Policy Research and Management Services Branch. Submission on "Trends in Provincial Health Care Systems of Canada" to the Canadian Health Administrator Study (work in progress).

33. Public assistance recipients also receive a large number of health and social benefits, including prescription drug coverage, from the province. However, these services are cost shared on a 50-50 basis with the federal government under the Canada Assistance Plan Act.

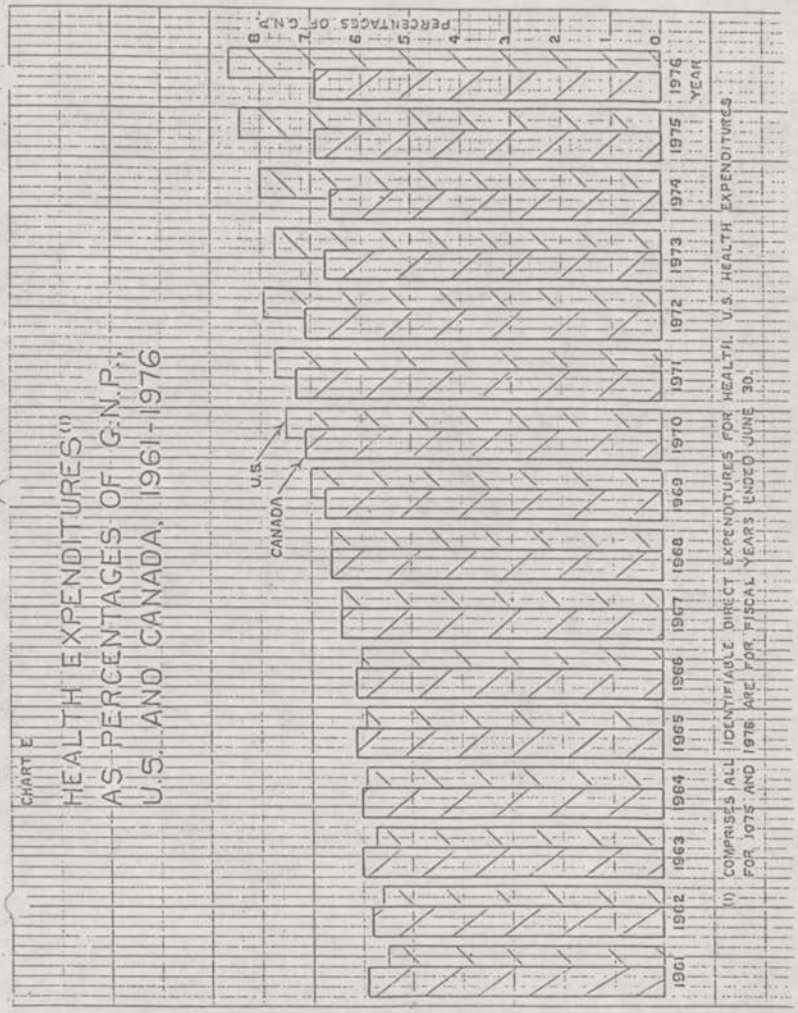
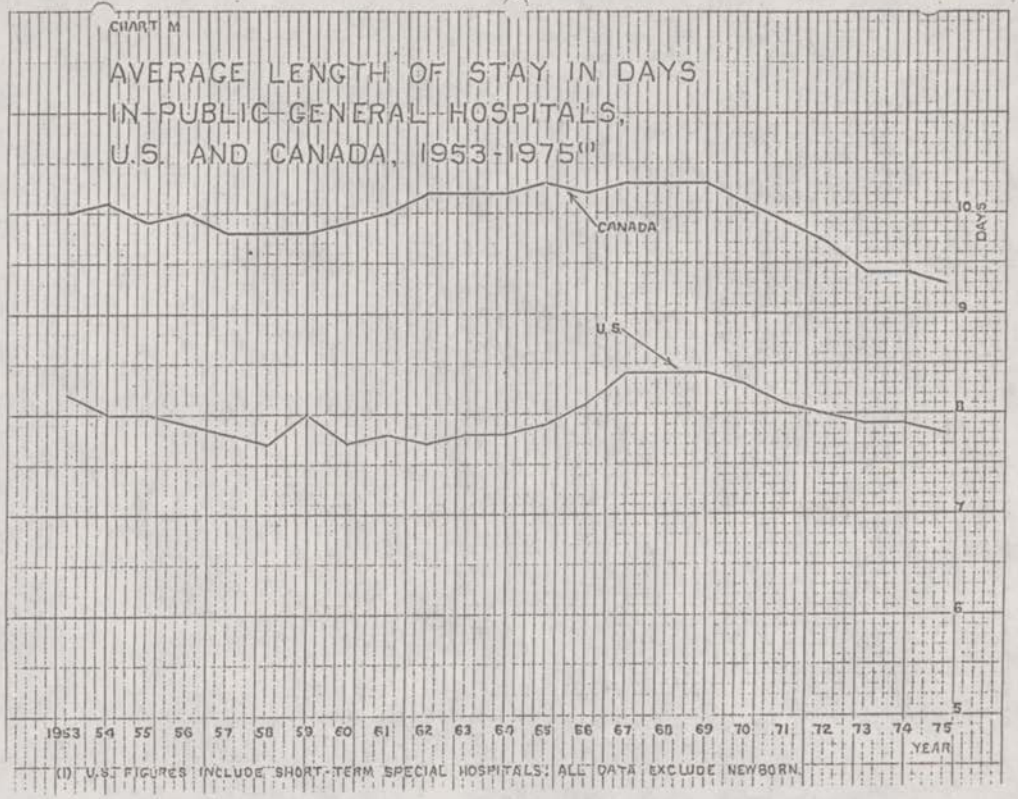


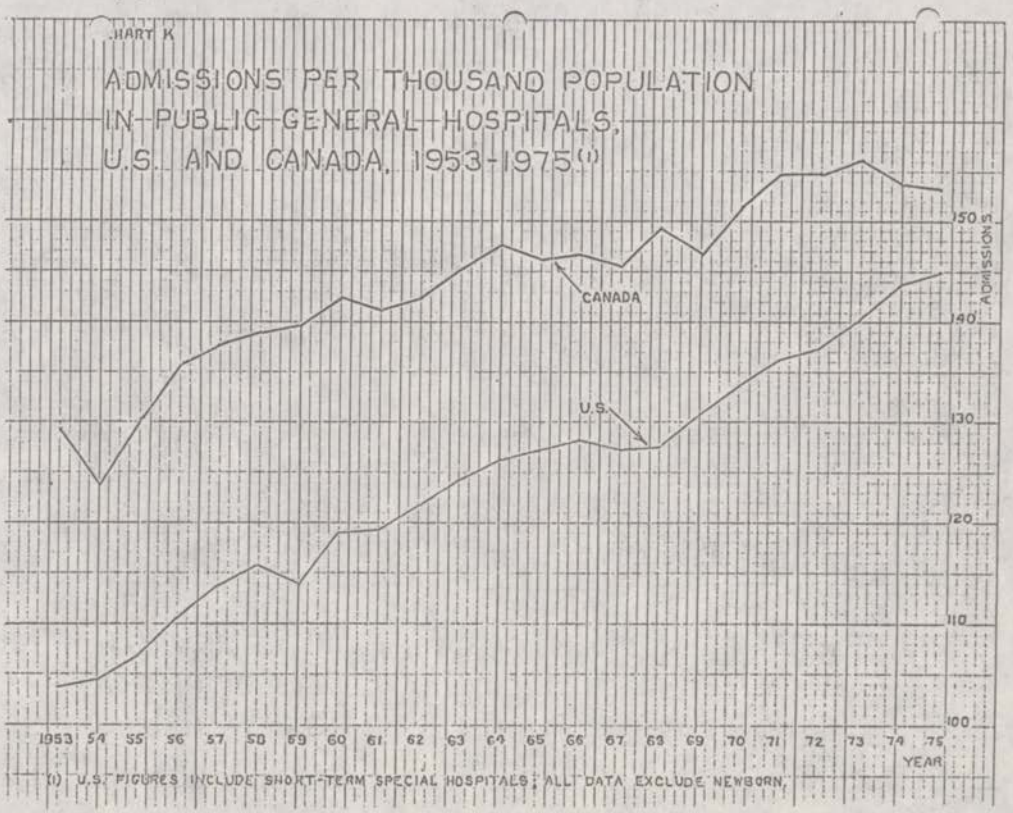
CHART E
HEALTH EXPENDITURES (1)
AS PERCENTAGES OF G.N.P.
U.S. AND CANADA, 1961-1976
PERCENTAGES OF G.N.P.
0
1
2
3
4
5
6
7
8
U.S.
CANADA
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
YEAR
(1) COMPRISES ALL IDENTIFIABLE DIRECT EXPENDITURES FOR HEALTH. U.S. HEALTH EXPENDITURES FOR 1975 AND 1976 ARE FOR FISCAL YEARS ENDED JUNE 30.

CHART M

## AVERAGE LENGTH OF STAY IN DAYS IN PUBLIC GENERAL HOSPITALS, U.S. AND CANADA, 1953-1975(1)




(1) U.S. FIGURES INCLUDE SHORT-TERM SPECIAL HOSPITALS; ALL DATA EXCLUDE NEWBORN.


HART K
ADMISSIONS PER THOUSAND POPULATION IN PUBLIC GENERAL HOSPITALS, U.S. AND CANADA, 1953-1975 (1)
CANADA
U.S.
ADMISSIONS
150
140
130
120
110
100
1953 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75
YEAR
(1) U.S. FIGURES INCLUDE SHORT-TERM SPECIAL HOSPITALS; ALL DATA EXCLUDE NEWBORN.

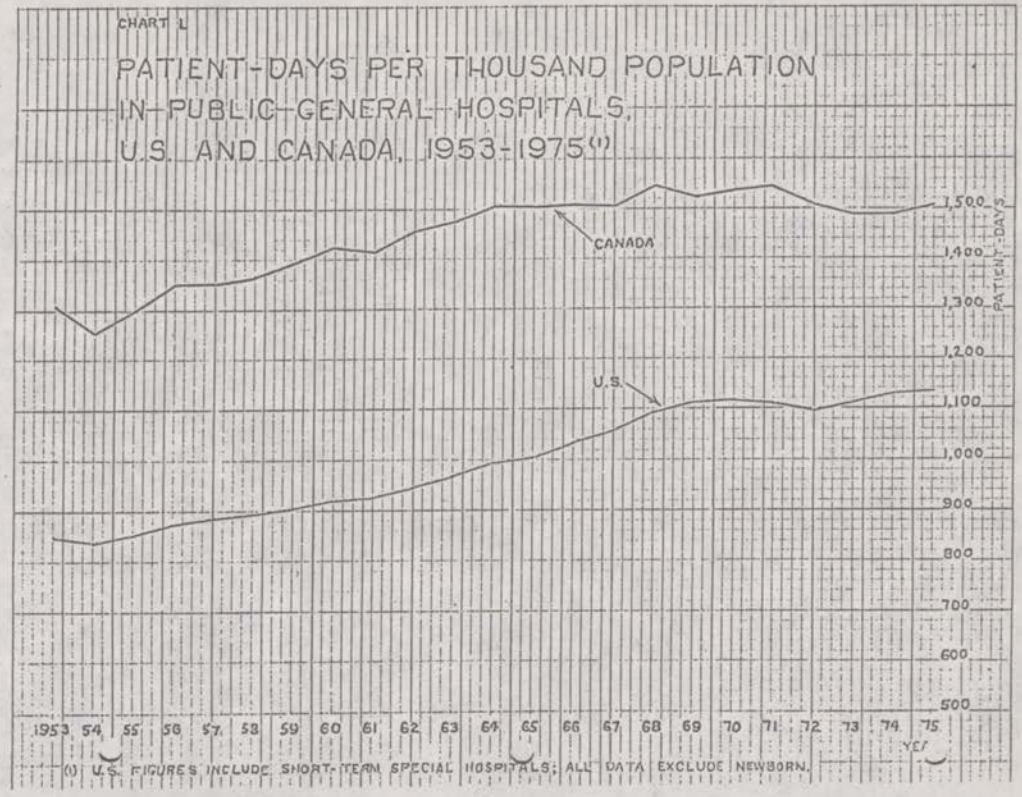


CHART L
PATIENT-DAYS PER THOUSAND POPULATION IN PUBLIC GENERAL HOSPITALS, U.S. AND CANADA, 1953-1975 (1)
CANADA
U.S.
PATIENT-DAYS
1,500
1,400
1,300
1,200
1,100
1,000
900
800
700
600
500
1953 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75
YEAR
(1) U.S. FIGURES INCLUDE SHORT-TERM SPECIAL HOSPITALS; ALL DATA EXCLUDE NEWBORN.

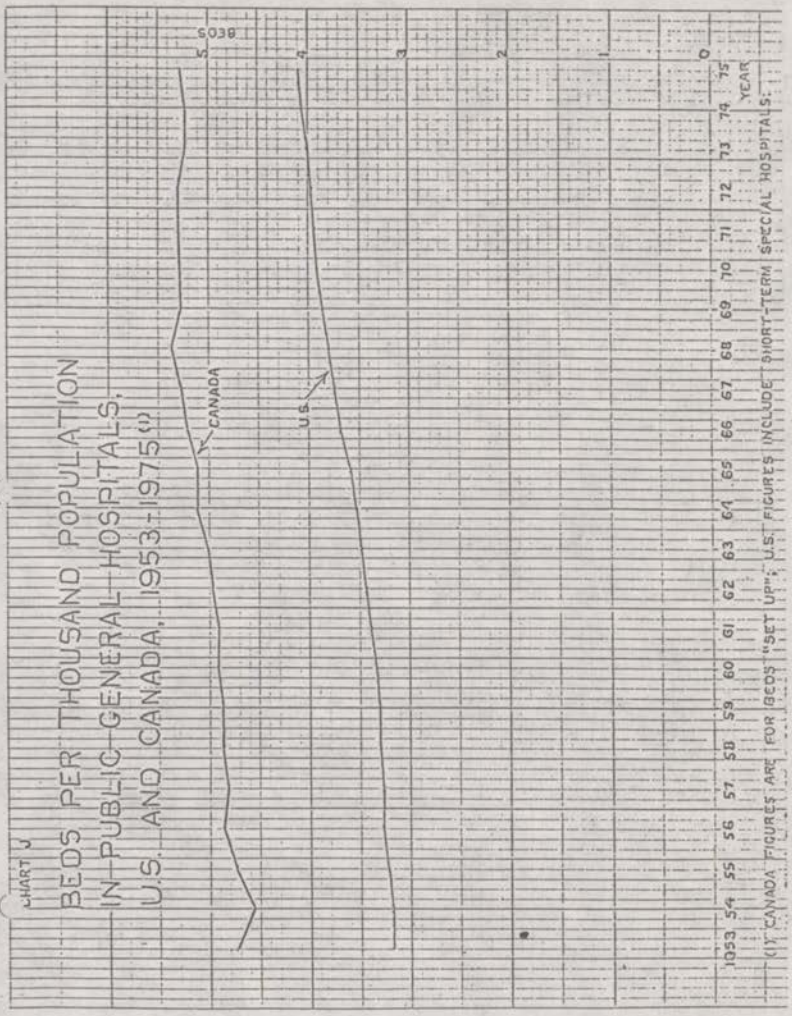
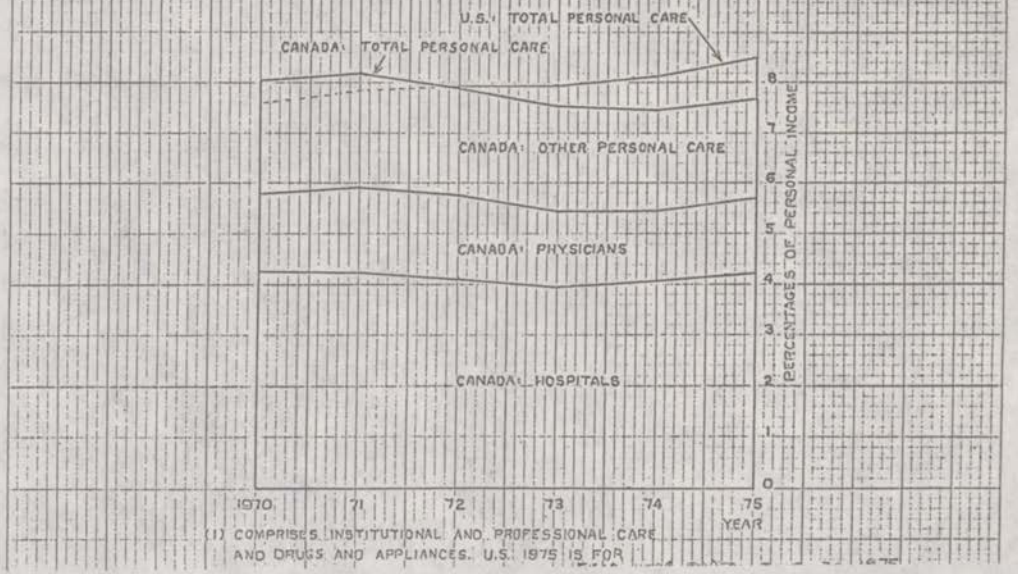


CHART J
BEDS PER THOUSAND POPULATION
IN PUBLIC GENERAL HOSPITALS,
U.S. AND CANADA, 1953-1975(1)
BEDS
5
4
3
2
1
0
CANADA
U.S.
1953 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75
YEAR
(1) CANADA FIGURES ARE FOR BEDS "SET UP"; U.S. FIGURES INCLUDE SHORT-TERM SPECIAL HOSPITALS.

CHART C

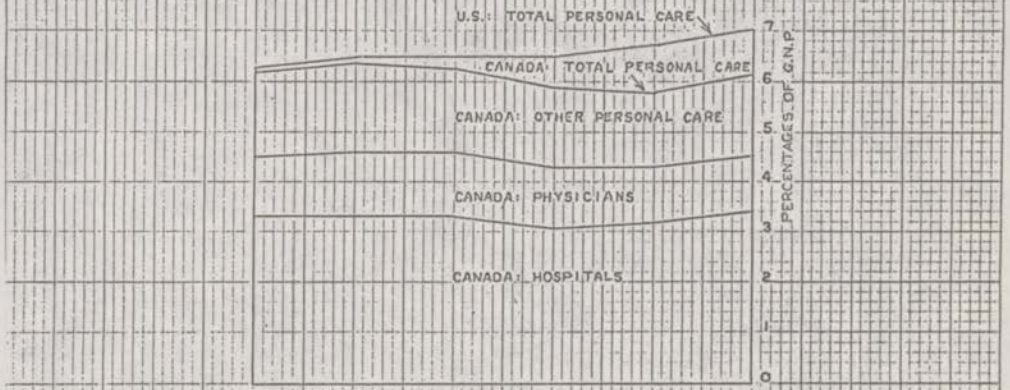
# COMBINED PUBLIC AND PRIVATE COST OF PERSONAL (1) HEALTH CARE, U.S. AND CANADA, 1970-1975, AS PERCENTAGES OF PERSONAL INCOME




(1) COMPRISES INSTITUTIONAL AND PROFESSIONAL CARE AND DRUGS AND APPLIANCES. U.S. 1975 IS FOR

CHART B

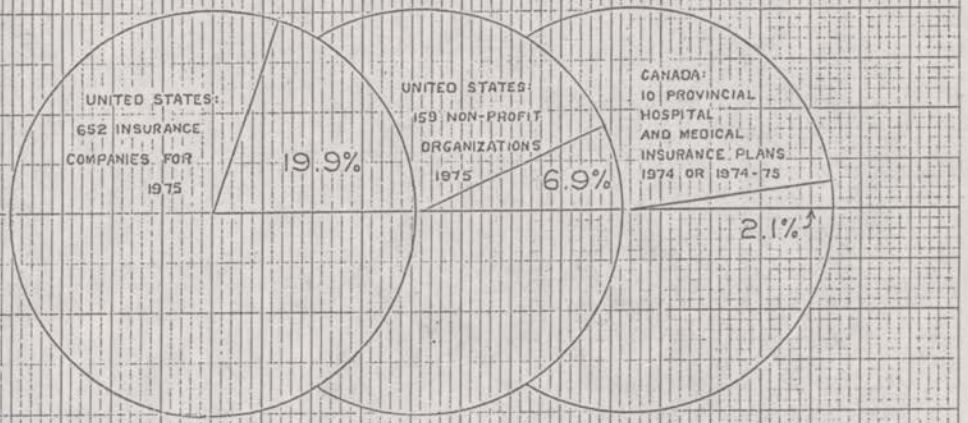
## PERCENTAGES OF U.S. AND CANADIAN G.N.P. DEVOTED TO COMBINED PUBLIC AND PRIVATE COST OF PERSONAL[1] HEALTH CARE, 1970-1975




(1) COMPRISES INSTITUTIONAL AND PROFESSIONAL CARE AND DRUGS AND APPLIANCES. U.S. 1975 IS FOR FISCAL YEAR ENDED JUNE 30, 1975.

CHART F

## HEALTH INSURANCE PLANS' ADMINISTRATIVE COSTS AS PERCENTAGES OF TOTAL COSTS, U.S. AND CANADA, 1974 OR 1975



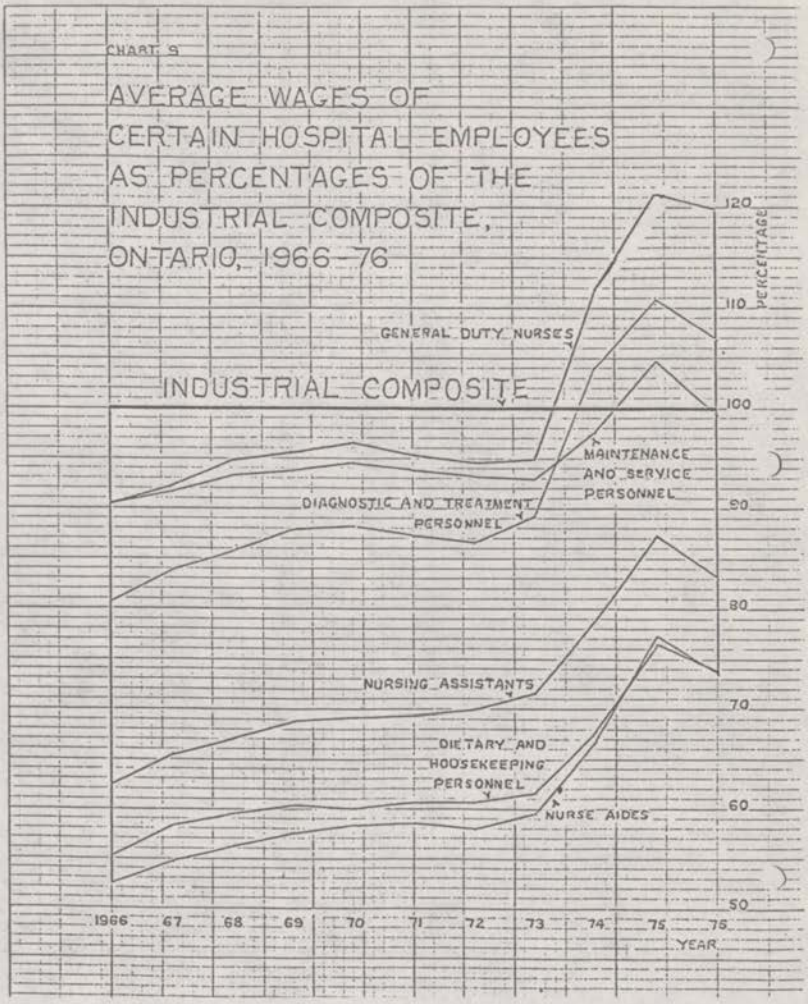


CHART 9
AVERAGE WAGES OF CERTAIN HOSPITAL EMPLOYEES AS PERCENTAGES OF THE INDUSTRIAL COMPOSITE, ONTARIO, 1966-76
GENERAL DUTY NURSES
INDUSTRIAL COMPOSITE
MAINTENANCE AND SERVICE PERSONNEL
DIAGNOSTIC AND TREATMENT PERSONNEL
NURSING ASSISTANTS
DIETARY AND HOUSEKEEPING PERSONNEL
NURSE AIDES
PERCENTAGE
120
110
100
90
80
70
60
50
1966
67
68
69
70
71
72
73
74
75
76
YEAR

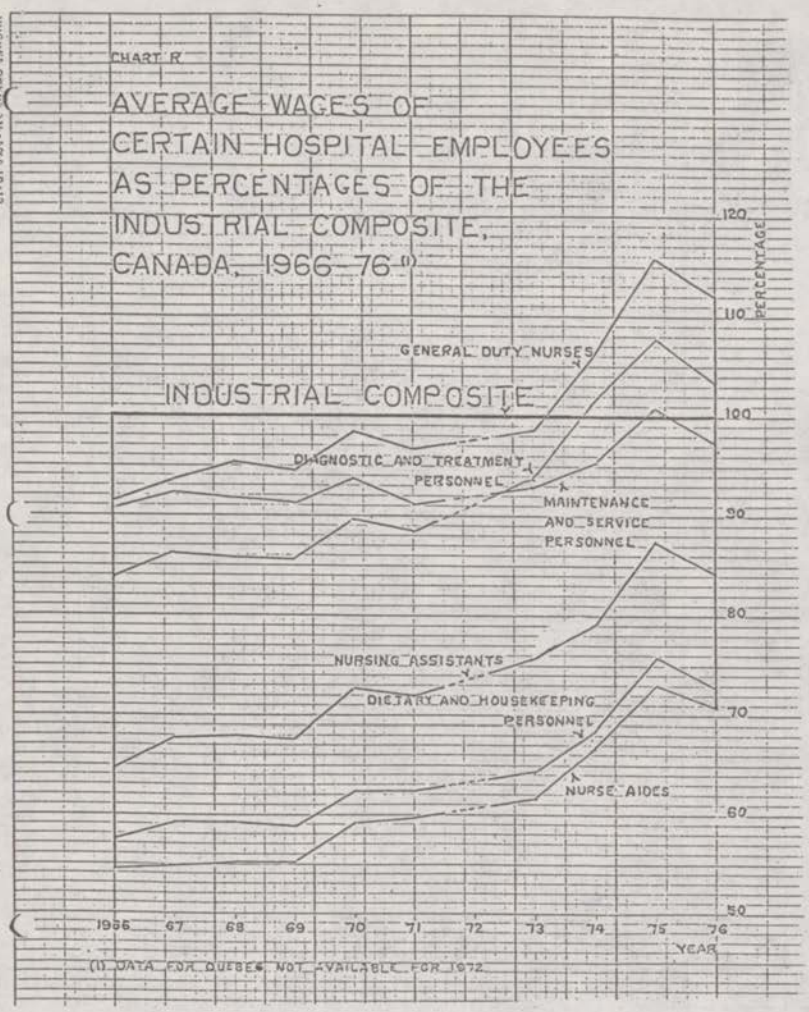


CHART R
AVERAGE WAGES OF CERTAIN HOSPITAL EMPLOYEES AS PERCENTAGES OF THE INDUSTRIAL COMPOSITE, CANADA, 1966-76 (1)
PERCENTAGE
120
110
100
90
80
70
60
50
GENERAL DUTY NURSES
INDUSTRIAL COMPOSITE
DIAGNOSTIC AND TREATMENT PERSONNEL
MAINTENANCE AND SERVICE PERSONNEL
NURSING ASSISTANTS
DIETARY AND HOUSEKEEPING PERSONNEL
NURSE AIDES
1966 67 68 69 70 71 72 73 74 75 76
YEAR
(1) DATA FOR QUEBEC NOT AVAILABLE FOR 1972

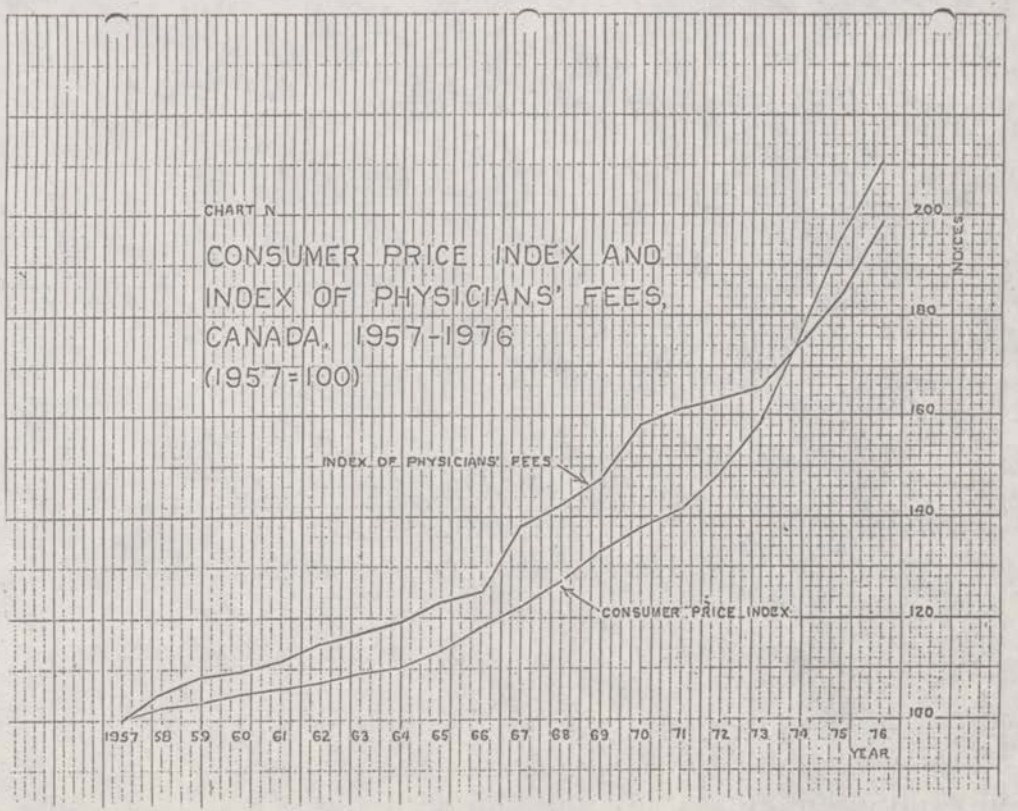


CHART N
CONSUMER PRICE INDEX AND INDEX OF PHYSICIANS' FEES, CANADA, 1957-1976 (1957=100)
INDEX OF PHYSICIANS' FEES
CONSUMER PRICE INDEX
INDICES
200
180
160
140
120
100
1957 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76
YEAR

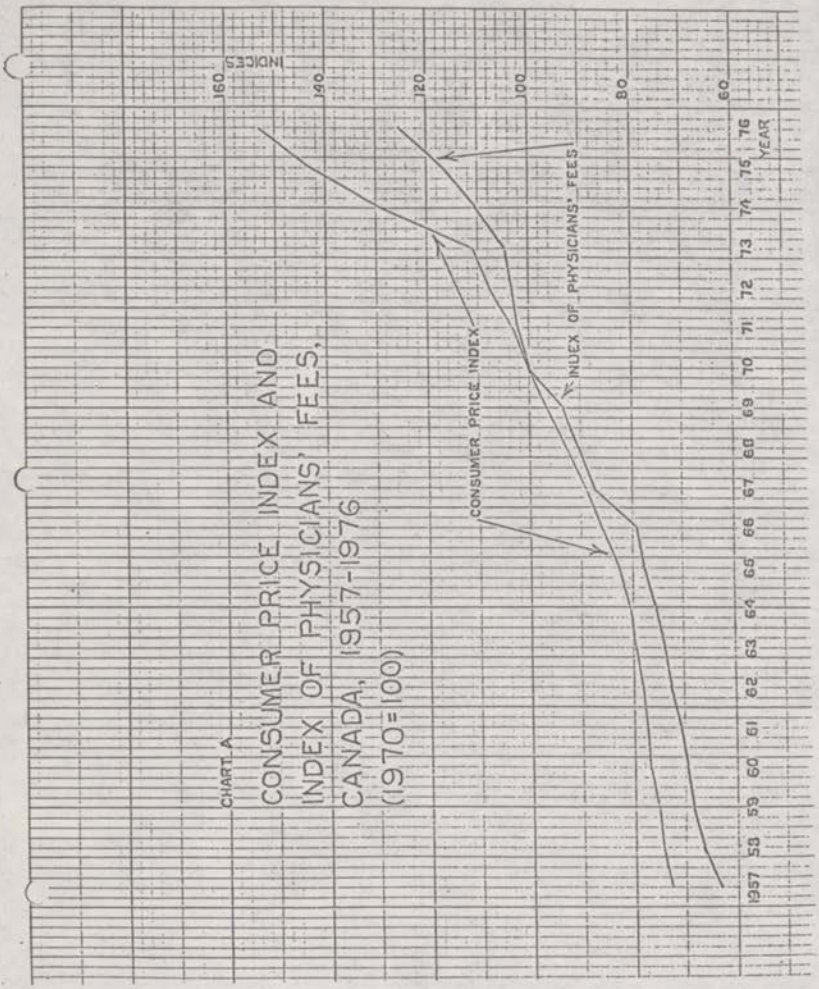


CHART A
CONSUMER PRICE INDEX AND
INDEX OF PHYSICIANS' FEES,
CANADA, 1957-1976
(1970=100)
INDICES
160
140
120
100
80
60
CONSUMER PRICE INDEX
INDEX OF PHYSICIANS' FEES
1957 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76
YEAR

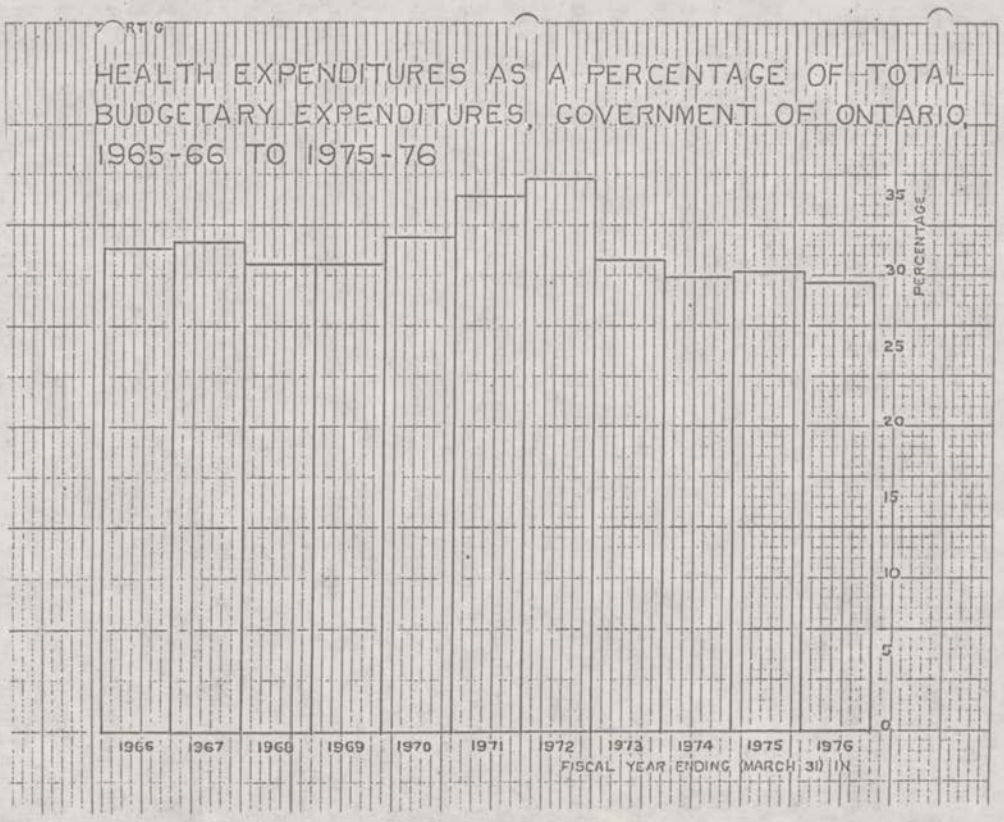


CHART G
HEALTH EXPENDITURES AS A PERCENTAGE OF TOTAL BUDGETARY EXPENDITURES, GOVERNMENT OF ONTARIO, 1965-66 TO 1975-76
PERCENTAGE
35
30
25
20
15
10
5
0
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
FISCAL YEAR ENDING (MARCH 31) IN

Senator KENNEDY. Their conclusions are a bit different from yours. Certainly I am prepared to see a group from the Academy of Sciences in the United States do an effective kind of evaluation on the strengths and weaknesses, both of the United States system and the Canadian system.

You are quite right, certainly, in talking about universality and comprehensive, and they have cost controls, and no one has suggested that more is better. We are spending $2 billion a year now and keeping unnecessary hospital beds open. We ought to have some of those beds closed down. So when you talk about closing hospital beds, I do not know whether that means better health care or worse health care.

We overuse, we overuse in technology, we overuse in many instances in the numbers of personnel highly concentrated areas. We have much more than we probably should have in some areas, much less than we should have in others.

When we talk in generalities, either about closing or other factors, I do not know what the criteria is you use. You have had national health insurance in Canada since 1968. You still have a better infant mortality rate than we do in the United States. You still have a life expectancy rate that has not declined or altered.

I do not know by what figures or criteria you use to show that with adoption of national health insurance, it is an inferior system. It certainly is a humane system, as we listened to our Canadian friends this morning. And as we have seen in most recent national polls taken in Canada, 84 percent of the people find it highly desirable. [Applause.]

So we have a country which is close in terms of shared values, shared concerns. For example, in my own State of Massachusetts, more people have come from Canada than from any other country in the world. Whether it is Ireland, Italy, Greece, Lebanon, we have all nationalities, but more from Canada than anywhere else, and we have shared values and shared concerns.

We listened to those particular witnesses here this morning. They said the same types of things in Detroit, and they said the same types of things in Washington, and they said the same types of things when they have been polled nationwide. None of the outstanding indexes that would measure a health care system has varied since they have had national health insurance. You hear about a mother who is willing to adopt a handicapped child because she wanted to share that love and affection, and you listened to a mother here in the United States that is faced with many other financial problems.

Where do you put the dollars-and-cents value on those? Where do you put it? When everyone of those witnesses nodded and expressed they were free from the fear of health care illness and sickness, what kind of dollars and cents are you placing on that factor there versus listening to every mother or parent who talked about the human tragedy they are facing and the enormous emotion involved. No comment made about that, Doctor. No comment made by you on that particular factor.

The final fact is with regard to cost controls, you mentioned they have effective kind of cost controls. When you listened to the mother here this morning talk about the local county problems, the agencies that she was facing, the State agencies they were facing, the Federal

agencies they were facing, and the voluntary agencies they were facing, and still unable to get any kind of results on it—bureaucracy to the ultimate end.

And these people [indicating the Canadians] were getting services.

As I say, people talk and say, whether you carefully selected the witnesses—but you get five familities here, and we have had five that sat at our hearing in Washington and five in Detroit and five or six in every other place, and trying to match them, but the fact of the matter is that is the percentage of people in Canada that approve the system. I daresay you can go and say that 16 percent disapprove it. No one is suggesting here that there are not problems with it.

Maybe I will ask the person in the medical profession, Dr. Murray, if she wants to give any kind of reaction to these comments.

Dr. ROBILLARD. I wanted to make a brief comment because you stated a couple of points that I just cannot let them go. I am not going to enter into an oratorical remarks with a Kennedy because I would lose.

Senator KENNEDY. You would not with the American Medical Association or the Hospital Association, those that have health care industry in the Nation. They would agree with you very, very strongly.

Dr. ROBILLARD. I do not care. I am not in politics.

Senator KENNEDY. You would be amazed at the number of doctors in politics—a different form of politics. So is Dr. Murray.

Dr. ROBILLARD. Covering catastrophic illness, I made that point briefly, but I made it as something we were grateful for. So we are not interested and do not care, the fact that people that have problems before, do not have them any more, that this is of no interest to us, I think I made this point clearly enough and I do not need to insist on it. I testify as a physician in Canada. I testified on what I see. I testified that a hemorrhage in the phallus of a man cannot be seen without a CAT scan, and if you anticoagulate him, he is going to die. If he dies, he is not going to feel any worse about it, but I will. I know that he died because I did not have the equipment. I know a number of things of this sort that I can testify upon, and any commission you care to name, be it the Academy of Science or anything, I have no axe to grind. I am talking about medicine.

I think actually we are in the process in Canada of reducing our standard of medicine below the American standard, the U.S. standard. I do not think it is just for the public. I am a technical person. I am a scientific person. I know my discipline. I am not a politician. I am ready to testify about what I know.

Senator KENNEDY. Dr. Fox?

Dr. FOX. Mr. Chairman, I know I surrendered my right to testify——

Senator KENNEDY. I will give you 2 or 3 minutes and then I will hear Dr. Murray.

Dr. FOX. I merely wanted to make the point that in this country, 81 percent of our population has adequate health insurance. That is a HEW statistic. Sixty percent of our population has catastrophic insurance.

Now the people that we heard from this morning from the United States, I have to say I cannot believe that they are covered by catastrophic insurance. Catastrophic insurance is among the cheapest forms of insurance there is. And the reason that many people are not

covered is because they simply have not heard about it or have simply decided to save a few dollars and not invest in catastrophic insurance. I think that point has got to be made.

Many of these problems, and I felt as you did, Senator, that these were very, very sorrowful stories, could be covered if those people had catastrophic insurance.

Senator KENNEDY. Well, the fact is under HEW criteria they would have been all considered to have adequate coverage. Most of them have Blue Cross-Blue Shield. When you are making $10,000 or $12,000, which is the median income in the United States, and you have a medical bill of $8,000 or $10,.00, and you are paying 20 percent or 25 percent, and you are paying $2,500, that is a catastrophe.

That is a catastrophe to that family. That is a catastrophe. It is not to those in this country that have very generous incomes but it is to the average family or young parents who have just had a child. That is a catastrophe to them, but it is not under the "catastrophic" type of health insurance.

The fact of the matter is these kinds of bills are increasingly evident all across this country. People are writing to us about them.

Dr. Fox. Catastrophic insurance is customarily thought by those people that I know to start at about $12,000 and go on up to $25,000, $50,000, $100,000 or $250,000. It is not that expensive.

Senator KENNEDY. $600 was catastrophic to the Mosses. He is a young graduate student, and $600 was catastrophic to a young family who are students. It would certainly seem to me and unquestionably that several thousand dollars up to $12,000 is catastrophic to most of the people that testified here today.

Dr. Fox. Mr. Moss certainly presented a sad story, and I still do not understand how the first coverage that he had during his wife's first pregnancy could have gotten away from him. I think I would have been checking with a lawyer because I think there was some slippage there.

Senator KENNEDY. That is the problem that we are getting into, a situation of doctors telling patients to go to a lawyer. I want to know what it is going to cost to get a lawyer.

In any event, Doctor, I want to welcome your comments. What we want to have, and we will explore with the Academy of Sciences, to get an objective group with objective criteria in measuring the different systems. But we must also recognize in evaluating what the importance of having people free from the fear, the humaneness of the system, that ought to be measured. We are talking mostly all around you with dollars and cents. There are those who question the system. What we basically used in the Canadian model is the fact that it is universal, it is comprehensive, and has effective cost containment and has a wide degree of acceptability by the people.

The fact of the matter is we can develop, and we have provincial governments, we have States, and there are going to be differences, and there should be. But to use the scare tactics which have been so much apart in the part, in this country when we were debating social security or whether or not we were going to have medicare—I was in the Congress at that time, and talking about socialism and Communism under medicare for our older citizens were scare tactics. The same kind of tactics are being used to debate national health insurance. The fact

is you have the amount of insurance that is paid out which does not meet the needs, and paying anywhere from 35 or 36 percent of the dollars that are actually expended under the system, and you have 24 million Americans with no coverage at all. And 53 million Americans who live in underserved areas. You are talking about those doctors who are in underserved areas who do not have adequate equipment.

We do not even have the doctors out there.

You are talking about competition from general practitioners when, 5 years ago, we only had 18 percent of those that were in an intern and residency program that were in general practitioners—we were graduating all specialists. The people that live in most communities, what they need are general practitioners. [Applause.]

I do not question that there are not enormous strengths in our own system. Doctor, say, I have personally experienced the best, I think the best in the world, in my own city of Boston, with my own health problems, in a hospital for 7 months with a broken back, a child who had cancer, a sister mentally retarded, a father 7 years with a stroke. We have been able to get the very best. We have been fortunate to also have been in the U.S. Senate that has a very, very good program. Senators are free from the fear of sickness and illness, and all the Congressmen are free from that fear as well.

But I just wish that we were doing as well for our witnesses that we heard this morning, as we have done for ourselves. [Applause.]

Dr. Murray, we have about 6 or 7 minutes, and I will ask Dr. Murray and Dr. Fox to make a comment.

Dr. MURRAY. I always have a little trouble trying to speak as a typical representative of American medicine because obviously I am not. I think quite frankly that is one of the problems with American medicine that they do not have more people like me in it. [Applause.]

I think if we take a moment and really look at what we are talking about, we are talking about a collection of people, physicians who trained for many years and learned certain skills, that is supposed to allow them to help their fellow human beings. In this country, at least, for decades, being a doctor has meant entrance into a small group of very privileged group of people able to earn huge sums of money, and still today you have to meet very strict qualifications to do that. It helps if you have some money to start with. It helps if you are male. It has always helped if you were white.

I think in the past 10 years only because of centuries of hard struggle, we have gotten a trickle of different kinds of folk like myself in American medicine. I am not interested in protecting the marketplace of the health industry. I did not become a doctor in order to insure that the values of the marketplace will prevail. I became a doctor quite simply to take care of people that are sick and need my skills. I do not have a CAT scan at Cook County Hospital either. You touched a nerve. We have something in common after all. Across the street, 20 feet away, there are three CAT scanners at a private institution. In order for me to get my patient across the street at 2 a.m. in the morning, it takes a lot of effort and muscle on my part and $300 of the taxpayers' money.

I would suggest to you that the American medicine ought to be about is what we are trained to go, and that is take care of sick people. The health of our people is too important to be left to the whims of the marketplace.

Let that rest with car manufacturers and the like. [Applause.]

I do not think my son's health is a commodity that should go up and down with inflation or employment. I do not think the health of all of these people we heard today is something that we can barter away.

We can trust to paid peopde, paid by the State, the security of our Nation—I am not saying they do a very good job of it—we entrusted to them. We pay people to enact our laws, and we pay people to keep our houses from burning down, and I will suggest to you that it is only rational that when it comes to a matter as important as our people's health, there is something we cannot leave to chance. Every civilized group of people comes together to guarantee as a group the health of these people are insured, and that is why, quite frankly, I find your remarks insulting. They do not speak to my experience or the experience of my neighbors and my family. Even as a physician, I still have the same fears that these people have in terms of my health and the health of my children.

I think it is clear to a large number of Canadians, and I hope it will become increasingly clear to most American citizens, that what we are talking about is really a very simple and quite frankly rather mild change that simply says that we ought to take our health resources and use them in a common fashion, and we ought to be able to control our own destiny. [Applause.]

Senator KENNEDY. I will give Dr. Fox an opportunity since you had your hand up.

Dr. FOX. I have three points to make.

No. 1, my credentials. I practice on the South Side of Chicago in an underserved area, and I take care of many medicaid and medicare patients.

Item No. 2. American medical establishment is thought by some not to be representative of younger physicians. I would like to tell you that 14 percent of the membership of AMA consists of students and physicians in training—14 percent—that is a pretty young group. They are represented.

The third thing I wanted to say is I completely agree with Senator Kennedy that we should have an objective evaluation of the two systems of health care and really make a determination. The reason I was so concerned to have Dr. Robillard here today was so that he could make some kind of presentation, pointing out some of the pitfalls in the Canadian national health system, and I certainly appreciated him being able to appear.

Senator KENNEDY. We want to thank our witnesses here. You can see it is not a uniformity of view and we want to thank you who joined with us here this morning, including our senior citizens and others who have been very patient. We thank them for their interest.

At this point we will insert in the record additional statements submitted to the subcommittee.

[The statements referred to follows:]

PRESS STATEMENT FROM
CHICAGO COALITION FOR NATIONAL HEALTH SERVICE
407 South Dearborn Street
Chicago, Illinois 60605

AT SENATOR KENNEDY'S HEARINGS ON NATIONAL HEALTH LEGISLATION

Press Contact: Ann Prosten (373-0506)

The Chicago Coalition for National Health Service welcomes Senator Edward Kennedy and his Committee to the City of Chicago. To this hearing Senator Kennedy continues his leadership seeking reform of America's ailing health care system. We particularly salute the Senator's recent, bold critique of President Jimmy Carter's 10 principles relative to National Health Insurance. It took political courage to separate himself from his national leader on this important issue.

Nonetheless, we cannot support the Senator's latest proposals because they represent movement away from the Kennedy-Corman bill in the direction of Mr. Carter's compromise which the Senator has so eloquently denounced.

We know that the Senator and his proposal will be sharply criticized by those powerful interests that dominate American medicine - the insurance companies, the drug industry, the American Medical Association and the American Hospital Association - who will find even the limited new Kennedy proposals unacceptable. We most emphatically wish to dissociate ourselves from these critics who have contributed most to the present inequities and high cost of health services.

We say to the Senator, "These groups will not be appeased. The enticements being offered them are not only inimical to the development of a new health system, but demonstrate the folly of compromise."

Mr. Kennedy's support of the Kerr-Mills bill paved the way

for Medicaid and Medicare but at the price of gutting universal national health insurance and yielding skyrocketing payments to hospitals and private practitioners. Much of the public confusion and disenchantment with government programs are the direct result of this impossible formula: unsupervised government payment to self-aggrandizing private medical interests. At their worst, they create Medicaid mills and, at best, they are too costly because of high fees, excessive hospitalization and medical/surgical services.

We wish to acknowledge that some of Mr. Kennedy's new principles are excellent: universality of coverage, comprehensiveness of services, the elimination of co-payments and the development of standards and regulations to assure quality.

Unfortunately, the mechanisims laid out in the proposed legislation will defeat these very principles:

1. By preserving fee rewards, as did Medicaid and Medicare before it, the new legislation almost assures runaway costs that has discredited the prior programs.

2. By giving the private insurance companies administrative roles, even with "safeguards", will result in billions of excess costs which will diminish available services. The experience of the Province of Ontario, under its conservative government, illustrates this point. Their health scheme was commenced under private auspices but when 14% administrative costs became the standard, the Tory government took over administration and performed the service at a 2% cost.

3. The Kennedy principles fail to include occupational health as part of the program and for affirmative action, so deficient in the health field, receives no notice.

The Chicago Coalition for National Health Service is part

of a nation-wide grouping which has come to believe that only a thoroughgoing reform of the health system, a national health service, can meet the needs of our society. The elements of this service is contained in legislation introduced by Dr. Ron Dellums (D-California) We would urge Mr. Kennedy to initiate additional principles now to be found in Mr. Dellums bill including a democratic system of control by consumers and workers in the health system, and facing the crucial issue, eliminating of fee rewards and profit-making in the health system. We firmly believe that the problems presented by persons testifying today, dramatically revealing the hardships the present health care system is capable of imposing, can only be met by the establishment in this country of a national health service.

Family Nursing
Virginia T. Williams RN
1004 N. Front Street McHenry, Illinois 60050 815 344-0499

TESTIMONY FOR SENATOR EDWARD M. KENNEDY HEARING ON
NATIONAL HEALTH INSURANCE, CHICAGO, NOV. 28, 1978

My name is Virginia T. Williams. I am a registered nurse, holding an M. S. degree in Community Health Nursing. I function in solo, independent practice as a generalist, serving families in the "well" community. I live and practice nursing in McHenry, Illinois -- a city of about ten thousand people. I have lived and worked there steadily over the last fifteen years, after a period of nursing work and study in other areas for some fifteen years before that. Since I was born and grew up in McHenry, however, I have always called it home.

My general awareness of nursing needs there dates back to 1943, the year I entered nursing school. My independent practice of the last six years, however, enables me to speak very specifically to the needs of more than six hundred client families and their logistic and economic problems with health care.

Families' needs for nursing care vary. Some have had a family member hospitalized, or receiving medical or surgical care, or undergoing rehabilitative or other therapeutic care programs. Most have benefitted as much as possible from medical care; from diagnostic, therapeutic, surgical, or radiologic measures. Most still continue to need nursing care, support, and direction to retain independence.

Some clients choose not to be confined to a hospital at all; others have

more than used up their hospital bed-use privileges; still others choose, in terminal illness, to live out their remaining days at home. Their need for nursing care does not differ from that in institutions. They require comfort, safety, nutrition, help with medications, shots, and treatments.

Unfortunately, those people who have returned home, as well as those who did not submit to being institutionalized, have extremely limited access to nursing care. Insurance policies seldom cover such care to the extent needed. A variety of limiting clauses are attached to each statement providing nursing coverage. Examples include: "--- provided with twenty-four hours (or three days, or two weeks) of hospital discharge", "--- on written order of a physician", "--- that nursing care be of at least three hours duration (or eight hours duration)", "--- services of a private duty nurse."

Medicare insurance includes provision for nursing care, but few of the elderly who are hospitalized receive continuation of nursing care after discharge. This requirement also imposes a burden on the physician. In prescribing nursing care, he is precribing for services he has not studied or performed.

It is clear that the limited expenditure of medicare funds for home nursing care, in proportion to massive expenditures on institutional care, demonstrates a serious inequity.

Those elderly and ill who were not hospitalized for care have even less recourse to nursing care at home. The few occasions when nursing is requested demand prescription by physicians who order nursing care in a setting where they have probably never visited their patients, and are unaware of their needs, their resources, or their alternatives.

My reason for speaking to this issue is to recommend that nurses who provide

nursing care be reimbursed for that phase of health care, independently of an attachment to medical care. Nurses function as primary health care providers. They participate in the earliest and most basic measures of preventing illness by identifying deviations from healthiness, often before medical care is even sought. They help in maintenance of acquired states of wellness long after medical treatments are stabilized, and in spite of continuing chronic illness. Nurses promote rehabilitaion to individual potential. None of these activities are oriented to or performed by physicians.

Nurses are prepared to provide health care independently. Health maintenance, i.e., the prevention of illness, occurs with understanding normalcy of of one's own body. This is what nursing is about. Medical care is an altogether different learned field; it need not be, it must not be involved in other professional work.

Nurse generalists in the community work with families who constantly search for direction in caring for aging parents, for family members who are retarded or handicapped, and for those with terminal illnesss. They support the elderly through declining years to maintain wellness and potentiate remaining skills and strength.

Mr. Kennedy, include nurses as independent health care providers in your health care bills, so that people may be allowed to continue <u>living</u> at home rather than <u>waiting to die</u> in institutions. Provide for nursing care and reimbursement separate from medical orders, as nursing was neither studied in medical schools nor is it delivered in medical practice.

Thank you for consideration in this delicate issue.

Signed: Virginia T. Williams, R.N.

Virginia T. Williams, R.N., M.S.

Senator KENNEDY. The subcommittee stands in recess.

[Whereupon, at 12:05 p.m., the subcommittee adjourned subject to the call of the Chair.]

# NATIONAL HEALTH INSURANCE, 1978

WEDNESDAY, NOVEMBER 29, 1978

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE COMMITTEE ON HUMAN RESOURCES,
*Denver, Colo.*

The subcommittee met, pursuant to notice, at 9:40 a.m., at the St. Thomas Episcopal Church Parish Hall, 2201 Dexter St., Denver, Colo., Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senator Kennedy.

## OPENING STATEMENT BY SENATOR KENNEDY

Senator KENNEDY. I would like to recognize Senator Dominick, who is kind enough to join us.

[Applause.]

Senator KENNEDY. A particular word of welcome because Senator Dominick was a member of the Human Resources Committee and a member of the Health Subcommittee. I can remember when we were out here—how many years ago was it, Peter—5 or 6 years ago when our Health Subcommittee came to Denver.

We visited Mercy Hospital and a number of the other centers, very fine centers, within this community. We enjoyed that particular session.

Of course, we are delighted to see him here and wish him well and look forward to his presence.

Also, before I make a comment, just a brief opening comment, I want to express our very warm sense of appreciation to our Canadian friends who have joined with us here today, and we look forward to their testimony. They have fought blizzards and snowstorms and all kinds of things, which our friends in Colorado are familiar with, in joining with us. They arrived here in Denver about 4:30 this morning. They made a very considerable effort to come to join with us, and we look forward to their testimony. I think we ought to give them a round of applause.

[Applause.]

Senator KENNEDY. We are grateful to them. I think all Americans are very proud of our historical relationship with Canada and the Canadian people.

Often, we think of Massachusetts as having a large Irish or Italian or Greek population, or Polish, French, but the largest numbers of people have come from Canada. I think all of us in this country are proud of our association and relationship.

We have shared values, shared interests, and shared concerns, so we look forward to their testimony. I will say more about them in the introduction. We are enormously grateful to them for being with us, as we are our senior Senator from Colorado, who I will say a brief word of introduction about in just a moment.

I want to thank Father Marion Hammond for making this magnificent place of worship available to us this morning. We understand they have just gone through an extensive renovation. I think all of us see it has been highly successful. It is a very glorious and magnificent setting for our meeting this morning.

They have some wonderful sidewalks for the handicapped members of the parish, which should not go unnoticed, as a recognition by the members of this community and Dr. Hammond as well. We are very honored to meet at this setting.

I am delighted to have this opportunity to bring the Senate Health and Scientific Research Subcommittee to Denver as part of a series of field hearings, being held all over this Nation, on national health insurance.

Contrary to conventional political wisdom, there is a growing grassroots coalition for a national health plan. Here in Colorado, as elsewhere across the country, this coalition consists of working men and women, senior citizens, farmers, nurses, religious groups of every denomination, minority groups, women's groups, the young physicians—the interns and residents.

And I believe the coalition will continue to grow in size as the middle class begins to feel the pinch of rising premiums, increasing deductibles and coinsurance, and diminishing benefits.

There are many in Congress who believe that national health insurance is an idea whose time has come and gone in the United States. I wish they could all be present in this hearing room today. They would draw very different conclusions. For if health insurance is an idea whose time has gone, then the American economy will bankrupt this Nation.

If health insurance is an idea whose time has gone, then millions and millions of Americans will continue to share the plight—the needless suffering and anguish—of those Colorado families who will testify here today. If national health insurance is an idea whose time has gone, then 26 million Americans will continue to have no coverage at all, another 18 million will live with totally inadequate coverage, and 52 million will have inadequate access to health care.

Today, in Denver, in this hearing and in subsequent events, we will pay special attention to the health care needs of children. Every parent knows the fear that their child may become seriously ill. That fear is shared by parents around the world, no matter what the nature of the health care system. But in the United States, that fear is compounded by the fear of financial ruin.

We penalize people for being sick in this country. When a child is sick, we penalize the parents financially. Science has enabled children to live today who would have died a decade ago. But society has forced young parents, just starting out in adult life, to mortgage their future in order to pay for their child's care. No other industrialized nation in the world, except South Africa, does that to its young people. They all have universal, comprehensive national health insurance. And

there isn't a single political leader in any of these countries who wants to turn the clock back and substitute our system for theirs.

The problem is not confined to children. And children would be ill served by a solution confined to them. Medicare has shown us that piecemeal approaches just won't work. The elderly pay more for their care today, out of their own pockets, than before medicare was passed, and although medicare has provided needed services, it has been a contributor to health care inflation.

The lesson is clear—you can't control costs through a piecemeal approach. Moreover, you can't make needed system reforms with a piecemeal approach. We don't want one system for children, one for seniors, one for women—with all the waste, duplication and inefficiency that creates. We want one cohesive system, responsive to the particular needs of individual groups, with strong cost controls at all levels.

Critics say we simply can't afford national health insurance now. The truth is, we can't afford not to have it; for if we do nothing at all, and leave the current system alone, this Nation will spend $252 billion on health care in 1981. I will just mention for the audience today that if you look at this chart, it represents a chart that was developed by the Congressional Budget Office—that is a nonpartisan group, Democrats and Republicans of all different political persuasions, with a highly competent staff.

This chart was developed some 2½ years ago by the Congressional Budget Office that compares the alternative programs that have been introduced into the Congress and the Senate of the United States.

I draw particular attention to the lines of the chart on the left, which is current policy. That is, if we do nothing at all, we are going to spend $253 billion by 1981—if we do nothing at all.

The other is the targeted approach, which is catastrophic health insurance, which shows that if we implemented catastrophic health insurance programs, we actually would be spending more without prospective budgeting or effective kinds of cost containment than if we do nothing at all.

Then the premium financed approach, which is a mandated employer-employee approach, and the one over at the far end, on your right, which is actually the tax finance S–3, which is a heavy budget item in terms of expenditures, much smaller non-Federal cost, but has effective cost controls, the point being that if we do nothing at all with the system, we are effectively seeing the explosions of health care costs, and we are going to be in an extraordinarily difficult situation.

I just mention at this point here, since we will listen later to our friends from Canada, what has happened in Canada with effective kinds of cost containment.

In 1968, the United States was spending 6.5 percent of their health dollar in GNP; Canada, 6.8 percent. They implemented national health insurance in Canada in 1968. In 1978, they are spending 7.1 percent. They have gone from 6.8 percent to 7.1 percent. We have gone from 6.5 percent to 8.8 percent. That is effective cost containment they have in Canada.

What we are going to be interested in from our friends in Canada is whether they are satisfied as consumers with their program.

The last national poll that was taken in Canada showed 84 percent approval rating of that program. We will be listening to them with comparable health needs with some of the members of this community, the Greater Denver community, trying to match them up, family with family, Canadian families that have similar kinds of health problems as the Greater Denver families.

We have done the same in Chicago, the same in Detroit, and the same in Washington, with wide differences, different illnesses and ailments, and I think the story will be an impressive one.

I think with those comments, we will look forward to hearing from the Senior Senator from Colorado, and a good friend, Gary Hart. He has introduced health insurance legislation over a period of 5 years. We know he is very interested in the issue and we look forward to his comments.

Of course, we look forward to working with him closely in the Senate over the years on this issue.

Gary, we are delighted to have you with us. We know you have a very full program. We welcome your participation in our hearing. We look forward to your testimony.

## STATEMENT OF HON. GARY HART, A U.S. SENATOR FROM THE STATE OF COLORADO

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

I want to do two things here today. First of all, add my welcome to you and the committee from the State of Colorado. We think these hearings obviously have stimulated a great deal of public interest from all points of view; and I think they cannot do anything but help raise the level of concern and education about this issue.

I want also to take this opportunity to very briefly describe a proposal which I have been promoting for the last 3 or 4 years.

As you know, Mr. Chairman, despite an expenditure of more than $160 billion each year, which is about 9 or 10 percent of the gross national product, this country's third largest industry still features sharply escalating medical care prices, inadequate coverage of expenses for too many of our citizens, inadequate protection against catastrophic costs, uneven distribution of resources and services, and an absence of incentives to improve the efficiency and effectiveness of health care delivery.

In a country with one of the highest standards of living in the world, it is still all too possible to go without needed care or to become financially destitue as a result of illness. I think we all agree, including leaders of the medical profession—some of the most progressive of whom reside and practice in this State and region—that something has to be done. The question is: What should it be?

I, along with almost all of our colleagues in the Senate, respect the tremendous leadership that you have provided on this issue over the years. It is a difficult issue. There are no easy solutions. I think you, more than anyone else, have brought that fact to the attention of the American people.

Other witnesses, as you have indicated, Mr. Chairman, will discuss the health care problems facing us today.

I want instead to briefly outline a proposal for resolving what I consider to be our most urgent health care problems and then turn the witness stand over to the knowledgeable witnesses from this community and Canada.

Mr. Chairman, I introduced the legislation that I will briefly describe, two Congresses ago. I hope during the next session it will be accorded the hearings and serious concern that I believe it deserves.

A good mutual friend of ours, Paul Simon of Illinois, will reintroduce a companion bill in the House of Representatives. The simple key features of this proposal, Mr. Chairman, are, first of all, it provides a wide range of health care services to preschool children and expectant mothers.

In addition, it provides comprehensive coverage for all Americans against the costs of catastrophic illness;

Second, it emphasizes preventive health care, and contains provisions to help hold down overall health care costs;

Third, it relies on private health insurers and existing medical institutions, and it minimizes the role of the Federal Government;

Fourth, it is competely voluntary, and it has a sunset provision requiring review of the program and reauthorization after 5 years; and

Finally, it is affordable in these belt-tightening times, and it should be relatively easy to administer.

The proposal's centerpiece is the initiation of comprehensive medical care for children aged 5 and under, and pregnant women. Like your proposal, it would provide complete care, irrespective of ability to pay, for every one of these persons who need it.

The selection of children and pregnant women is a logical one. They are the future citizens and our most treasured national resurce. They also represent our future health care costs, so that providing care as early as possible is a sound investment.

Children and pregnant women also offer the ideal group for which to implement preventive practices and policies, a central component of a truly effective and cost-effective national health care program.

Furthermore, children are a fairly stable population for whom care can be provided routinely by primary care physicians or nurses and other health care professionals. Therefore, focusing a national health care plan on them would reduce the potential for providing unneeded services and runaway costs.

It is important to note that in 1976, the per capita expenditure for children under 19 years was $249, compared to $547 for those aged 19 to 64, and $1,521 for those 65 and older. Children constitute one-third of our population; yet, use only one-seventh of our health resources.

Similarly, good health care for pregnant women is readily producible, fairly predictable and, though not minimal in cost, has been demonstrated time and again to be tremendously valuable in improving the health of newborn infants and reducing future illness.

Despite existing Federal programs, children—especially poor children—recieve fewer health care benefits than any other group. Less than 50 percent of eligible children receive standard immunizations against costly and potentially fatal diseases.

Last year, only 21 percent—15 percent under the age of 6—of children eligible for HEW's early and periodic screening, diagnostic and treatment program, actually received benefits. One in five infants born prematurely will die within the first year of life and the others will be prone to serious and often irreparable illnesses. Yet, it is medically possible to reduce much of the problem simply through routine care prior to and during pregnancy.

Under the legislation that I propose, participation by both recipients and providers would be voluntary. Physicians would have a choice of participating in the program exclusively, simultaneously with the standard fee-for-service system, or not at all. Patients could choose any participating doctor they wish.

Payment by the Federal Government to providers of services would be a fixed amount per enrolled individual. Patients would sign up with participating providers who would receive payment in advance. This "capitation" form of payment provides incentives to physicians to deliver necessary care in the most efficient manner, and it eliminates any incentive to provide unnecessary goods or services.

The program would be administered by a national board established within the Department of Health, Education, and Welfare, assisted by a National Advisory Council and local boards. The board would set capitation rates, administer the program, and review and improve it as needed. The board would also involve public officials and doctors in the task of holding down the skyrocketing costs of medical care that you have so adequately demonstrated.

Finally, Mr. Chairman, this plan has a sunset provision, so that after 5 years, its continuation or expansion will require reauthorization by the Congress. I fully expect the plan to provide a working example of an effective health care delivery system.

The program I advocate today would cause a modest increase in Federal spending. To finance it, personal income taxes would be raised.

What will people get in return?

In many average families there will be one child under six. Under this plan, that family will save an average of $335 per year in medical costs for that young child. In addition, when the wife becomes pregnant, the family will save $1,700 in pre- and post-natal care. Clearly, this average family gains more in health benefits than it pays in taxes.

Every family of any income will have free insurance against catastrophic illness, protecting it from financial devastation by catastrophic illness or injury.

This payment plan is fair because every taxpayer will contribute to an improved national health system—according to ability to pay. Also, larger families, which will benefit more, will contribute a slightly larger amount if they have more children under 6 years of age.

This proposal is not cast in stone. I welcome constructive comments from experts in the area as well as interested citizens. While it does not—ideed no plan cannot—solve at once all the ills of the present system, it does represent a reasonable program that is fiscally responsible and not difficult to administer.

Once again, Mr. Chairman, I want to thank you for offering me this opportunity to outline this proposal. I know we will have a chance next year to go into it in greater depth.

I would ask your permission to insert a much lengthier and comprehensive statement regarding this proposal in the record.

Once again, I thank you for coming here. I think your presence and the presence of this subcommittee here will do nothing but good in terms of helping our citizens understand the complexity of this issue.

[The prepared statement of Senator Hart follows:]

Testimony by Senator Gary Hart
Before the Subcommittee on Health and Biomedical Research
Human Resources Committee
National Health Insurance Hearing
Denver, Colorado
November 29, 1978

I appreciate this opportunity to express my concern about the critical condition of our nation's health care system. Despite the expenditure of more than $160 billion each year -- nine percent of the Gross National Product -- this country's third largest industry features sharply escalating medical care prices, incomplete coverage of expenses, inadequate protection against catastrophic costs, uneven distribution of resources and services, and an absence of incentives to improve the efficiency and effectiveness of health care delivery.

In a country with one of the highest standards of living in the world, it is still all too possible to go without needed care or to become financially destitute as a result of illness. The time to improve the present system is long overdue. I look forward to joining you and others in the debate and passage of needed legislation at the earliest possible date.

I greatly respect the leadership you have provided for this issue. Hearings, such as this one, which you are holding across the country have served graphically to depict the plight of so many citizens as no set of statistics could ever do. I join the people of the State of Colorado in welcoming you here today and thank you for giving us the opportunity to participate in the national debate on this issue.

Other witnesses will discuss the health care problems facing us today. I want instead to outline a proposal for resolving our most urgent health care problems. This will be one of several to be presented to the Congress for debate next session. I introduced this legislation in the past two Congresses and I hope that during the next session it will at last be accorded the hearings and serious consideration that it deserves. Congressman Paul Simon of Illinois will again introduce the companion bill in the House of Representatives next session.

Before discussing my proposal in detail, let me first describe its key features.

1. It provides a wide range of health care services to preschool children and pregnant women. In addition, it provides comprehensive coverage for all Americans against the costs of catastrophic illness.

2. It emphasizes preventive health care, and contains provisions to help hold down overall health care costs.

3. It relies on private health insurers and existing medical institutions, and it minimizes the role of the Federal government.

4. It is completely voluntary, and it has a sunset provision requiring review of the program and reauthorization after five years.

5. Finally, it is affordable in these belt-tightening times, and it should be relatively easy to administer.

The proposal's centerpiece is the initiation of comprehensive medical and dental care for children aged 5 and under, and pregnant women. Like your proposal, it would provide complete care, irrespective of ability to pay, for every one of these persons who need it.

The selection of children and pregnant women is a logical one. They are the future citizens and our most treasured national resource. They also represent our future health care costs, so that providing care as early as possible is a sound investment.

Children and pregnant women also offer the ideal group on which to implement preventive practices and policies, a central component of a truly effective and cost-efficient national health care program.

Furthermore, children are a fairly stable population for whom care can be provided routinely by primary care physicians or nurses and other physician extenders. Therefore, focusing a national health care plan on them would reduce the potential for providing unneeded services and runaway costs.

It is important to note that in 1976 the per capita expenditure for children under 19 years was $249, compared to $547 for those aged 19 to 64, and $1,521 for those 65 and older. Children constitute one-third of our population, yet use only one-seventh of our health resources.

Similarly, good health care for pregnant women is readily produceable, fairly predictable and, though not minimal in cost, has been demonstrated time and again to be tremendously valuable in improving the health of newborn infants and reducing future illness.

Despite existing Federal programs, children -- especially the poor -- receive fewer health care benefits than any other group. Less than 50 percent of eligible children receive standard immunizations against costly and potentially fatal diseases. Last year, only 21 percent (15 percent under age 6) of children eligible for HEW's early and periodic screening, diagnostic and treatment program actually received benefits. One in five infants born premature will die within the first year of life and the others will be prone to serious and often irreparable illnesses. Yet, it is medically possible to reduce much of the problem simply through routine care prior to and during pregnancy.

Under this legislation, participation by both recipients and providers would be voluntary. Physicians would have a choice of participating in the program exclusively, simultaneously with the standard fee-for-service system, or not at all. Patients could choose any doctor they wish.

Payment by the Federal government to providers of services would be a fixed amount per enrolled individual. Patients would sign up with participating providers who would receive payment in advance. This "capitation" form of payment provides incentives to physicians to deliver necessary care in the most efficient manner, and it eliminates any incentive to provide unnecessary goods or services.

The program would be administered by a national board established within the Department of Health, Education and Welfare, assisted by a National Advisory Council and local boards. The Board would set capitation rates, administer the program, and review and improve it as needed. The Board would also involve public officials and doctors in the task of holding down the skyrocketing costs of medical care.

Finally, my plan has a sunset provision, so that after five years its continuation or expansion will require reauthorization by the Congress. I fully expect the plan to provide a working example of an effective health care delivery system on which we might base implementation of a comprehensive program for the entire country.

The program I advocate today would cause a modest increase in Federal spending. To finance it, personal income taxes would be raised.

What will people get in return?

In many average families there will be one child under six. Under this plan, that family will save an average of $335 per year in medical costs for that young child. In addition, when the wife becomes pregnant, the family will

save $1,700 in pre- and post-natal care. Clearly, this average family gains more in health benefits than it pays in taxes.

Every family of any income will have free insurance against catastrophic illness, protecting it from financial devastation by catastrophic illness or injury.

This payment plan is fair because every taxpayer will contribute to an improved national health system -- according to ability to pay. Also, larger families, which will benefit more, will contribute a slightly larger amount if they have more children under six years of age.

This proposal is not cast in stone. I welcome constructive comments from experts in the area as well as interested citizens. While it does not -- indeed no plan cannot -- solve at once all the ills of the present system, it does represent a reasonable, fiscally responsible and administratable plan with which to begin.

It is time to resolve our differences and serve the public's best interest by improving our national health system. We at once have a duty to ensure their health at a time of crisis in their health care system as well as restore the health of their political order at a time of general disappointment in government. I believe the plan I have outlined here today is a sure step toward doing both. Thank you.

Senator KENNEDY. I want to thank you, Senator Hart, for your statement. We will look forward to a more comprehensive elaboration of these points that you have made and look forward to working with you.

We of course welcome the stress and empasis on the children and the issue of child health, the stress that you put on preventive health care and expectant mothers, the focus that you placed on it.

Some of the concerns that I would have with the program would be just related as one program toward children up to 5, unless it was part of a gradual phasing in of a program, for example, of a comprehensive program, that you would have; situations where children up to 5 are looked after, but when they become 6, what happens to them?

You can see a situation in a family where there are two or three children, one or two that are 3 and 4, others that are 8 and 9 and getting a whole comprehensive range of services, for the small ones, and yet once they become 5, they are excluded from the system. I would have concerns unless it is sort of a gradual, phase-in program, where it is up to 5, and as a part of a comprehensive program, when they become 5, then it is phased in over a period of time through our total population.

Clearly, we have to deal with the issues of the economy, the economics. We have to also, try to make sure that, as we start down the road in any new program, that we do not repeat the mistakes of the past. I think that is a very, very important element in any kind of system where we have added additional resources. This is what has happened in medicare, for example, where the elderly today are paying a good deal more out of their budget than they were paying prior to medicare.

With all of the opting out of various physicians, we are down to about 50 percent of physicians willing to take medicare. I do not know what the statistics are here in this State. In my own State of Massachusetts, which had 71 percent of the doctors taking medicare and medicaid, it is down to 50 percent.

In 1 year, it dropped; they tell me in Florida to about 30 percent. It is moving down dramatically. These are aspects that I am concerned about.

The other point, in terms of catastrophic health, is how we measure catastrophic health. For an elderly person who is trying to get drugs, not being able to get $1, or $2, or $3 for their drugs, it is a catastrophy.

The average senior citizen pays $125 over 65 on drugs. Many of them spend a good deal more on it. The fact of those $5 or $6 a month is a real catastroph for them. A few hundred dollars for a young married couple, whether in Colorado or Massachusetts, is a catastrophe for them, let alone the general catastrophic figures of $10,000 or $15,000, which is obviously a burden.

We are going to hear—of about how Canada, for example controls costs and deals with the problems that you have mentioned here. They provide of preventive health care for children, comprehensive care for children, catastrophic programs for others, and still do it at a controllable cost; so we look forward to working with you.

As you pointed out, it is a complex problem. Part of our effort is to try to hear from those who have been thinking a good deal about it and working on it. We know you have.

Senator HART. I thank the Senator for his remarks. I think we all are headed in the same direction. We all want the most equitable, fair, just health care system we can have in this country.

I think differences are how we get there.

Senator KENNEDY Good.

Thank you very much.

Senator HART. Thank you very much.

Senator DOMINICK. Has your bill been introduced?

Senator KENNEDY. The question was whether the bill itself has been introduced? The answer is no. The specifics have not, Peter, It will be in the early part of next year, the revised bill on health insurance.

Senator DOMINICK. It will have to go to the Finance Committee, will it not?

Senator KENNEDY. All health insurance proposals are jointly referred to our committee and Finance; S. 3 and Senator Hart's bill, which he commented on here today, have been jointly referred. Both committees have the proposals. The financing aspects are in Finance and the delivery aspects are part of our Human Resources Committee. They would be jointly referred. In the House, they go just to the Commerce Committee.

Senator DOMINICK. Finance did have jurisdiction.

Senator KENNEDY. We now have a different parliamentarian, Peter. It is amazing what happens when the parliamentarian changes.

We had in our cost containment bill this year both committees having jurisdiction, our Health Committee as well as the Finance Committee.

Senator DOMINICK. Would the chairman yield further?

I notice that the list of witnesses from Canada come mostly from Manitoba. I have been to New Brunswick and Quebec and Alberta to Sasketchewan and British Columbia; and my question then is, why are the witnesses only from Manitoba?

wofamhtcedil

Senator KENNEDY. The question from Senator Dominick is that he noticed most of our friends from Canada were from Manitoba; and the question was, why from Manitoba. We do have two from Winnepeg and one from Saskatchewan and three from Manitoba. The particular answer is, that is the closest area to Denver. We had yesterday all of our witnesses from Ontario Province. What we have tried to do in the different areas, we will pretty much have at least some from just about every Province.

Now, for the benefit of the group that has joined us here today, our audience, we have six pairs of families, primarily from the Greater Denver area, but also from Durango, Fort Collins, and from Lyons, Colo., and matching them with families in Canada. We cannot match completely the age, the income and the illnesses, but it comes pretty close to it and how the different systems either deal or do not deal with it. That is the purpose.

We will move through and ask each of the families to try to move through their particular experience and form some general and specific observations.

We will move to David Ogle first, from Boulder.

**STATEMENTS OF INA SANDERS, WINNIPEG, MANITOBA, CANADA; MR. AND MRS. DELBERT GILROY, PLENTY, SASKATCHEWAN, CANADA; AGNES CALLAGHER, WINNEPEG, MANITOBA, CANADA; MR. AND MRS. MALCOLM PASKOV, WINNEPEG, MANITOBA, CANADA; VICTORIA CHRISTIANSEN, SELKIRK, MANITOBA, CANADA; MR. AND MRS. RON COLOMEY, DUGLAD, MANITOBA, CANADA; DAVID OGLE, BOULDER, COLO.; RAYBURN MILLER, DURANGO, COLO.; MR. AND MRS. MICHAEL HARROUN, LYONS, COLO.; MR. AND MRS. KEVIN BOWERS, DENVER, COLO.; MR. AND MRS. RICHARD BELDT, DENVER, COLO.; AND MR. AND MRS. GREG GOODWIN, FORT COLLINS, COLO.**

Senator KENNEDY. Mr. Ogle, tell us about how old you are, a little bit about yourself. As I understand it, you have retired. Maybe you could respond to those questions.

Mr. OGLE. Mr. Chairman, I am 64 now. I originally retired at 62 and took my social security.

Do you want me to go ahead and explain my situation in Boulder?

Senator KENNEDY. Let me ask you some questions.

Where did you work?

Mr. OGLE. Before I retired, I was in the carpet business in Jackson, Miss.

Senator KENNEDY. When did you move to Boulder?

Mr. OGLE. It would be 2 years ago in April.

Senator KENNEDY. Did you find out at that time that your wife had breast cancer?

Mr. OGLE. It was a very tragic thing, Mr. Chairman; we had no indication of it whatever. We had saved our money, bought this home in Boulder, because my son lived here and my grandson, and moved in and fixed this house up the way we wanted it. We were in this house 1 month, and this cancer showed up.

Senator KENNEDY. Then what happened? Did she have a mastectomy?

Mr. OGLE. Yes; she did.

Senator KENNEDY. How long did she stay in the hospital?

Mr. OGLE. Totally for the mastectomy, about 15 days.

Now, I want to explain this.

By the time we had discovered it, this cancer had already moved into her lung cavity, so she was in rather serious shape.

Senator KENNEDY. And then what happened?

Mr. OGLE. Well, of course, we got her home and the chemotherapy started and they were using a new drug called Adromycin. It looked promising for awhile. It looked like we might get the thing arrested. Then the body became immune to this new drug, and then her downfall was rather rapid.

I would like to mention this.

Do you have any idea what Adromycin treatments cost?

Senator KENNEDY. You tell us.

Mr. OGLE. Every time she went to the doctor during this 14-month period when she was ill, the bills ranged from $175 to $200. She went about twice a month, so it was $400 that I had to dig out.

Senator KENNEDY. When did your wife die?

Mr. OGLE. She died 1 year ago in August.

Senator KENNEDY. What were the total medical expenses?

Mr. OGLE. In the neighborhood of $10,000 that I had to cough up.

Senator KENNEDY. The total expenses were around $15,000. You had some form of insurance?

Mr. OGLE. I did have for the hospital operation only, but of course it was not totally covered; but none of the chemotherapy or treatment—I had no way—I was 62 and my wife was 61—so medicare did not fit in.

Senator KENNEDY. How did you pay that off, the $10,000 bill?

Mr. OGLE. It was a tough cookie. I scraped around. Of course, we did not move out here without some savings. It was a marginal retirement.

Senator KENNEDY. Did you use all your savings?

Mr. OGLE. No; I did not. I cashed in an insurance policy; we had two automobiles, sold one of the cars, and finally just scraped up enough money to pay them. I did not pay them all at once. Finally, I got everybody paid.

Senator KENNEDY. Did you find that there was much emotional strain in meeting the financial burdens as well?

Mr. OGLE. Senator, you have no idea.

On a cancer patient, the doctors really do not know how long they are going to last. It is guesswork. It could have gone on and on and completely wiped me out. It does not take long when you return to a hospital to eat up your savings.

Fortunately for Mrs. Ogle, she lived 14 months; it was fortunate for me, too. So it did not wipe me out.

But the financial strain, not only on me but on her, we could both see that we had planned this for many, many years, this home, this retirement; and we both could just sense seeing it all wiped out as these doctor bills began to skyrocket.

I think it actually contributed to her downfall and it gave me a lot of hypertension. I am taking pills for it now.

Senator KENNEDY. Let me just make a brief comment.

More and more of our senior citizens, elderly people, are affected by it. I think what we want to try to understand is whether this is really such a dramatically unusual situation. The fact of the matter is, from a medical point it is not.

This kind of situation, which substantially draws down on a lifetime of savings and other kinds of financial strains, is something which is evidenced in a number of families here in this country.

I would next like to ask Mrs. Sanders, from Winnepeg, Manitoba, some questions.

I understand Mr. Sanders is 64 years old.

Mrs. SANDERS. That is correct.

Senator KENNEDY. He is nearly the same age as Mr. Ogle.

What happened to your husband a few years ago?

Mrs. SANDERS. They diagnosed his having arteriosclerosis, and in December, they did an arterial bypass in his left lung.

Senator KENNEDY. That as I understand is not an uncommon disease?

Mrs. SANDERS. No, it is not, nor is that an uncommon surgery. In 6 months, that collapsed. We were back where we started from. So the only thing that we could do is sympathectomy surgery, where they take a little piece out of the sympathetic nerve, let blood down so he would not lose his leg. This was a concern then. That was 6 months after the first surgery.

Senator KENNEDY. He had other surgery after the first?

Mrs. SANDERS. Yes.

In October of the same year, he had prostate surgery.

Senator KENNEDY. That also is reasonably common in elderly people.

Mrs. SANDERS. He was 57 at that time.

For the next year, he was not too bad. In 1973–74 was not too bad—there was other surgery in 1972; but in 1974, he started to black out in January, and he would just black out and fall down wherever he was, at the least exertion. Then he lost the use of his right arm completely, so by December, they did an angiogram, and then they did what they call subclavian bypass where they put an artery from one arm to the other to take blood; to keep the one arm alive, they had to take blood from one arm to the other. They did think of doing a bypass on the carotid artery in his neck, but his circulatory system was so bad that they did not think he would stand to have one artery blocked off while they repaired the other one.

Senator KENNEDY. Let me ask you, as I understand, since 1974, your husband has been in the hospital 62 weeks?

Mrs. SANDERS. Since January 1976.

Senator KENNEDY. Since 1976, he has been in the hospital 62 weeks for a series of different medical operations, medical procedures that are not really that unique for a senior citizen, maybe unique in terms of the whole cluster of these illnesses and sicknesses, an he has been home, as I understand, for 67 weeks, but required special nursing care when he was home.

Mrs. SANDERS. Yes; plus other things.

Senator KENNEDY. Plus drugs?

Can you tell me how you were able to afford this kind of medical expense? What kind of insurance do you have there?

Mrs. SANDERS. Manitoba Medical Care, which paid for everything except the nursing care in the home. The reason I had nursing care was because I was working and I had to continue to work because he had to retire early and we could not live on what he was getting. So I had to continue to work.

On account of his condition, we had to have someone in the home.

Senator KENNEDY. In terms of the hospital bills, surgical bills, the medical bills itself, what did it cost?

Mrs. SANDERS. It cost us nothing.

Senator KENNEDY. I understand at home you received a hospital bed; is that correct?

Mrs. SANDERS. That is correct.

Senator KENNEDY. An air mattress, wheelchair?

Mrs. SANDERS. Yes.

Senator KENNEDY. Visiting nurses every day?

Mrs. SANDERS. Yes.

Senator KENNEDY. Did that cost anything?

Mrs. SANDERS. That did not cost us a cent, plus the doctor comes, and he is a geriatric specialist. I figured out his hospital bill since 1976; they told me that they do it on a per-patient, averaging out in the part of the hospital he was in, and $109 a day, and it comes to around $334,000 since 1976. Then there is all the surgery, the tests, everything.

When he is in the hospital, everything is provided, his drugs. We have a pharmacare which pays for our drugs. We pay the first $50, and after that we receive back 80 percent. We pay 20 percent.

On top of all of this, and the reason I could have a nurse, we have GSMIP, another medical plan.

Senator KENNEDY. To sum up this situation, you had one retired family here that came to Boulder, Colo., with a certain amount of savings prior to the age of 64, with a modest insurance policy and, as I understand, it cost about $392 a year. You had a series of illnesses and sicknesses for your wife with cancer; it dug in substantially to your savings; and you sold your car and you cashed in your life insurance; you mentioned the emotional trauma on you and your wife when she was very ill.

On the other hand, in Winnepeg, we heard from Mrs. Sanders who's husband, of the same age, 64, had a series of medical illnesses, sicknesses, which again are related to elderly people, and a series of different periods of hospitalization, operations, very extensive home health care. We heard on the one hand, a very heavy financial strain on Mr. Ogle, and Mrs. Sanders being virtually free from the payment of hospitalization and from the medical bills.

Let me ask you something, Mrs. Sanders.

Were you satisfied with the medical attention you received? There is a great deal of concern about whether Canadians are really satisfied with this.

Mrs. SANDERS. You mean with our medical plan?

Senator KENNEDY. The hospital, the attention you received from your doctors and what you received from the hospitals.

Were you satisfied with that?

Mrs. SANDERS. Yes; extremely so, except all this time my husband did not have arteriosclerosis. They have just diagnosed—the good doctor we have now—Schydrecker [phonetics] syndrome. So I would have felt a lot worse had I had to pay for all that surgery, which I am sure some of it was not necessary.

Senator KENNEDY. They have a little excess surgery up there, too? [Laughter.]

I do not think anyone is questioning the fact that you are not going to have either diagnosis or probably unnecessary kinds of surgery in the United States or in Canada, even under any of these bills, or that there are not going to be mistakes that are going to be made. I do not think anyone questions that particular fact. That is going to be the case no matter what kind of system.

The question is, at least part of it is, whether we are going to be able on the one hand relieve the people from the extraordinary kind of emotional pressures and financial pressures and do it in a way where we have an effective kind of cost containment and a way in which the consumer is generally satisfied with the doctor-patient relationship and also the hospital-patient relationship; and we will hear others on that issue as well.

Now, Mr. Miller is from Durango, Colo.

Tell us a little bit about what happened to your first wife in 1975.

Mr. MILLER. She was in the hospital for an exploratory operation. When she reached her fifth hospital, they did the exploratory and I found out she had cancer and she lived 3 weeks afterward. She was irrational for quite some time due to cancer that these hospitals did not recognize. I did not find out about it.

At that time, I had major medical, which I depended on to pay some of expense, and I ended up spending about $12,000 of my own money.

Senator KENNEDY. You ended up paying, even with major medical, $12,000 of your own money?

Mr. MILLER. Yes. A good bit of this was for someone to care for her in the home until I got home from work. I stayed until they came in the morning and they stayed until I came back from work.

Senator KENNEDY. Did you eventually sell your business?

Mr. MILLER. Yes; I sold the business principally so I could stay with her rather than have people staying with her.

I would take her—well, the last hospital was in San Diego. My father was dying of cancer, and I figured I could get her medical attention there the same as I could from Durango, and they died 5 weeks apart.

Senator KENNEDY. Were you hospitalized during this period of time yourself?

Mr. MILLER. Yes; I went in for an ulcer, about 5 or 6 days; I don't remember exactly, but with a major medical, it did not pay any of that expense because you pay the first $1,000 whenever you go in.

Senator KENNEDY. You pay the first $1,000?

Mr. MILLER. Yes.

Senator KENNEDY. Now, did you convert your insurance to another type of program?

Mr. MILLER. I tried to. That is my biggest grievance, is insurance companies. I tried to convert this—I got hold of an agent and told him I wanted hospitalization. I knew I had paid out too much with major medical. I told him I did not want to cancel the major medical unless I was sure I could pick up a hospital plan. This was November 14, 1977. During this time, he quit the company and another one had taken over, and he finally told me that the underwriters had accepted me, except I would have a $11 a month premium more than I had already paid him for the first month. I paid him the $11. I had a history of ulcers. He said I was then insured.

I asked him to send me a monthly premium. He wanted a checkmatic, and I wanted a monthly premium. I waited for some time and I did not receive any premium. I sent him a quarterly premium and asked the company, not the agent, and asked the company if they would bill me quarterly which, in the meantime, I got sick and came here to Denver for open-heart surgery.

Senator KENNEDY. You had open-heart surgery?

Mr. MILLER. Yes.

Senator KENNEDY. You had expenses associated with that as well; do you remember that?

Mr. MILLER. Quite so.

Senator KENNEDY. How much was that?

Mr. MILLER. Well, the hospital bill was over $8,000 itself, without doctors. The doctor bill was in excess of $3,000. Of course, after you have open-heart surgery, you do not go back to work for a couple months. I go back to work after a couple months. My grievance is not with the doctor. The doctor has done a wonderful job on me, and I am grateful for it.

The hospital real estate is pretty high.

Senator KENNEDY. As I understand, you had major bills from the time your wife was suffering from cancer. She later died. Then you attempted to convert your program to another program and that was unsuccessful. You had open-heart surgery yourself and hospitalization, with an additional $6,000, as I understand, for yourself; is that correct?

Mr. MILLER. Yes.

Well, I had over $8,000. Of course, I paid up this $12,000 on my first wife.

Senator KENNEDY. $12,000 on your first wife and $8,000 on yourself?

Mr. MILLER. Plus the doctor bill, over $3,000.

Senator KENNEDY. $3,000 on the doctor bill.

You also had this maze of trying to get a transfer of your hospital insurance, or change it, or alter it for other kinds of coverage?

Mr. MILLER. That is true.

Senator KENNEDY. Whatever the merits of the particular situation are, we should not lose track of the fact that this is a patchwork quilt, different kinds of insurance, different kinds of insurance coverage, and whatever happened here, it appears you fell through the crack.

But at a time when you were under a lot of trauma for your wife and your own kinds of health needs, you were trying to make these do the right things in terms of coverage, and you end up with very substantial bills.

Mr. MILLER. I have sent the doctors' letters telling them I accepted the bill as my bill. The insurance companies told me they are not going to take care of it. I have sent a little money, not much, and told them to take it in good faith, that I would pay the bill. I have had my home appraised and they are going to loan me money, and these people will be paid.

I wrote the insurance commissioner for the State of Colorado 2 months ago, certified. I got a return card that he had received it. I have not heard anything from him.

Senator KENNEDY. You are trying to pay off that bill? It is going to take you a while to do it, do you not think?

Mr. MILLER. Just long enough to mortgage your home.

Senator KENNEDY. You are not asking for something for nothing. You have been a working person, you have run a business, and you are willing to pay either taxes and premiums which are necessary for coverage; and all you want to do is make sure you and your family were covered, as I understand it?

Mr. MILLER. This is true.

I made it clear that I did not want major medical unless I could secure a hospital plan.

Senator KENNEDY. Mrs. Christiansen, you, too, have known serious illness resulting in your family and you have had 10 children.

You might tell us what happened to your 14-year-old son.

Mrs. CHRISTIANSEN. Yes.

In 1968, we were told he had leukemia. He was hospitalized for 7 weeks for them to get his blood in order. Then in 2 months time, his blood would be down again and he would have to go in for another 6 weeks in childrens hospital in Winnipeg.

Beginning in June 1970 he got Hepatitis and he passed away.

Senator KENNEDY. This is your son?

Mrs. CHRISTIANSEN. That is my son. He was 12 years old. He passed away when he was 14.

In 1974, my husband had a serious heart attack. They gave him 3 months to a year to live. He rushed to Winnipeg Hospital. Selkirk is 30 miles away from Winnipeg. He was rushed to the Winnipeg General Hospital by ambulance. He was taken to intensive care. He stayed there for 2 weeks. They put him on the ward and I was there one night visiting him and he started to collapse.

I went and got the nurse. She took him in intensive care again. He was there for 2 weeks. They kept him in the hospital for 5 months at that time. Then he was brought home; he had oxygen, and he used a tank of oxygen in 3 days to maybe 5. When he used the oxygen, if he felt OK, then he would use it maybe once a week, but that was all paid for.

What I am telling you now is, it never cost me 1 cent for any of this I did not have to go into my purse for anything.

Every month or every 2 months he would land in the hospital and have all the tests. He would spend a week or 2 weeks in there. They went on from this—this was February 1974 when he had his heart attack; and this went on to August 1976 when he passed away.

Now, in June 1975, my daughter was in sports, and she came home one day and she said her knee was sore. I took her to the doctor. She had water on her knee, or something. The doctor phoned me the next morning. I had to have an X-ray taken of it.

He phoned me the next morning and said, "We will take her to Children's Hospital, the fourth floor," and I knew right away that is where my son was, the fourth floor. He took her in there. They told me that it was cancer of the bone and he would have to have her leg amputated.

So then I had my husband in the car with me; he had an oxygen tank in the car, and doctors told me do not tell your husband, it would be too much of a shock. When I got into the car, he said, "What is it now?" I said, "Just what we thought." He was upset, but in the long run, I was happy because the next time when I could not take him into Winnipeg with me, he believed me and came home when I said that Judith is OK. It was to my advantage that I did not listen to the doctors because I could have and he would not have believed me after that.

But after that, she had her leg amputated June 11, 1975.

In July, she had a lung operation. In August 1975 she had another lung operation—she had 11 lung operations to July 1977. But thank God now, since last July, it is over a year and a half and she is completely clear. Last week, she went right through the whole test and she is completely clear, and now I have got her a new car so she can drive to Red River College, which is 40 miles from Selkirk. Every day she

drives there and back home. She is taking a child life course and wants to work in childrens hospital. [Applause.]

Senator KENNEDY. That is enormously good news.

What has it meant to you—you have experienced a good deal of health crises in your family—to be relieved of this financial strain?

Mrs. CHRISTIANSEN. If I had to worry about this—and my husband lived for 2½ years, and he gave him 3 months to a year—if we had to worry about our finances, I have got a $60,000 home and two cars; I have got a TV, microwave; I have got everything—I cannot wish for a better life than I have now. She has had three prostheses so far. They are all paid for. She has got a wheelchair at home. She has crutches in case she takes off her leg. That is all free to us. It has not cost me 1 cent for any of this.

Senator KENNEDY. I think on this pair we see on the one hand, the wife of a working businessman running his own business, seriously ill, sick with cancer, died, medical bill of $6,000. He had open-heart surgery. He had a $6,000-bill himself for the hospital and $3,000 in doctors bills, somewhere around $15,000 or $16,000, even with an insurance program. And what it has meant to that family versus on the other hand the Canadian family, who had a son who had cancer, husband had similar heart illness and sickness, not very unlike Mr. Miller, and also had another child who was sick with cancer.

On the one hand, we have Mr. Miller, of Durango, who is going to be paying off that very sizable bill with a few dollars at a time. He is willing to bear that burden, not asking for something for nothing, recognizing his own responsibilities, willing to pay it. Plus there is the human tragedy and the loss of his wife, and the emotional strain of that, and mortgaged up to here in terms of his own future.

At least the relief that Mrs. Christiansen feels from the financial side has gone through a good deal herself and has had good news about her second child, but is at least relieved.

Let me ask you and see what surprise you have for us.

How do you react to your system just generally? What has it meant to you to be relieved of these financial problems?

Mrs. CHRISTIANSEN. It meant everything to me. Because if I did not have that with those things happening to me, I had enough worries, because I had my husband at home and I did not have to worry about finances.

Senator KENNEDY. How about the doctors?

Mrs. CHRISTIANSEN. They were all wonderful.

Senator KENNEDY. And the hospital?

Did you have a choice in doctors in the Canadian plan and a choice of hospitals, as I understand it? If you do not like it, you can get it changed: is that right?

Mrs. CHRISTIANSEN. In Selkirk, my husband was rushed to the hospital and I knew all the nurses in the hospital because my daughter is a nurse, so I phone in to tell them—I get my husband into the hospital by ambulance, and the doctor that is on duty will look after him. We have got 14 doctors in Selkirk.

Senator KENNEDY. You are well satisfied with the kind of attention you got from the doctors?

Mrs. CHRISTIANSEN. Oh, and how.

Senator KENNEDY. We will go to Mr. and Mrs. Goodwin, from Fort Collins, Colo.

Maybe you could tell us a little bit about yourself, tell us how old you are and what kind of rare disease you have. Maybe you could tell us about it.

Mrs. GOODWIN. I am 24 years old; I have been married since August. I am employed as a medical technologist at the hospital in Fort Collins.

My disease is fairly rare. It is not very well known. It is called Winbrolbin's disease [phonetic], very similar to hemophilia; treatment is somewhat similar, not quite so severe as hemophilia. I do not have joint problems that hemophiliacs have. I do have occasional hemorrhages, which are totally unexpected. I never know what is going to happen.

Three weeks ago, I had a hemorrhage in which I lost in sequence one-third of my blood volume. I am not insured because no insurance company will cover me.

Senator KENNEDY. Have you tried to get insurance?

Mrs. GOODWIN. When I lived in North Carolina 2 years ago, I called every insurance company in the phone book and got no further than merely telling them what the disease was. They automatically said for 1 year we cannot cover you whatsoever. That was the general opinion. After 1 year, we will cover you for anything that is not related to your blood problems.

Senator KENNEDY. Do you have continuing medical expenses?

Mrs. GOODWIN. They are very unpredictable.

When I was in college, and when I was dependent on my parents, it was no problem. I was covered by CHAMPUS benefits, since my father died a military-related death. I do not really remember what they were during that time, because it was not important to us. We paid, in essence, 20 percent of all medical expenses.

Now, in the past 5 years, I have had probably more medical problems than I had previously. It ranges around $1,000 a year, I guess, would be the average. All of this has to come out of my own pocket. One thing that is fortunate, as a medical technologist and working in a hospital, normally after I have worked a certain period, I can get hospital tests paid for by the hospital. I am not covered right now because I have to have worked 3 months' time. Of course, if I have a hemorrhage and I cannot work, then it extends my period of time before I am covered. For that reason, I worked last night and I have not had any sleep.

Senator KENNEDY. This situation is, that you were covered as a child and not covered as an adult when you are out on your own with the same disease, same symptoms, same types of needs in term of medical treatment. You cannot get any coverage now, and I undertand you are working and your husband is working.

Mrs. GOODWIN. He is a student working half time.

Senator KENNEDY. It does not make a great deal of sense. It appears we have a system or nonsystem that penalizes you for being ill or sick.

Mrs. GOODWIN. It certainly does.

We have decided that if my expenses ever get catastrophic, which is a very likely probability, if I am in a car wreck or if I have some

major injury, I will need massive transfusions. Transfusions at the hospital where I work cost approximately $70 per transfusion. I cannot get those on an outpatient basis. I have to be admitted to the hospital. There is also the hospital bill. This is all, as I said, not covered by insurance. We have decided that if it comes to a point where we must, we will transfer all of our joint property to his name, pay off what we can and file bankruptcy after we are divorced.

Senator KENNEDY. That is a fearful indictment of our system, but that is what we are talking about. It is the real world. The option of divorce, is one situation just to deal with health cost burdens of the family.

Mrs. Gallagher, how old are you?

Mrs. GALLAGHER. I am 31.

Senator KENNEDY. Can you tell us what happened to your husband?

Mr. GALLAGHER. He was diagnosed with a chronic form of lukemia in 1973, and with chronic lukemia it is not anything drastic. From November 1973, until February 1978, he was doing really well, just going for his regular blood tests, just regular blood test and see a doctor every 2 months. I think it was February 22 when he went for his blood test and his lukemia had completely become acute. He was a terminal patient.

The best form of treatment for him to have his life prolonged was to have bone marrow transplant. The only place available to have bone marrow transplant is in Seattle, Wash. So our medical program covers out of the Province 75 percent, but then we would have to pay 25 ourselves. They told us treatment could cost between $10,000 and $50,000. So this meant we were facing a debt of $10,000 when we left.

My husband lived 21 days in Seattle. He died there. The total cost came to $31.897. So later on this summer, the medicare of Manitoba sent me a bill for almost $8,000; $8,000 was too much for me to pay. I could not believe this. I simply did not have the money. So I applied for extended care benefit, and it was approved.

Senator KENNEDY. What is extended care?

Mrs. GALLAGHER. Extended care is because my husband had to go to Seattle for this treatment, because it is not available anywhere in Canada, it was not by choice; it was the doctor's decision for him to have this, and extended care meant they would cover this $8,000, provided that I could not pay for it, provided there were no sources of money.

Senator KENNEDY. Did you work?

Mrs. GALLAGHER. I did not work. I have an arthritic spine. I was not able to go back to work, cannot work. They compromised for that.

Senator KENNEDY. With this situation, you have two young women, one 24 years old, Mrs. Goodwin, and 31-year-old Mrs. Gallagher, and one we heard a very moving comment about being covered as a child, not covered as adult, denied an opportunity to obtain insurance. You do not have a day go by when you are not concerned, your husband is not concerned, about the situation with serious illness or sickness or accident or whatever. You are living with that; versus Mrs. Gallagher, whose husband had serious and rather rare health needs, bone marrow transplant, done in the United States, and under the existing program, the Province program in Manitoba, willing to pay three-fourths of

it. But because of the financial situation of Mrs. Gallagher, it was willing to pay the whole thing.

Mrs. GALLAGHER. The whole thing; that is right.

Senator KENNEDY. What has that meant to you?

Mrs. GALLAGHER. If I had to pay $10,000, if I had to pay the $31,000, it meant I would have to sell my house, get rid of things we have worked for very hard, get rid of that.

But because we are covered like this, and what my husband has left me, I have a reasonable income, and I am not faced with this financial burden for his medical bills. The $8,000 would have meant, if I had to pay that, I do not know what would have happened, probably sell my car or do something like this. There was just no way.

Senator KENNEDY. You were satisfied?

Mrs. GALLAGHER. Yes; I was satisfied on the whole. Sometimes I feel with medicare system that we have, it is excellent, I must say; sometimes I just feel that doctors tend to tell you what you should hear, what they want you to hear.

Senator KENNEDY. We have that every place.

Mrs. GALLAGHER. Otherwise, it is excellent.

Senator KENNEDY. Mr. and Mrs. Kevin Bowers, from Denver. These next three cases focus on children.

Mr. Bowers, would you tell us a little bit about how old you are and how old is Mrs. Bowers?

Mr. BOWERS. My name is Kevin Bowers. I am 21 years old. My wife is 23. We have been married 2 years.

On July 30, 1977, we had our baby boy, Jeremy. He was 2 months premature. He was transferred to Childrens Hospital here in Denver, intensive-care unit.

He had all the problems related with newborn babies premature, lung problems. He had a valve across the heart supposed to close when the baby is born and it did not. Eventually, in time, that did close. He got alone fine for the first 2 weeks. Then his heart would quit and we would have to go back to revive him.

In September, they found his windpipe had an opening the size of a pin head. At that time, they formed a tracheotomy. He was in the hospital until the end of October. The total bill at that time came to $30,000, and with the insurance coverage that I have—I do have major medical—but at that time it only paid $10,000 at that visit.

In January, he went in with pneumonia. At that time, he was there for a month. He came back home in March and went back in again. He was not gaining any weight. When he was born, he weighed 3 pounds and three-quarter ounces. Up to that time, he only weighed 6 pounds. He was not growing at all.

They took him to the hospital and did tests on him and came up with what they called Sweirersjames Symptoms [phonetic]. Nobody really knows what Sweirersjames Symptoms was. At that time, at Colorado General Hospital, a pulmonary specialist got involved and more or less told us they could help the baby. They took over the case.

He went in the hospital and came home toward the end of May, a 3-week visit. In July, he went back in and they did a test and came out with what they called congenital emphysema.

He had to go back in again and had the right upper lobe of his lung taken out. He was taking air in quickly and would not take it out fast

enough. They found that he had an extra bronchial tube right underneath the trachea, and they tied that off. He still was not gaining any weight. They increased his calorie intake. At that time, that did not seem to help. The total bills at this time are now around $68,000. They are still coming in. Major medical has paid $25,000. The rest of 20 percent that I have to pay. We brought him home with oxygen. The insurance will pay 80 percent of oxygen. With the company we are getting the oxygen from, I had to pay them first, and the insurance would send me money back at least 2 months later. There was a 2-months lag. He was going through at that time two bottles of oxygen a week. The bottles then were $16.50 apiece. I had to rent regulators. We had to buy all machinery at home, and he is on a mist machine, which I paid $460 for.

Two months later, they did pay. I had to buy a suction machine. I paid $250. Two months later, they paid 80 percent of that. I am not covered on any of the medicine. That all comes out of my own pocket.

Senator KENNEDY. Overall, what will you have paid?

Mr. BOWERS. So far right now myself, I have paid around $1,500. Before the baby came, my wife was working; we bought a new car, and I owned a new pickup, and I have since sold both of them. We did buy a house. Since then, my father-in-law has assumed the loan in order for me to keep the house. I tried working two jobs in order to catch up on some of these bills.

Senator KENNEDY. How much are you making now yourself?

Mr. BOWERS. Right now I make $15,000 a year.

Senator KENNEDY. What do you owe?

Mr. BOWERS. So far, around $14,000.

Senator KENNEDY. Twenty-one years old?

Mr. BOWERS. Twenty-one.

Senator KENNEDY. Just starting out in life, and do you think you will have medical bills going on in the future as well?

Mr. BOWERS. Yes, sir. He still has the trache. He is going back in every month for dilation of the windpipe. They really are not sure how long he is going to have to be going back in. Each time he goes in, he usually stays on an average of 2 weeks.

Senator KENNEDY. Mrs. Colomey, what happened to your daughter when she was 7?

Mrs. COLOMEY. Admitted to a hospital with bronchitis. In the night her lung collapsed. She was placed on a respirator. She was placed on a respirator for 5 months and a tracheotomy was performed when she was 2 months old. She was in constant care 24 hours a day for 5 months. In that time, she contracted severe blood infection; she had a weight loss and she had many types of antibiotics, specialists, different tests.

After 5 months, she got off the respirator and another 5 months in the hospital with more tests. She was still losing weight, and they diagnosed her as having cystic fibrosis. She had six blood transfusions.

When she was 10 months old, she came home with a tracheotomy. We had equipment at home for suctioning. You have to do a suction through tracheotomy and she was home for 2 months.

Two days before Christmas in 1976, she was admitted with meningitis. She spent another 2 months in the hospital. She had to have surgery after the meningitis, the fluid was building up on her brain. It took

2 months to clear up. In that time, we took the trache tube out. She came home. She was home for 1½ years. She has been in twice this year. She is on antibiotics all the time.

She faces being in the hospital two to three times a year for all the infections.

Senator KENNEDY. For the future, for the immediate future——

Mrs. COLOMEY. She will indefinitely be on the antibiotics and other drugs.

Senator KENNEDY. Again, what does this cost you?

Mrs. COLOMEY. Her cost for 1976 was $52,000.

Senator KENNEDY. How much did you have to pay?

Mrs. COLOMEY. Nothing, we never paid for anything. We had home care. When she was at home with the tracheotomy, the machines were supplied and everything was brought in, everything was covered. We did not pay for anything. Our drugs were paid for.

Senator KENNEDY. What do you think about the problems that Mr. Bowers is facing here?

Mr. COLOMEY. I am glad I am not him.

Senator KENNEDY. I think you can see in this situation two children of a young married family, a fellow who is working at two jobs. making $15,000, above average income, ready to work, and working hard, covered with insurance, very sizable debts, mortgages, sold his car, 21 years old, facing additional medical bills over the period of the future.

Mrs. Colomey, on the other hand, with one child, had a series of different illnesses and sicknesses, looking down the road as well to several hospital stays over the period of the next 2 to 3 years. She has been relieved of the financial responsibility in this area.

The interesting point that I just underlined at this point here is what I mentioned earlier in the day, is that Canada is providing these services at less of the national gross product than we are. Here you are hearing the tragic situation of Americans who even when covered, falling through the cracks of the system, and we have heard just about how they have all had some form of insurance and still their back is against the wall in trying to deal with their problems.

In Canada, they are effectively relieved of that financial burden. They are still doing it at present of gross national product less than the United States.

Even the critics—we had an interesting doctor who joined us yesterday in Chicago who was expressing views about the Canadian system, about not having enough CAT scanners, and the development and other types of situations, and they are under sponsorship—he was there under the sponsorship of the Illinois Medical Society—even he admitted they had effective cost controls and effective cost containment, and all the people were effectively covered.

I think we are hearing from our Canadian friends that they are well satisfied with the system.

Mr. Beldt, how old are you?

Mr. BELDT. I am 24. My wife is 19. We had a little girl born August 29, this year.

Senator KENNEDY. Do you work on a farm?

Mr. BELDT. That is correct. She was born 3½ months premature, weighed 1 pound 9 ounces at birth. She was born was a 70-percent to live and she had to have an operation to close an artery. She is up to

4½ pounds. She has finally got off the respirator. As of this morning, she is breathing 21 percent oxygen, which is room air. She has got a doctor's bill, just the hospital, here at Childrens Hospital in Denver, of $66,000, and the doctor bills for the staff and the newborn center is right at $3,200, and that does not count any anesthesiologist. We do not have any insurance.

We felt under normal situations we could probably pay for the child without any insurance. We were estimating somewhere around $2,000 for the hospital expenses.

Senator KENNEDY. The child has not been brought home?

Mr. BELDT. No.

Senator KENNEDY. As I understand, if your baby had been born 10 years ago, it would not have probably survived, but because of the progress in science, the baby is surviving today?

Mr. BELDT. I do not know what it is about our system where we have been able to make progress in science, but certainly not in humanity. We are able to save that child today in our technological know-how but we are taking a young married couple working in agriculture and seeing their—I do not know whatever savings you had—but you surely pretty much mortgaged your future in terms of financial responsibilities.

All that adds to a young family trying to get started and the pressures that it brings to your relationship as well.

Senator KENNEDY. Mrs. Paskov, what do you do?

Mrs. PASKOV. I am a dental hygienist.

Senator KENNEDY. You have a 9-year-old daughter?

Mrs. PASKOV. That is right.

Senator KENNEDY. As I understand, you discovered medical problems when she was 2 years old.

Can you describe those to us?

Mrs. PASKOV. She became ill when she was 16 months, and for 6 months, she went undiagnosed. When they finally diagnosed her with cystic fibrosis, there was severe damage done to her liver and her spleen. She was hospitalized and had 10 admissions.

Her prognosis was very grim at the time because 2 years later she developed portal hypertension. That meant she had to undergo surgery that was not done in Winnepeg, a child that young. They had suggested that we take her down to Philadelphia. But because of the severe hemorrhaging, she could not be moved. Therefore, it was our decision to get it done or else take our chances.

The shunt worked, but my daughter is on constant pancreatic medication. It is an enzyme. Without it, she cannot digest food. She takes up to 100 capsules a day. It is broken up into powder because she does not swallow. When she comes down to respond to infection, she is on antibiotics and her drug bills are horrendous. All of this is subsidized, completely by the Manitoba medicare. We do not have to pay deductible portion or the 20 percent. Any inhalation therapy or oxygen she should require is supplied to us free of charge. If I cannot get her to the hospital for treatment, physiotherapy treatments, because my car broke down, they will supply taxi fares. They will do anything to get treatment to the child.

What can I say? Without it, I guess my husband and I would have to take on another job, and I could not care for her, because we would be too busy, I guess, supporting her medical bills.

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Senator KENNEDY. I think you have made some comment on the difference it has made to you and your husband being relieved emotionally from that burden.

Has that meant a lot to you?

Mrs. PASKOV. Yes.

Senator KENNEDY. We are talking about dollars and cents charts, figures, lines, and directions, but we do not talk about what it means in terms of emotional relief to families tht are burdened, young families, in both Canada and the United States, what it means to them to be relieved of this burden.

I think you made some comments. I would like for you to elaborate.

Mrs. PASKOV. Emotionally, we can spend a lot more time with her. I might say since 1974, she has been well; she has not had any admissions, but she does have to take her drugs constantly and she is a very well-adjusted little girl, attending grade 4. One day of absence. It is all due to the excellent medical care she was given and, of course, she has got her mother and father at home when she comes home from school instead of working.

Senator KENNEDY. I tnink again we see with these young families—how old are you?

Mrs. PASKOW. I am 32.

Senator KENNEDY. We have heard from these young families, the difference in how the system, or nonsystem treats young children in Canada, vesus the United States. We are talking about our society and we are talking about the failure by society to meet these particular responsibilities.

We have not been ingenuous enough or either courageous enough or willing enough or compassionate enough, listening to the kind of scare tactics which have been very much a part of the whole debate and discussion on national health insurance; and we are seeing what the results of it are in human terms.

We will go to our final witnesses.

Mr. and Mrs. Michael Harroun, from Lyons, Colo.

Could you tell us, Mrs. Harroun, a little bit about how old you are and where you work?

Mrs. HARROUN. I am 28. My husband is 30. He works on a dairy farm. I work part time at elementary school.

Senator KENNEDY. I believe it was 2 years ago you had a tragic accident on the farm. I am wondering if you might be able to tell us a little bit about it. I know it is difficult. Perhaps you could tell us a little bit about it.

Mrs. HARROUN. It was last year, in January, 11 months ago. It is difficult for me to explain the accident.

Senator KENNEDY. There was a serious accident on the farm involving your child?

Mrs. HARROUN. He was 2 years old.

Senator KENNEDY. Agricultural accident.

What happened?

Mrs. HARROUN. He sustained massive brain damage. We were in the country so we drove him to the hospital ourselves. He was immediately put on a respirator and a neurosurgeon was called from Boulder and brain surgery was performed. But they gave him almost

no hope, gave us no hope in the beginning. He was in the hospital about 14 hours and he died.

Senator KENNEDY. Then what happened? Did you receive a bill afterward?

Mrs. HARROUN. Yes.

We had no medical insurance at all. Our bills totaled about $4,000 for this 14 hours, and almost $2,600 from the hospital alone, another $1,200 from the neurosurgeon. We were not thinking of course at the beginning of the bill; it did not occur to us to even make arrangements to have it paid.

When we got the first bill, we were very surprised at how much it was. We waited, and I guess after we got the second bill, we went into the hospital to make arrangements. They said they had to have at least $30 a month. Our income for 1977, just gross income, was a little over $6,000.

Senator KENNEDY. For both of you?

Mrs. HARROUN. Yes; I was not working because I was staying home with the children. We also have a 7-year-old.

Then a friend told us about Hill-Burton funds, which is supposedly there to help low-income families with large medical bills. We tried to apply, but the woman in the credit office told us that it was too late because we had already received a statement. We got in touch with Senator Haskell and told him our problem. He wrote to the hospital and arranged for us to fill out an application, which we did, but it was rejected. They said we should have looked at the signs posted in the admissions office that says there is such a fine.

Senator KENNEDY. Your child lived for 14 hours, and you received a bill for $4,000?

Mrs. HARROUN. Yes.

Senator KENNEDY. You lost the child and have this enormous bill. They are telling you you should read a sign during this period of time?

Mrs. HARROUN. Yes.

Senator KENNEDY. You are paying, as I understand it, $5 a month on the bill?

Mrs. HARROUN. We are paying $20 a month to each, the clinic and the neurosurgeon, and we asked the hospital if they would please wait until we had some of our other bills taken care of, because 2 weeks after the accident, our mobile home burned and was just about destroyed. We had fire insurance, but it cost a lot to start over. We had help from a friend and family, but still we had a lot of bills coming in all at once.

We asked if they could just please wait until we had things straightened out. They still wanted at least $15 a month for 2 months, and back to $30. So we just send them $5 a month and they accept it.

Senator KENNEDY. You are going to continue to do that until the bill is paid off?

Mrs. HARROUN. Yes.

Senator KENNEDY. Have you had surgery, Mrs. Harroun?

Mrs. HARROUN. Yes.

Senator KENNEDY. Could you tell us a little bit about it?

Mrs. HARROUN. Well, we wanted to have another child, and I was sterile, so we went to a medical center and had tuber plasting, which

is opening of the tubes; and we had no insurance for that, either, but we have most of that paid by contribution.

Senator KENNEDY. Now, as I understand it, after the earlier tragedy, you did have a form of insurance, but when you went to the hospital to have that surgery, it was not permitted or not included because it was considered elective surgery, so it was not covered by the group policy; it that correct?

Mrs. HARROUN. Yes.

Senator KENNEDY. What was that bill? How much was that?

Mrs. HARROUN. Around $900. Quite a bit less because we went to a medical center and had a discount.

Senator KENNEDY. Mr. Gilroy, you are, I understand a farmer?

Mr. GILROY. We farm on our own in Saskatchewan.

Senator KENNEDY. How long have you worked on the farm?

Mr. GILROY. Started farming on my own after my dad took sick when I was 17.

Senator KENNEDY. How many years was that?

Mr. GILROY. Quite a number, over 30.

Senator KENNEDY. You have a daughter 18 years old; is that correct?

Mr. GILROY. That is correct.

Senator KENNEDY. Could you tell us a little bit about that? I understand she is retarded?

Mr. GILROY. Yes; she is severely retarded. Lois and I started out and we were married and had two children, a girl and a boy, and they were perfectly normal, and they are married now. Then in 1960, Nancy was born, and basically the roof feel in. We kept Nancy at home for 14 years and finally it got—well, Lois' nerves and my nerves got so bad we could not handle it any longer. Actually, she took quite a bit of care. Nobody really realizes what you are getting into in a setup like that.

Finally, 4 years ago, 4 years ago this coming February, we finally could not handle it any longer, and we got her into a home in Saskatoon and in the daytime, 5 days a week, she goes to a school—they say "school," but actually it is just an activity for her, and basically her bills for 1977 were $15,708. The bills before that, I cannot really say what they were for sure; 1977 would naturally be more than the years before; because of inflation, prices are going up all the time; and in 1978, we have got those bills yet, but we checked with the home before we left, and her bill per day is $48.36. That is all paid for. We do not have to pay anything.

Senator KENNEDY. I think we see in the last two farm families, very young families, tragic accident on the farm, the loss of a young child and hit with a very substantial medical bills, and back to try surgery so they could have a family again and find out that because of the small print, so to speak, the elective surgery provisions, are denied that kind of reimbursement.

In the experiences that we have seen here with our American friends, all really neighbors in Denver, Colo., or other communities, working in rural areas, retirees, young people, young married families getting started, a businessman, and similar situations in Canada with entirely different financial result. emotional result, from the point of view of being relieved of the extraordinary burdens.

I will ask our American friends what kind of reaction they have to what they have heard this morning from our Canadian situations.

Would any of you like to make a comment? You have been hearing these witnesses all morning, as we have. I would be interested in your own reaction, or perhaps if you have a question to ask them as well.

Mr. OGLE. Senator, I think it is a fantastic thing that Canada has for all of these tragic cases. I think it is sort of a blight on the United States of America—not on you, sir—that a similar program has not been initiated in this great Nation, the greatest Nation in the world. It is almost incomprehensible that we do not have such a plan. [Applause.]

Senator KENNEDY. I do not know whether any of the younger families would like to ask a question or make any brief comment.

Mrs. GOODWIN. I do have a brief comment.

Four years ago, I spent some time in New Zealand. I did not have any problem while I was there, but a friend who was with me on a trip sprained her ankle, and we were very worried at this time, well, we are in a foreign country; what are we going to do? How are we going to find a doctor?

A friend was a nurse in New Zealand, and she told us, just go to the hospital.

We went to the hospital. They gave her crutches. They X-rayed her and examined her, and the bill was zero. I was very impressed. At this time, I was very much considering moving to New Zealand for that reason.

Senator KENNEDY. Do any of the others have a comment? You have listened to our friends across the water here, and I do not know whether you have any other reaction.

Mr. BELDT. I think this is a pretty good deal that our neighbors in Canada have. A lot of us are in a situation where we make too much money to get any assistance from Federal or State aid, and we are by far a long way from being able to pay our bills in full within our lifetime.

Senator KENNEDY. Let me ask our Canadian friends: What would you do if a politician ran in Manitoba or Winnepeg and Saskatchewan and wanted to take that health program away from you?

Mr. GILROY. He would not get any votes.

Mrs. CHRISTIANSEN. We would work against him.

Senator KENNEDY. You would work against him now?

Mrs. PASKOV. I believe in the previous government we had to pay about $17 a month for our Manitoba hospital care, which was really minimal to what you people are paying down here, but when the new government was elected, even this was abolished and that was their ticket.

Senator KENNEDY. It is not a bad ticket to run on.

We want to thank you.

We met yesterday with the American Medical Association, Blue Cross, Chicago, Illinois Medical Society, and we are hearing from some of the other groups, and we can hear from many of the groups in Washington; but I think today what we do hear is that in Canada they have a universal program and it is comprehensive. It covers just about every one of the types of illnesses and sicknesses in the hospital or at home. It is universal. It has effected cost containment as we see from

statistics which are shown here. They are doing it at a percent of gross national product less than we are doing here in the United States. It is effective.

I think we have heard from our witnesses general acceptance and approval of the program from a consumer's point of view. It is humane and compassionate.

On the other hand, we see the gaps and the burdens and the bureaucracy and the patchwork and the exclusions and the small print that exists for programs of insurance, if you have any. We also heard from two rural families that do not have any; and we see the extraordinarily—not only drain and emotional drain from illness and sickness with a family, people that they love, but also the extraordinary financial burdens that they are facing.

I think this points up to what the issue is and what we must try and do about it.

I want to thank our group here. [Applause.]

Senator KENNEDY. We have three more witnesses. We have 1 hour and 10 minutes remaining and we will try and move them through. If there are other people that would like to make a brief comment, put your name on a yellow pad over at that table and we will sign you up. We will divide the time that we have among as many as we can.

Let us all give our Canadian friends a nice, warm welcome.

[Brief recess.]

Senator KENNEDY. We will hear from John Stencel, president, Rocky Mountain Farmers Union.

John, we are glad to have you.

## STATEMENT OF JOHN STENCEL, PRESIDENT, ROCKY MOUNTAIN FARMERS UNION

Mr. STENCEL. Mr. Chairman, I would like to take this opportunity to thank you for allowing me to have this opportunity to give this short and concise statement.

I would like first to say to you that I also have one of my fellow State Presidents in the audience, Jim Stephens, of the Montana Farmers Union, as well as a lot of my members here in Colorado as well as Wyoming.

We not only have supported a comprehensive national health insurance plan, but we have supported it for a great number of years; as a matter of fact, since 1947.

Beside that, here in Colorado, we have put together a coalition of 17 groups, starting in 1971, to support the National Security Health Act.

Senator KENNEDY. John, we recognize that. You are president of the Farmers Union, which has been a long-time member of the Coalition for National Health Insurance. Your president has appeared many times before our committee and spoken very eloquently and persuasively about the program. It is a long tradition and we listened to two young couples that work in agriculture in this country and how important this kind of program is for those people that work in rural America. That is why we are particularly interested in having your comments and your views expressed here.

Mr. STENCEL. Adequate health care in rural America as well as rural Colorado and Wyoming is below the standard of even urban and suburban America. But I would just like to make a short statement.

Senator KENNEDY. Fine.

Mr. STENCEL. We in Farmers Union would like to take strong exception to another segmented program in the health care area. We need a universal and comprehensive plan, and we have been fighting for that plan for many years, as I stated earlier, since 1947. We intend to continue to step up that fight in our organization.

Catastrophic health insurance would be a catastrophe. It would be impossible to control costs. It would be a delusion.

The average farmer, the average American would be wiped out before he or she would be eligible for any benefits. Of course, we believe children should be given priority consideration, and provided with a full range of health care services.

The experiences of medicaid and medicare show clearly this can be done best through a complete and comprehensive program. It cannot be done by covering only some people and not others because the program would not have the leverage and the support to control costs. It would be impossible to create system improvements. It would be an administrative nightmare. Negotiated family health plans would have to be renegotiated because of the young children, and catastrophic insurance would be carved out of them. Families would be medically split up. The very young would receive services under one program, but not their 5- and 6-year old brothers and sisters.

We learned a long time ago that organized medicine responds to such situations by increasing services under the programs that pays the doctors the most, and decreases services of the program that pays the least. The result would be galloping inflation and costs in terms of fees.

We in Farmers Union strongly urge the members of the new 96th Congress to do the job that needs to be done. We need to enact a comprhensive and universal national health insurance program.

We appreciate the opportunity to make this statement.

[Applause.]

Senator KENNEDY. Very fine, John, A good statement, And we thank you for making it.

Next, we will hear from Alex McCahon, president of the American Hospital Association.

We are delighted to have you here this morning. You have appeared on a number of occasions before our committee and we look forward to your testimony.

## STATEMENT OF J. ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. McMAHON. Thank you, Senator Kennedy.

It is a pleasure to be here in Denver to have the opportunity to appear before you on behalf of your committee, and point out some of the positions that the American Hospital Association, representing some 6,400 health care institutions and about 27,000 personal members, takes on national health insurance.

We have a full statement, Mr. Chairman; we would like to have that in the record.

Senator KENNEDY. It will be included in its entirety.

Mr. MCMAHON. I will summarize, with your permission, the shorter statement that you have before you.

We pledge to continue the discussion, Senator Kennedy, because discussions are going to continue. We have, as has been pointed out this morning, a substantial number of problems.

We also as you well know have a substantial number of advantages in the health system of the United States.

What we have to do is to alleviate the problems, not impair the system we have. We pledge to continue to provide you data and information based on our experience. These hearings are very useful. I read summaries of testimony before and I have listened to the comments this morning. They indicate the range of desires and needs and interests that must be accommodated.

We pledge our support in the process of that accommodation.

I would like to address myself this morning, if I may, first to points of agreement that we have with you. And, second, some points of difference that we think might be worthy of further exploration. I would like to comment on some of our current problems and approaches, all of which are spelled out in our written statement in much more detail than I will give orally.

First, let us talk about the points on which we agree.

You will find that we agree with much that has been said here this morning; first, that all Americans are entitled to comprehensive health benefit coverage, including protection against cost of catastrophic illness.

Too many Americans—and though they represent a small percentage of the total, it is still too many—have either inadequate or no health insurance protection. Third, the cost of health care must continue to be reduced to a point that we think would be appropriate, a point of increase that squares with the increase in the gross national product.

Fourth, national health insurance should be consonant with the continuing development of the health care delivery system.

Fifth, there must be an ongoing commitment by all providers of health services to the quality of care.

Sixth, the Federal Government should require employers to purchase a basic set of benefits for their employees and dependents.

Seven, we must all promote and emphasize preventive medicine and health education.

Eighth, any program of national health insurance should promote the development of alternative delivery systems of the kinds, Senator, that we saw this morning at Mercy Hospital. We must continue innovation.

Senator, now if I may, some points of difference.

First, I think we differ on appropriate roles of Government and the private sector.

Second, I think we differ on the most effective manner of containing health care costs. Third, I think we have some differences on the timetable for the expansion of benefits and coverage.

Fourth, I think we have some differences on the way to finance this system.

Fifth, we have some differences on the impact of the centralized administrative and fiscal control structure. These differences I think we can approach in a way that does not obscure our common goal. We are pleased to note how many provisions of your proposal are similar in intent and objectivity to some of those we have been espousing for the past 10 years.

We have enclosed with our testimony a copy of our own principles for national health insurance, which not only deal with the financing but attempt to make certain that universal access to health services goes along with that financing.

I would like to come back to these differences in just a minute. First, let me sketch just briefly some major problems that we see in health care that must be addressed.

Obviously, the impact of inflation is a very real problem. Inflation in the health field, of course, is tracking inflation in the rest of the economy, but in addition, when you look at cost, even the cost pictures that are identified here, they are made up of about two-thirds of inflation that mirrors the rest of the economy and one-third in improvement of services. I am sure people that have testified before, the people in this room, want no diminution in our improvement in the delivery of health services.

Incidently, if you look at Canada, if you look at Western Europe, if you look at all the major Western nations, you find an experience not unlike that in the United States: That health care costs, because of the desires of people to obtain better health care, are rising faster than the economy as a whole.

Clearly, we must deal with demand for service, to teach people how to take better care of themselves, and to recognize that the demands placed on the health system have been one of the reasons for increases in costs. Obviously, all of us want to have the advantages of improvement in medical technology and in expansion of health manpower to broaden access, and of course all of us know what is going on in the research world providing better ways to take care of more people. We need to deal with that demand issue and not prevent the improvement that is going on.

Also, the cost of health regulation, as I have said many times before, Senator, the cost of regulation is one of the problems we have to bear and one of the things that brings about increases in health care costs.

We have asked the Government on many occasions to be more careful in the regulations that they impose on the health system, take a sharper look at the cost of the compliance with those regulations.

Finally, we want to be sure that the health care institutions can continue to be modernized and maintained and that they can continue to deal with increased intensity of service that sicker patients require and can continue to finance medical education.

On pages 5 and 7 of the short statement, or pages 13 to 17 of the long statement, I have outlined some recommended approaches to key issues.

The American Hospital Association has consistently supported a variety of programs aimed at conserving the Nation's health care resources, some of which are in place, some in developmental stages, and others yet in the process of formulation through legislative and administrative initiatives, State and Federal, and some of which we need to pay more attention to.

We think in the course of the development of a sound national health insurance plan that many of these things must be strengthened, improved, and expanded. I would like to say, as I have before, that some of the recent legislative initiatives to contain health care costs are not constructive. They would not approach—as our friend from the Farmers Union just pointed out—they would not approach things in a comprehensive way. They could be piecemeal. An attempt to put a cap on hospital costs is bound to impair the ability of hospitals to innovate, to do the kinds of things that we saw at Mercy Hospital this morning, and a cap would not enable hospitals to continue to expand services people want as new techniques are discovered.

With respect to hospital expenditure——

Senator KENNEDY. Of course, the other side of that is that if that is successful, then it is going to save the hospital a good deal of money. You were there this morning and they are doing the deliveries at half the cost if it were being done in the hospital.

The fact is if the other hospitals felt out of necessity they had to be more creative, maybe we would get more innovation. There is another side to the coin.

Mr. MCMAHON. There is no question to the fact that there is another side to the coin. What I am saying is that oppressive regulation, putting a cap on costs, is bound, as it always has, to inhibit the opportunity to experiment and try other things.

One of the excellent things we saw this morning was that low-cost center is still being backed up by all the technology and standby facilities of the hospital that is absolutely necessary when something goes wrong.

Senator KENNEDY. The fact is there is cost containment in my own State of Massachusetts. It is working now at about 11 percent, where the national average is considerably above it. We have cost containment. We have some of the finest medical institutions, teaching hospitals, in the country. It is true of Connecticut, Yale Medical School, and it is true in New York State, as we mentioned, and there has been no indication whatsoever that there has been any diminution in terms of quality of health care or really that in other States that do not have it that they have been more innovative or more creative.

What has been evident is that where we followed the completely voluntary sector, we do reach the conclusion that it is a good deal more expensive in terms of the increase in escalation of inflation. This is an old chestnut that you and I have talked about before.

But we want to hear from others on this. We will, I am sure, have a chance to go back around it again.

Mr. MCMAHAN. We will, indeed.

I am going to give you some information that says we do not agree at all with some of the charts you have up here. Voluntary cost containment programs that are under way in many States are being just as effective as those in Massachusetts——

Senator KENNEDY. You give me the States and what their percentages are.

Mr. MCMAHON. We shall.

Senator KENNEDY. Do you have it here?

Mr. MCMAHON. I do not. I do not know whether I have it in my briefcase or not. We have a piece of paper that we will be glad to make available to you that shows States with voluntary programs are doing just as well as States, as Massachusetts, Connecticut, New York, and the city of Chicago. The facts speak for themselves.

Senator KENNEDY. We will look forward to receiving it.

The fact is when we had the debate last fall on this, probably 5 weeks ago, on hospital cost containment, the numbers of States that had gone through the voluntary programs was significantly higher in terms of average than the nine States that had mandatory programs. We had facts and statistics. I happened to offer administration programs and debate it on the floor of the U.S. Senate, and we did not in the Senate have the statistics and the figures that you mentioned here, nor, I might add, did any Member of the U.S. Senate who opposed our position. Maybe those have been newly developed.

I welcome the chance to examine it and we will look forward to examining them with you.

Mr. MCMAHON. Fine.

Senator KENNEDY. Good.

Mr. MCMAHON. If I may continue, Senator, of the four key issues that I highlighted in the testimony, one is this business of hospital expenditure control. The allegation that hospitals in the past and today have not exercised cost restraint ignores the 100,000 trustees of hospitals representing the communities that are bringing about restraint. It ignores the efforts clearly that are being successful on the voluntary cost-containment plans that are under way. They have reduced hospital expenditures in Colorado, reduced the rate of increase a couple percentage points even before the introduction of the new Rate Review Commission.

That new Rate Review Commission looks as though—people in the Colorado Hospital Association tell me—as though it will continue the trend, but it will not make any drastic change in it.

I would also like to mention that we have supported comprehensive health planning, and point out we have testified before you on the extension of comprehensive planning. This is one of the areas in which we differ substantially from the American Medical Association. We thought a certificate of need ought to be expanded beyond the hospital setting. They have a different point of view. But it shows, as we talked before, that we are not always eye to eye with the AMA or with the other organizations; but that is one difference of opinion.

We supported utilization review. We talk constantly to encourage patients and people to take better care of themselves.

Now, if I could conclude just with a few comments back to those points of differences which I think we ought to continue to explore and I will be through.

In our review of your outline of national health insurance programs, Senator Kennedy, we recognize you are considering a number of significant modifications to your original health security plan. The overall thrust of your approach continues to rely on Federal Control

structures that would in our view sharply limit the innovation, creativity and flexibility that has characterized our health care system.

One thing we might learn from Canada is that their Federal-Provincial mix of controls is better than relying solely on the Federal Government—and I would be glad to elaborate on that if you have any questions.

While we agree with the objective of your plans to provide comprehensive and universal coverage, we believe an incremental approach to filling the gaps is in order. The reason we say that is that we must be in a position to continue to expand health care services as the financing becomes available.

We believe an essential task in designing the national health insurance program is a definition of the role of Government, consumers, providers and insurance carriers. Your outline suggests a role for the Federal Government that would, in our judgment, make all the other participants merely agents in a highly centralized, controlled health insurance system. The policy of the American Hospital Association aims to enhance the strength of our pluralistic system by retaining both authority and responsibility for decisionmaking at the community level.

I pointed out in the testimony that the regulation of insurance carriers by public authority could have several unintended side effects.

The earnings-based premium would remove employer-employee incentives to conserve costs. We spell out some other problems in our testimony.

We think the key to providing national health insurance programs is a pluralistic system where the Government takes increasing responsibility for the aged and the indigent, and where we continue to base the bulk of our system providing comprehensive coverage on employers and employees.

Finally, of course, you must make sure that the structure is modified so that that which insurance coverage promises can indeed be delivered by the system.

That brings me to the conclusion, Mr. Chairman.

We appreciate this opportunity and look forward to further opportunity to explore ways appropriately to control costs while we attempt to expand services and provide people with the kinds of access to sound and sympathetic care that they certainly deserve and give every indication they want.

Thank you Mr. Chairman.

[The prepared statement of Mr. McMahon follows:]

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
BEFORE THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE SENATE COMMITTEE ON HUMAN RESOURCES
ON NATIONAL HEALTH INSURANCE
DENVER, COLORADO

November 29,1978

Mr. Chairman, I am John Alexander McMahon, President of the American Hospital Association. Our Association represents some 6,400 health care institutions, including most of the nation's hospitals, long-term care institutuions, mental health facilities, hospital schools of nursing, and over 27,000 personal members. We appreciate this opportunity to participate in these discussions on National Health Insurance (NHI) and the outline of your proposal.

INTRODUCTION

I would like first to make some preliminary observations about our position and our view of the overall issue:

It is important for us at the outset to identify the matters on which we agree and the matters on which we disagree, and I will attempt to do that.

Second, it is important that you know that in the process of congressional committee investigation and study we will undertake to provide to this Committee, on an ongoing basis, our very best resources in addressing the issues of adequate insurance coverage and the provision of quality health care.

Third, because we are dealing with a wide range of the public's needs and its expectations, it is imperative that we share with one another an honest assessment of what we in the private sector, and you who represent us in the government sector, must do, what we can do, when we can do it, and how it all shall be done.

Nothing can bring home to us more forcibly the importance of this last observation than the kinds of experiences we have heard related in the course of this Committee's hearings earlier in Washington and in the cities you have visited subsequently. And this morning's experience adds movingly to the examples of the important problems that this Committee, and the membership of our Association, are addressing.

At this point, let me proceed then to describe to you the views that I believe we share. We believe that:

1. All Americans are entitled to comprehensive health benefit coverage, including protection from the catastrophic expenses of some illnesses and injuries.
2. Too many Americans, and specifically the aged, the self-employed, and the indigent, either have health insurance protection that is inadequate, or have no protection.
3. The cost of health care must continue to be reduced to a point of reasonable balance, a point that parallels the rate of growth of our Gross National Product, and the cost of health care must not add to the serious problem of inflation throughout our economy.
4. NHI should be consonant with the continuing development of the health care delivery system, eliminating, wherever possible, all forms of waste, abuse, duplication, and unnecessary administrative burden.

5. There should be an ongoing commitment by all providers of health services to the maintenance and the monitoring of the quality of America's health care delivery.
6. The federal government should require employers to purchase a basic set of private health insurance benefits for their employees and their dependents, with appropriate employer/employee sharing of premium costs.
7. We all must promote and emphasize preventive medicine through effective programs of health education, maternal and child care, and environmental protection measures.
8. Any program of NHI should promote the development of alternative delivery systems and procedures, including ambulatory and home care, and the growth of HMOs.

Mr. Chairman, I believe that all our points of difference, even where we differ sharply, have to do with the means of achieving what I believe is our common goal. Where then are these points of difference? They include questions as to:

1. The appropriate roles of government and the private sector.
2. The most effective manner of containing health care costs.
3. The timetable for the expansion of benefits and coverage, which our Association beleives should be based on economic conditions and system capacity.
4. The method of financing the nation's health delivery system, including the appropriate mix of payroll taxes, revenues, private premium payments, and the use of an "earnings-based premium" concept.

Let me review each of these specifically:

1. The appropriate role of government and the private sector. We believe one essential task in designing a national health insurance program is the definition of the roles of government, consumers, providers and insurance carriers. The overall thrust of your approach continues to rely on a federal control structure that would, in our view, sharply limit the innovation, creativity and flexibility that have characterized the health delivery system in this country. Experience has taught us that federal government control of vast social programs does not necessarily ensure that they will be more efficient or less expensive; in fact, considerable evidence exists to the contrary.

   Your outline suggests a role for the federal government that would, in our judgment, make all of the other participants merely agents in a highly centralized and controlled health bureaucracy. The policy of the AHA aims to enhance the strengths of our present pluralistic system by retaining both the authority and responsibility for decision-making at the community and state levels. It is our strong belief that such a decentralized structure is much more likely to result in efficient and prudent use of resources and to a fostering of innovative and competitive strategies in the delivery of health care.

   We believe the federal government's role should primarily be that of coordination and standard-setting, in addition to its continuing obligation to the aged, poor and medically indigent. Specific regulation of individual institutions, conditions of

participation, insurance administration and health care planning are more appropriately the responsibilities of state and local authorities.

For example, the regulation of insurance carriers by the Public Authority as proposed could have several, unintended, negative side effects. A result of eliminating experience rating as a basis for determining health insurance premiums could mean a diminution of concern for promoting programs of health education and preventive care. Providing assurance to carriers that unanticipated losses arising from greater subscriber utilization will be guaranteed would clearly alter the competitive forces found in the marketplace today. The effect of changes such as these lead us to recommend against their use.

2. The most effective manner of containing health care costs. As we will explain more fully elsewhere in this statement, the AHA is committed to the support of viable solutions to the problem of rising health care costs. A pivotal point in your program proposal is an immediate limitation on overall hospital revenues and expenditures. This is to be followed by prospective budgeting of hospital and physician expenditures, conducted by an agent of the federal government, as the primary cost control measure. We think this approach is inconsistent with rational, flexible, and innovative management.

Among the AHA's principal goals are improved efficiency through incentives to develop more integrated, coordinated health delivery systems; elimination of duplicative services and facilities through the strengthening of the health planning law and its coordination

with NHI; support of utilization review programs; and control of excessive demand through the contribution by individuals - to the extent they are able - to the cost of health care. We believe such commitments, in addition to the cost control innovations developed under existing statutory and voluntary programs, can effectively bring health care cost increases in line with the general rate of inflation.

Further, we believe a rational approach to cost containment requres the government to accept its share of responsibility for the control of expenditure increases generated by government support for medical education and technology development, increased regulation of a duplicative and non-beneficial nature, and entitlement programs which generate excessive demand for expensive inpatient services.

3. The timetables for the expansion of benefits and coverage. In addition to immediate expenditure limitations, your plan calls for the establishment of full benefits over a two-year period thereafter. While we agree with the objective of your plan to provide comprehensive and universal coverage for health services to all Americans, we believe that an incremental approach to filling gaps in coverage is in order. Progress toward this goal must be consistent with the nation's economic resources and with our capacity to meet the demand arising from these improvements in access to health care services. Certainly, we do not want to exacerbate the inflationary pressures in our economy.

In formulating its plan, the Association has taken into consideration the major problems facing our nation's health care system, which I will presently summarize. In calling for comprehensive

health care benefits, for example, the AHA plan would require that mandated employee-purchased insurance benefits be phased-in over a period of time as we are able to afford them, ultimately to include - as a minimum - preventive care, maternal and child care, inpatient, mental health, restorative, and outpatient services, and protection against the catastrophic costs of illness.

4. The method of financing the nation's health delivery system. We are concerned with your intended reliance on an "earnings-based premium" in the determination of employer premium levels. This method would, in effect, create an additional payroll tax, limiting opportunities in the marketplace for the competition that now exists among health insurance underwriters, and eliminating one of the methods of determining insurance premiums.

   The AHA believes that the efficiency and innovation of the health care system is enhanced by equitable financing through multiple sources of funding. Our proposal is designed to ensure an appropriate mix of payroll taxes, revenues, and private premium payments in the attainment of these goals.

These differences in how NHI should be approached should not obscure our common goals, and we are pleased to note, Mr. Chairman, how many provisions of your proposal are similar in intent and objective to those of the NHI plan supported by our Association. The AHA's plan for NHI (a copy of which is attached to my testimony) would not only ensure universal access to health services for all Americans by eliminating financial barriers, but it also addresses the issues of how health services should be financed and delivered and what regulatory mechanisms and administrative relationships should exist at the federal and state levels.

I would like now to briefly outline the major problems addressed by our plan, relating them both to current solutions and their implications for NHI.

## CURRENT PROBLEMS IN HOSPITAL CARE

In general, the predominant concern about health care has been expressed, both to this Committee and elsewhere, as the problem of rising costs. Within that issue, however, are also such problems as gaps in insurance coverage, the maldistribution of hospital capacity, and inappropriate utilization of services - all of which must be addressed in the development of NHI.

The fact that hospital and health care costs have been increasing at a rapid rate is not in dispute. Hospitals are concerned and are working actively to restrain health care cost increases within their control. Health care cost increases are a complex problem, and it must be recognized that reductions in the rate at which they increase cannot be achieved in a short time period without adversely affecting quality and accessibility of services.

Health care expenditures in nearly all Western nations are increasing at a rate greater than their gross national products. This worldwide phenomenon reflects the inherent values of our civilization, which supports the application of resources to improve and maintain health, to ease suffering, and to extend life. We recognize that at some point each nation must decide how much of its resources shall be spent on health care and how those resources must be allocated. Such decisions must be made on the basis of a coherent health policy which defines the roles of the public and private sectors and recognizes the complex factors which affect the delivery of health care.

Deliberations on national health insurance, therefore, must consider each of the following factors:

Impact of General Inflation

The cost of hospital services is adversely affected by our inability to control inflation in the general economy; therefore, NHI must be developed not in isolation, but in relation to that general economy. Hospitals buy a mix of goods and services, the cost of which moves at a rate greater than the consumer price index.

For example, malpractice insurance costs have increased 800 percent in the past seven years; and energy costs since 1973 have increased at over 20 percent per year. Food costs, which comprise about 10 percent of inpatient costs, have also risen substantially. These three components of the hospital market basket alone account for approximately one-third of non-labor hospital costs.

Indices developed by the AHA have shown that two-thirds of last year's 15 percent increase in hospital costs were due to price inflation in the goods and services which hospitals must purchase to provide patient care. In discussing rates of increase of hospital expenditures, it is erroneous to suggest that such rates are entirely a reflection of inflation in hospital costs. The fact is that they are a combination of inflation and real growth of the hospital delivery system in terms of improvements and expansion of services, as well as an increase in their intensity. Indications are that this cost-push problem will become more acute as we experience the cost effects of more stringent regulatory controls in the interest of consumer safety, increases in energy costs in the

interest of conservation and energy independence, and the growing inflationary pressures throughout our economy.

Demand for Services

The growing demand for health care services is one of the major factors influencing the growth in hospital expenditures. Increased demand is in part a reflection of our growing and aging population. We are living longer and the illnesses which beset an aging population require long term medical management and are costly to treat. NHI should be designed with sufficient flexibility to adjust to such variables over time.

Demand has also been stimulated by our deliberate decision to remove financial barriers to access to health care for many of our economically disadvantaged citizens. In the United States, we prefer and select health benefit plans with the broadest coverage and smallest direct self-payment. Further, when coverage is not comprehensive, our health insurance and public financing programs, for the most part, continue to favor high cost inpatient care.

Other factors which influence demand for health care include: advances in medical technology, the dramatic expansion of health manpower, and increased public awareness and knowledge of the potentials of medical science. For example, the increase in physician manpower leads to further identification of health problems, with a corresponding increase in demand for treatment.

In addition, the demand for services is increased by the many unsatisfactory personal health habits of individuals, and lifestyles

which lead to neglect or disregard of the individual's responsibility for his health. Further, despite dramatic technical advances, public expectations create demands exceeding the capacities of the health care system, as well as available economic resources.

Intensification of Services

The kinds of services being used by patients are increasing in intensity-both in terms of frequency of use and sophistication of technology, with inevitable cost consequences. This intensification is the product of a number of developments in our health system; the change in the mix of patients treated, the availability of new technologies in diagnosis and treatment, and the changing character of medical practice.

Maintenance of Service Capacity

Another factor in health care costs, which NHI must anticipate, is the modernization and maintenance of hospital service capacity. The costs of this aspect of service also have accelerated more rapidly than the CPI because of changes in the nature of facilities, inflation of construction costs, and the increased costs of capital.

The trend in hospital construction has been toward substituting semi-private and private accommodations for wards, replacing long-term facilities for patients with respiratory and mental illness with relevant short-term services in acute care hospitals, and replacing obsolete plants with modern facilities for better treatment and patient safety. Construction costs have also increased both in terms of materials and labor. Finally, hospital capital costs have greatly increased because of the need to use debt financing, a result of the declining availability of grants and philanthropy. In fact,

our data reveal that over 66 percent of hospital capital requirements are obtained through debt financing.

Manpower Development

Hospital costs are also affected by the need to continue to rely on patient care revenues to finance medical education in hospitals, a factor which must not be overlooked in the financing of NHI. The stimulus government has provided through its support of graduate medical education has resulted in a major expansion in physician internship and residency training programs. Much of the cost of providing this graduate medical education must be obtained from patient care revenues. In addition, many hospitals support clinical training programs for a variety of allied health professionals, adding directly to the costs of care.

Cost of Hospital Regulation

Government at all levels has not adequately met its responsibility in assessing the cost impact, effectiveness, and benefits of many regulations it has imposed on hospitals. Hospitals have been experiencing a steady and excessive increase in reporting and inspections, some of which are duplicative or conflicting. The regulation of hospitals is increasingly characterized by multiple centers of authority and accountability.

The Hospital Association of New York State, in a 1976 study, found that 40 federal agencies, 96 state agencies, 18 city and county agencies, and 10 voluntary and quasi-public groups - a total of 164 agencies - regulate 109 areas of hospital operations. Of the 109 areas, 82 are each monitored by 10 or more agencies. Recent studies in Minnesota, Pennsylvania, and Michigan have documented similar problems to varying degrees.

Thus, while calling for containment of hospital costs, government has required compliance with regulations which all too often add to costs without commensurate improvement in the quality of health care provided. Regulations under an NHI program should be assessed in terms of their cost effectiveness, their relationship to other, related governmental regulations, and their cost impact over time.

Recommended Approaches to Key Issues

The AHA has consistently supported a variety of programs aimed at conserving the nation's health care resources, some of which are in place, some in developmental stages, and others yet in the process of formulation through legislative and administrative initiatives, state and federal. We have, at the same time, been watchful of proposals - including proposals for NHI - which we believe, through our long experience, would jeopardize the continued provision of accessible and high quality medical care. However, let me emphasize again that we are by no means opposed to viable alternatives for the containment of health care costs, and neither do we feel less committed to seeking solutions to the nation's problems of health care costs than is the federal government.

We do not believe that any of the recent legislative initiatives to contain hospital costs approached the problem in a comprehensive way. These strategies which seek to single out hospitals by imposing a flat cap on revenues ignor the complexities and interdependence of the health care delivery system and, in our opinion, would cause distortions, further fragmentation, and disruption in the delivery of health care.

Hospital Expenditure Control

It has been erroneously asserted that hospitals exercise no constraints on their expenditures and have no incentives for cost containment due to the nature of the payment system. Some proponents of NHI believe that such a program should be the lever for total federal control over the resources committed to health care delivery, a policy with which we strongly disagree. We believe that such control would seriously undermine the strengths of our voluntary, pluralistic system, leading to a rigidity and uniformity that would stifle innovation and progress.

The fact is that there are already a host of constraints and incentives for cost containment. There are spending limits in Medicare and Medicaid, in payment systems of other third-party payers, and in state-level statutory and voluntary budget review programs, not to mention the impact of hospital governing boards, administrators and members of medical staffs who are concerned with these issues in the management and operation of our nation's hospitals.

Further constraints are included in a large number of other programs, all of which we have actively supported, such as comprehensive health planning, certificate of need (CON), medical audit, and utilization review. These constraints are refelcted in reduced lengths of stay, an increase in shared service programs, growth in outpatient care, and the recent significant moderation in the rate of increase in total hospital expenditures.

We are proud of the extensive Voluntary Effort (VE) to contain health care costs now underway through a joint program supported by hospitals, physicians, insurance carriers, health industry

manufacturers and suppliers, and consumer representatives. The VE includes a broad array of approaches to moderate the rise in health care costs, and specifically addresses hospital cost increases by setting a national goal of reducing the rate of increase in total expenditures by two percentage points each year in 1978 and 1979. We are convinced that the VE will continue to succeed as it has in 1978. In sum, the VE represents a comprehensive and consistent approach to the moderation of health care costs. We firmly believe such efforts can be more successful than government limits on hospital revenues.

Comprehensive Health Planning

AHA has vigorously supported community health planning and enactment of P.L. 93-641. We have worked actively and constructively in the implementation of this important law. Prior to its passage, we encouraged the development of strong certificate of need laws at the state level as a necessary component of effective health planning. Such mechanisms, used properly, can increase the efficiency of the system and avoid duplicative or unneeded health resources.

We have recently supported legislative measures which would further strengthen health planning, including extension of CON beyond the hospital setting, increased funding for planning agencies, and the provision of grants to assist in the voluntary conversion or closure of unneeded services or facilities.

Much attention has been directed to the issue of excess hospital capacity - overbedding. We recognize that excess capacity does

exist in some areas. However, in broad terms, the issue of excess capacity can be viewed as a maldistribution of resources in that excess capacity in one institution or in one geographic area does not meet the need for modernization in another community, nor does such excess capacity meet needs for additional capacity in another area where population shifts have resulted in a shortage of beds. Further, in areas in which there is excess bed capacity, hospital management has generally adjusted variable cost factors, such as staffing, to meet existing needs.

Certainly all efforts to convert, mothball, or close unneeded capacity should be carried out. As noted above, we supported legislation which would have recognized costs associated with voluntary conversion or closure of beds or services and provided an incentive and assistance to institutions taking such actions.

We believe that meaningful limitations can be placed on capital investment in the health care system which will further restrict such expenditures, while recognizing the need to maintain needed resources and provide for reasonable advances in health care delivery. In this regard, therefore, we feel that local and state planning agencies are in the best position to consider local factors in planning for health needs and in addressing problems arising from the maldistribution of services and facilities.

Utilization Control

AHA has supported the development of improved utilization review and medical audit. We have worked for the development of cost effective institutional quality assurance programs as a part of PSRO activities. We recognize that utilization review is a complex process and it is important that we avoid excessive administrative costs. The objective

of such quality assurance programs should be the maintenance of high quality care which is medically necessary and rendered in an appropriate setting. We believe these efforts can be important in identification and analysis of areas of high hospital utilization. Where such utilization patterns are determined to be inappropriate, corrective action can be taken which will have a beneficial impact on hospital expenditures.

Controlling Patient Demand

One of the important factors in the increase in hospital expenses that we referred to earlier is the fact that patient demand is generally unrestrained by the need to make out-of-pocket payments which would increase the incentive for patients to be cost-conscious while not increasing financial barriers to needed care. These measures include the restructuring of the current hospital deductible and coinsurance mechanisms, consistent with AHA's policy for NHI which advocates appropriate patient cost sharing.

Also, we have urged that programs be continued and expanded to encourage individuals with poor personal habits - such as smoking, alcohol abuse, and overeating - to change their attitudes and habits in the interest of prevention of illness. Further, we have supported various primary care programs and the Child Health Assessment Program, designed to screen illnesses and conditions before they reach a state requiring expensive inpatient treatment.

Conclusion

Mr. Chairman, it is our position that no single way of organizing health care services can be developed for application to all communities and that any program of NHI should build on the strengths - the diversity

and adaptability - of the present system. There is value to the public in preserving pluralism in the health care system because of the innovation and freedom it engenders.

We believe that hospitals are demonstrating innovation and adaptability in the control of costs, utilization, and excess capacity. We will continue to support measures which are consistent with personal choice, accessibility, high quality, and cost-effective care. We believe that these goals are essential in the formulation of a National Health Insurance program.

Thank you for the opportunity of participating in these hearings. We will be gald to respond to any questions you may have.

AMERICAN HOSPITAL ASSOCIATION

# STATEMENT

## PROVISION OF HEALTH SERVICES UNDER UNIVERSAL HEALTH INSURANCE

*Much has happened in the more than five years since the American Hospital Association's House of Delegates approved the* Policy Statement on Provision of Health Services. *The health care industry has been inundated by a host of legislative and regulatory interventions. Governmental payment programs have come under budgetary constraints that have resulted in a continuing erosion of the financial base of health care institutions. There also have been significant changes in public and societal attitudes, largely reflecting the movement from an economy of abundance to one of scarcity. Economywide scarcity has placed greater emphasis on the issue of the limitation of resources available for medical and health care services.*

*Throughout this period there has been a continuing interest in universal health insurance (UHI) on the part of Congress and several administrations, even though, as of this date, no program has been enacted. In fact, there has not yet been any indication of a broadly based consensus on the key financing, regulatory, and delivery systems issues that must be addressed in such a program. This lack of consensus, along with the growing concern with the potential impact of a UHI program on the federal budget, has raised the question of whether the Association needs or should have a position on this subject. This statement provides an affirmative answer to that question and reflects the viewpoint that the Association must be in a strong position to put forth the hospital field's recommendations on how UHI should be financed, on how medical and health services under UHI should be delivered, and on what the most appropriate regulatory structure at the federal and state levels should be if and when Congress and the Administration begin serious deliberation of UHI.*

*Among the most significant issues facing the hospital field is what regulatory system should be considered, if any, as part of a UHI program. The degree and type of regulation in the health industry currently varies widely from state to state and region to region across the country. At the same time, several major federal laws already exist that include substantial regulatory provisions, such as certification of need under the National Health Planning and Resources Development Act of 1974 and the quality assurance, utilization review, capital, and reimbursement controls that were added to the Medicare program in the 1972 Amendments to the Social Security Act. All of these controls supplement, and in some cases conflict with, state level regulatory provisions and procedures, such as state rate review, fire safety standards, and institutional and manpower licensure procedures. Moreover, Medicare and Medicaid already account for almost half of the nation's hospital revenues, and this figure will surely increase under any UHI program. Therefore, this statement includes specific regulatory provisions aimed at bringing some coordination, equity, and rationality to the morass of governmental regulations under which it has become increasingly difficult to operate.*

*The new statement sets forth the American Hospital Association's current position on the financing, organization, and regulation of the nation's health system under a program of universal health insurance. This position is based on the view that as a nation we must build on the strengths of our existing delivery and financing systems. It reflects the need for government to improve its programs of financial assistance for the aged, poor, and near-poor, those segments of the population for which it should assume primary responsibility for ensuring financial access to health services. In addition, it emphasizes the need for government to restructure and integrate the fragmented and sometimes conflicting elements of health regulation into a more coordinated, equitable, and cost-effective regulatory process at the federal and state levels. Only through such a total program can the nation achieve as comprehensive a level of health insurance benefits as it can afford for all its citizens.*

*The development of this total program will require public debate to identify the financing, material, and human resources the nation is willing to commit to health care services. In turn, government must be willing to commit sufficient resources to carry out its own obligation in this total program.*

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**Principles and goals**

Good *health** for all persons is fundamental to the best interests of our nation. The health of the nation is achieved through a variety of means. For example, adequate housing, proper nutrition, absence of environmental hazards, public health measures, and personal choices of lifestyle constitute important elements in the prevention of illness and in the maintenance of well-being. *Medical and health care services*† comprise those elements involved in the diagnosis, treatment, and prevention of disease or illness and in the restoration of individuals to well-being.

The nation's health and the health of all individuals reflect the combined efforts given to each of these elements. These efforts require financial, material, and human resources that are limited. This limitation creates a situation in which programs of medical and health care services compete for these finite resources with programs of housing, nutrition, and environmental and public safety, as well as with other programs and needs of society. One of the most difficult tasks facing the nation thus becomes the selection and support of an appropriate mix of available means, or pathways, for attaining and maintaining an acceptable level of health for all citizens.

The achievement and maintenance of health through medical and health care services must be a national, as well as a personal, concern. Both as a nation and in our communities, we must strive continually to improve the quality and consistency of care and to provide accessible health services at a reasonable cost in a manner that recognizes the dignity of all individuals. Both users and providers of health services must be aware that such services constitute but one of many approaches to health, and that optimizing resources for this approach at the expense of other approaches may not result in an optimal level of health for the nation as a whole. The responsibility for maintaining perspective on the various approaches to the health of the nation, and for determining the appropriate allocation of resources for health care services, should be shared by the public, the government, and the providers of these services.

Each individual, to the extent he or she is able, has the personal responsibility for protecting his or her own health and for seeking health care when required. The health care system, to the extent of its resources, has the responsibility to make available needed services and to inform individuals of methods for protecting their health. These services may be administered through a variety of arrangements, and all health care services or programs should be conceived and delivered within a setting of mutual trust among all parties involved. Institutional *health care providers* have acknowledged their relationships to other providers and government bodies, their responsibilities to those in need of services, and their unique position with regard to the kinds of services they are capable of delivering. Because government has assumed responsibility to provide financial assistance for the aged or those who cannot afford health services, it must *ensure* that a coordinated and *equitable* regulatory process for these services is developed.

Failure to resolve acute social and environmental problems adds to the total cost and amount of necessary health services. It must be realized that the pace at which these problems are addressed and solved affects directly the organizational burdens and total effectiveness of the provision of health and medical care services. To address the host of problems presented by illness and disability, including the consideration of sociological and environmental conditions, coordinated planning is necessary to determine the needs for programs and services and the *appropriate* resources to meet these needs. The efficiency and effectiveness of those programs and services offered should be continually evaluated. Programs to deal with social, environmental, and custodial care problems that affect the public health should also be coordinated with the evolving system for medical and health care.

*Basic medical and health care principles and goals*

The provision of good medical and health care should be developed according to four essential principles:

1. The maintenance of good health is a responsibility of each individual, to the extent of his or her capability.
2. Medical and health care services should be made available to all individuals and should be so organized as to be readily accessible to all.
3. The extent to which health care services are provided should be based upon the realistic assessment of limitations on resources.
4. No single way of organizing health care services can be developed for application to all communities, and the system should build on the strengths of its diversity and adaptability.

From these principles, the following goals are derived for the provision of medical and health care:

- All individuals should have adequate information to assist them in their acceptance of the responsibility for protecting their own health and for seeking medical and health care as needed (see pages 2 and 4).‡
- Medical and health care services should be provided in a compassionate and skillful manner on the basis of individual needs regardless of financial status, mental or physical handicap, race, color, religion, sex, age, or national origin (see page 5).
- Mechanisms should be established for ensuring the adequacy and necessity of health services, for coordinating *health education* and prevention programs conducted by health and community organizations, and for evaluating and appropriately implementing new medical technologies (see pages 3 and 5).
- Priorities should be established for the provision of health services, including health education, on the basis of a

* This and other words and phrases defined in the glossary (page 9) are italicized the first time they appear in the text.

† Throughout the text, the terms *health services* or *health care services* are used as equivalent terms for medical and health care services.

‡ Refers to page in this statement on which the accomplishment of the goal is discussed.

realistic assessment of community needs and of resources available to the community, as determined through *regional planning* processes (see pages 3, 5, and 6).

- All *health care institutions*, including those institutions providing acute, long-term, and health-related custodial care, as well as all federal, state, and local governmental hospitals, along with major services provided in noninstitutional settings, should be coordinated through appropriate planning processes into a more effective system of health services (see page 7).
- All medical and health care personnel should be oriented to the maintenance of good health and to the prevention of illness, as well as being oriented to the treatment of illness after it becomes acute (see pages 3 and 5).
- In fulfilling its responsibility, government should assume full responsibility for payment for health care services that are provided to the *poor* and varying responsibilities for payment for services for the *near-poor*, the *aged*, the *disabled*, and the *unemployed*, and it should coordinate private health insurance coverage for the rest of the population and ensure that adequate payment is made to providers of these services (see pages 6 and 7).

**The delivery of health services**

The system for the delivery of health services should have as its ultimate goal the best possible medical and health care for all persons. The system should focus on individual needs, be personalized through the skills and compassion of health personnel, and recognize the dignity of the individual.

The system for the delivery of health services should provide *comprehensive health care services* within available resources. The system should be oriented to the maintenance of personal good health and to the prevention of illness, as well as to the treatment of acute illness.

Providers should meet generally accepted standards of effectiveness, high quality, and efficiency. Additional emphasis should be given to the development of measures of quality of care and standards for evaluating effectiveness and efficiency of health services. The goal of providing good health care in an economical manner should be promoted at all levels. Providers should be evaluated on the basis of their ability to meet this goal.

Innovation should be encouraged, and the benefits of alternative choices through a multiplicity of health providers with varied types of organizational forms, sponsorship, or ownership should be preserved. There is value to the public in preserving the existing pluralistic system of health delivery. Conscience and free choice should be preserved.

There are many ways in which health care providers can organize to deliver good quality services to the community and to make these services more accessible, efficient, and effective. No single way of organizing health services can be developed for application to all communities and, in fact, the diversity and adaptability of our current system is a strength that should be built on as the system evolves in the future.

Health care providers should take the initiative to expand and improve health services in the community, or to better address problems of access to services. Special emphasis and effort should be given to improving care in underserved and unserved areas of the country. Providers and others in the community are in the best position to take such initiatives and, as a consequence, any changes in the delivery system should be developed, coordinated, and implemented by health care providers, the patients served by these providers, and the community. Innovative health service programs should be monitored and evaluated through *health services research and development* to determine whether they meet the same standards of quality, effectiveness, and efficiency being applied to established means of service and, if they do, to determine how these innovations can be more broadly applied.

*The hospital's role*

The *hospital*—its governing board, medical staff, administration, and *health professionals*—is the key organizational component and resource for the delivery of health services in the community. As a consequence, hospitals should be involved in the coordination and implementation of changes in the health system, with or without UHI legislation. Effective steps should be taken now by hospitals to organize themselves voluntarily in order to improve their capability to deliver comprehenisve health services to the community.

These activities will require coordination with physicians and other health care entities in the community and can serve as building blocks toward the development of an improved delivery system. In fact, many hospitals have already taken the leadership in developing consortiums for a variety of functions, while others have formed multi-institutional systems as a more highly structured mechanism to enhance efficient and effective operation and to expand access to a wider range of health services. Cooperative efforts in this regard can better meet the health care needs of the community, avoid unnecessary duplication, develop appropriate alternatives to inpatient care, and strive for proper utilization of health resources. Hospital representation in planning any of these joint activities should include members of the hospital governing board, medical staff, administration, and other professionals within the institution.

As part of their planning, hospitals should become more knowledgeable about all health-related activites in the community. Careful appraisal by each institution of the community it intends to serve is essential to effective personal health services planning. The institution should be aware of program decisions of neighboring institutions and of other proposed new programs in the community pertaining to health care services, facilities, health education, and manpower development. It should examine the need for various types of services in the community and the available sources of financing these services, recognize its interdependence with other health organizations and community groups with health interests, and encourage continual creative interaction. The goals of the institution should be related to its resources and to the health needs of the people to be served. Because there are limited resources upon which to call, hospitals should participate with other institutions to distribute effectively those limited resources and, where resources are inadequate, to develop programs for raising additional funds. Inasmuch as health services financing, regulation, and organization are



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usually established within state boundaries, hospital associations can be helpful in promoting interaction among hospitals. State hospital associations have the benefit of a general overview of the delivery system across the state.

Hospitals organizing themselves within health planning areas should consider some of the following examples of joint activities that can assist in improving the health delivery system. Open discussion is a basic ingredient for success in all of the following activities.

- Develop community planning activities, including a joint evaluation of health care needs and the development of an overall plan for health delivery, *health maintenance*, and education resulting from an agreement on what should be done. This includes the pooling of data and the development of an inventory of services available in each hospital and health-related community organization.
- Share fiscal information where such information is valuable for mutual planning and delivery programs.
- Improve patient referral systems and related information transfer systems.
- Develop shared administrative and clinical service opportunities.
- Develop means for improving access to and availability of health services.
- Examine and develop cost effectiveness measurements.
- Pool resources to promote and support effective working relationships within the framework of local health planning agencies, quality assurance organizations, third-party payers, and other involved organizations.
- Develop emergency medical services systems, including disaster planning.
- Work with local educational institutions and professional groups to set educational standards for health personnel and to identify appropriate clinical opportunities for the education and training of health personnel.
- Assist in developing effective means for measuring the quality, use, and economic delivery of comprehensive health services.
- Encourage research in the delivery of health services.
- Develop and participate in communitywide health educational and informational activities to actively encourage responsible decisions about health, as well as responsible use of health services by its community.

*Comprehensive health delivery systems*

Although no single way of organizing medical and health care services in a community can be universally applied, certain characteristics of a more accessible and effective delivery system can be identified as long-range goals for the community. These include the provision of good quality comprehensive services on a coordinated and effective basis in geographic areas across the country. *Comprehensive health delivery systems* are those entities that embody these elements and can serve as models for providers and others in the community as constructive change in the system is planned and developed. Whether within the concept of a *health care corporation*, a *health maintenance organization*, a consortium, a joint venture or shared service program, a multi-institutional system, or other groupings, hospitals should take initiatives and participate in systems for improving health care delivery.

Such systems should bring together physicians, other health personnel, management, and facilities into a cohesive structure with the capacity to make available comprehensive health care to the community, either directly through its own facilities and services or by contract with other health providers. They should have specific responsibility for ensuring the quality and effective delivery of health services by all of their providers, including those with whom they would contract—physicians, dentists, other health professionals, and health care institutions. Such systems should build on and develop modern management processes to maximize the efficiency and effectiveness of health delivery.

Comprehensive health delivery systems should provide services to subscribing members through their own resources or through affiliation with other providers, and should engage in education, research, and other activities related to the provision of health services. They could be established in a variety of ways depending upon community need, resources, and precedent. Sponsorship could be local, or it might be based on broader geographic areas. However organized, the governing boards of these systems should include representatives of the community served, health care institution governing boards, physicians, and management. Each system should guarantee opportunities for its members to express their reactions to the quality, cost, convenience, and accessibility of services.

The basic responsibility of these systems should be the provision of health services to the public they serve. Their programs should ensure:

- Good quality health care monitored through utilization services.
- Accessibility, availability, and continuity of preventive, emergency, ambulatory, restorative, inpatient, and home care, and health education in a continuum so as to economically provide opportunities for prevention of illness, the maintenance of health, and the most appropriate level of care as needed.
- Fiscal responsibility and accountability to the community served and cooperation with areawide planning.
- Participation in communitywide health education activities to teach and encourage the responsible use of services by patients and coordination of efforts to respond to educational needs of specific populations in making decisions about their health.

Physician leadership and participation is fundamental to the comprehensive health delivery system concept. Therefore, these organizations should:

- Implement the principle that medical judgments related to health services are made by physicians or under physician supervision.

- Ensure that the physicians' and other practitioners' responsibilities and professional relations are defined in accordance with rules and regulations adopted by the system and its component institutions.
- Ensure that judgments pertaining to the practice privileges of physicians and other practitioners are made only after appropriate peer review.
- Afford the opportunity and provide incentives for all physicians to affiliate with it.
- Encourage physicians practicing within the system to participate in management by serving on committees for budget, planning, utilization review, and other similar activities.

Each system should identify its service area and should plan its services and facilities to meet the health needs of all those residing in that area who voluntarily choose to obtain health services from the organization. Geographically defining a service area will provide an opportunity to address problems of access to the *disadvantaged* and to underserved areas through these systems. Some comprehensive health delivery systems may be the only one serving a particular area, while others may coexist and, within the constraints of the planning process, compete in the same area. Contractual arrangements or affiliations also may be sought to achieve the desired level and extent of services. This approach is especially important in the development of an effective system that avoids unnecessary duplication of services and facilities.

### Health manpower

An essential ingredient for the effective delivery of health services is competent manpower. The responsibility for maintaining an adequate health manpower supply should be shared by hospitals and other health care providers, health care professionals, educational institutions, government, and the community. The goal of a coordinated program should be to ensure that competent health manpower with the required skills is available in sufficient number and in the right setting to provide necessary health services at a reasonable cost.

*Manpower goals and objectives*

To achieve their manpower goals and objectives, all components of the health delivery system should support:

- A nationally coordinated program to guide the local collection of uniform health manpower data to facilitate manpower planning, production, and distribution.
- Long-range planning by state and local agencies to identify health manpower needs for given geographical areas, with sufficient lead time for the development of appropriate educational programs to prepare adequately trained health personnel.
- The establishment of research centers, involving universities, health planning agencies, hospitals, and other health care organizations, to conduct manpower planning and demonstration projects to investigate the effective and efficient uses of health manpower resources.
- Cooperative arrangments for basic and continuing education, including the provision of adequate facilities for clinical training, with input from the employers, health professional groups, and educational institutions to ensure the production and maintenance of the proper types and numbers of health personnel with the skills needed to meet the requirements of the health delivery system.

The health delivery system also should:

- Identify and implement acceptable and flexible alternatives to existing concepts regarding distribution and use of health manpower to meet health needs.
- Encourage and support programs to ensure that all persons, regardless of financial status, physical handicap, race, color, religion, sex, age, or national origin have equal employment opportunities in accordance with job requirements.
- Encourage, develop, and maintain policies and programs designed to produce upward career mobility.
- Encourage development and utilization of acceptable methods of employing more capital intensive production techniques as a means of economizing.
- Encourage employees of health care institutions to maintain a high level of competence.

In establishing a coordinated health manpower program, the health delivery system should take into account the major factors that influence health manpower requirements. These include changes in the organization and delivery of health services and changes in productivity brought about by new technology, expansion or modification of roles, and delegation of tasks. The system should work toward achieving a balance between generalization and specialization of health personnel to avoid underutilization, overtraining, and duplication of health manpower.

With leadership from the private sector, uniform standards for the *credentialling* of health professionals and selected *allied health personnel* should be developed by a consortium consisting of health professionals, health providers, educators, and public representatives to verify the importance of professional education or training and skills gained through professional experience.

Methods within each health care institution also should be established and/or improved to measure continuing competence based on job performance. Health professionals and institutional providers should support methods recognized for re-evaluating such competence. Health professionals should be held responsible for keeping their skills current. Institutional providers should develop mechanisms for periodically evaluating the competence of the health personnel working within the institution.

Alternatives to existing licensure provisions for allied health personnel should be identified, demonstrated, and evaluated to determine their effectiveness. Alternatives should be adopted if they provide improved measures for ensuring competence, flexible and cost-effective use of health personnel, and geographic mobility.

The educational system should provide basic educational preparation and continuing education and training of health personnel. The responsibility for this system should be shared

by the nation's educational institutions, hospitals, other health providers, health personnel, and professional associations.

This system should be responsible for:

- Preparing health personnel to perform more effectively in the provision of services directed to health education and the prevention of injury and disease.
- Promoting programs for the continued training and education of health personnel.
- Developing a knowledge of and sensitivity to the special health problems, needs, and value systems of all groups in the community.
- Ensuring adequate resources and number of skilled teachers for basic and continuing education programs.

Society should ensure the availability of adequate funds for the establishment and maintenance of education and training programs for health manpower. When a hospital or other health care agency assumes responsibility for educational and training activities, the financial resources that such activities require should be met, to the extent appropriate and possible, through tuition, scholarships, private or public grants, or other nonoperating sources. To the extent that the necessary resources are not so provided, they become financial requirements to be met by all purchasers of care. The cost of continuing education should be a shared responsibility of professional organizations, employers, employees, and educational institutions. The hospital's share of costs for basic and continuing education represents a legitimate financial requirement of providing health services. Continuing evaluation of health manpower programs is necessary to ensure a flexible, workable system to meet current and future health needs.

### Financing health services

A primary goal of universal health insurance should be the removal of financial barriers to access to health care services and the development and implementation of a step-by-step plan for making comprehensive health insurance *benefits* available to all the people. In addition, the design of the program should recognize that the method of financing can significantly influence the distribution, organization, utilization, and operating efficiency of health care resources. Because of the complexity of the interrelationships between the financial mechanism and the characteristics of the health delivery system and because of the lack of necessary resources to make comprehensive benefits universally available immediately, federal legislation should outline broad objectives for the financing program and a process for the gradual achievement of these objectives.

The principal financial objectives of the UHI program should include:

- The achievement of an equitable sharing of the cost of health care among all persons, recognizing differences in family income, and a method of sharing costs that, to the extent of available resources, should reduce hardships resulting from the cost of illness for all income groups and eliminate for the poor and near-poor the financial barriers to the acquisition of good health care.
- The development of more effective means of allocation and more efficient use of resources in the delivery of health care through appropriate incentives for consumers, providers, insurers, and government to coordinate the delivery of comprehensive health care services.
- The maintenance of a viable and strong pluralistic health care delivery system for the nation through the provision of adequate financing to ensure the availability of good quality health care services.
- The maintenance and establishment of greater incentives for philanthropic giving, an essential element in preserving a pluralistically financed program, to support the development of innovative comprehensive health delivery systems.

In order to achieve equitable sharing of the cost of health care among all persons and to ensure adequate levels of financing, multiple sources of financing should be used, including both governmental and private sources. Government contributions should be made through the purchase of health insurance benefits from prepayment plans and private health insurance companies. The federal government also should require employers to purchase a basic set of benefits for their employees and their dependents, with appropriate provisions for employer/employee sharing of premium costs.

The governmental purchase of health insurance benefits for the aged and disabled should be financed out of existing Social Security taxes and additional benefits for these groups, and coverage for the unemployed should be financed by general federal revenues. Insurance coverage for the poor and subsidization of the cost of insurance for the near-poor should be financed out of general tax revenues of both federal and state governments, with the greater share being a federal responsibility.

Federal legislation for UHI should include provisions for the phasing-in of progressively more comprehensive health insurance benefits for both government and private beneficiaries. Government at all levels must not promise more than what can realistically be financed or delivered. Federal legislation should establish an independent agency, reporting directly to the President, to advise Congress on a basic set of UHI benefits and develop a plan to reach the long-range goal of comprehensive health services for all. Subsequently, Congress should enact legislation to implement this basic set of benefits. The independent agency should be charged with the continuing responsibility to assess periodically the progress toward developing priorities for the eventual achievement of comprehensive care, report to the President and Congress on the phasing-in process, and serve in an advisory capacity for legislative amendment.

In order to encourage consumers to obtain, and providers to render, the most cost-effective kind of health services, the design of these insurance benefits should encompass a sufficiently broad scope of services from the outset. The benefits structure should also include the requirement that those individuals who are able should contribute, through out-of-pocket payments, toward the cost of their care. Mechanisms, such as a health care card for *postpayment*, should be developed for collecting patient contributions in a manner that re-

spects human dignity and ensures that no person will fail to seek needed health services because of insufficient family income. The design of the benefits structure should recognize the inherent conflict in the goal of protecting individuals from high-cost catastrophic episodes of illness, while not encouraging the use of high-cost, complex medical technologies where not medically appropriate or effective.

Federal legislation for UHI should include standards for developing *prospective payment* methods to be employed at the state level in conformance with federal regulations for approving *rates of payment* to qualified providers for covered health insurance benefit services. These standards should allow payments only to providers approved in accordance with guidelines for quality and adequacy of service; define the adequacy of institutional payment, as measured by the fiscal solvency of efficient and effective health care institutions, in accordance with the principles expressed in the AHA statement on the *Financial Requirements of Health Care Institutions and Services;* permit physicians to be compensated by various methods of payment, such as fee for unit of time or service, *capitation,* salary, salary plus incentive, or combinations of these; provide incentives for the use of that component of care that is most appropriate under the circumstances to provide the care economically; and encourage providers to participate in comprehensive health delivery systems.

In addition to the payment mechanism inducements, the federal government should develop grant and loan programs, and private philanthropies should be encouraged to assist providers in the creation and operation of multiple comprehensive health delivery systems meeting federal standards. Federal legislation should in no way eliminate or limit philanthropic incentives for such support.

**Health services regulation**

A more coordinated, equitable, and cost-effective regulatory process for health services should be developed as an integral part of a UHI program. Because the delivery of health services and most health services regulation are local matters, the development of an improved regulatory process should be built on existing structures and administered at the state level.

*Federal responsibilities*

As a means of reconciling the conflicts between the federal government's role as purchaser of health care services for specific population groups and the general responsibilities it may have for regulating health services in the public interest, an independent agency, separate from the Department of Health, Education, and Welfare (DHEW), should be established. This agency should be the primary body for continuing assessment, surveillance, and policy development of the UHI program, to ensure the maintenance of standards and guidelines for effectiveness and financial viability in the delivery of health services. These standards should cover quality of medical and institutional services, planning and capital development of health resources, and methods for determining the reasonableness of the prices of health services. In this regard, the agency should develop guidelines for alternative prospective payment programs that states may employ in fairly determining provider payment. Incentives also should be developed for health providers to participate in comprehensive health delivery systems. In addition, this agency should develop a means for ensuring that an adequate system of appeals is in effect at all levels of government to guarantee due process to all providers and purchasers, including the right of judicial appeal.

The activities of this agency should incorporate those of the existing federally-mandated bodies currently charged with these responsibilities, and it should ensure that there will be coordination of the activities of all federal agencies concerned with health programs, and that there is appropriate reconciliation between federal and state programs. The agency should begin its activities by examining and evaluating existing health care regulations in order to eliminate all unnecessary, duplicative, and ineffective regulations and guidelines. Special attention should be given by the agency to the assessment of the cost effectiveness of both existing and proposed regulations. It should have the ultimate authority to veto or otherwise alter inconsistent governmental activities.

The activities of this agency should recognize the rightful role and prerogative of the states and permit sufficient latitude to the states with respect to the individual nuances and characteristics of the population, the geography, the economy, and the level of education and resources. At the same time, the agency should identify in sufficient detail the responsibilities and administrative structures for health services regulation at the state level in order to provide consistency to this regulatory process throughout the United States.

The DHEW should not have any regulatory authority, but should continue to have programmatic responsibilities for such health-related activities as health manpower and training assistance, biomedical and health services research and development, and public health. The DHEW also should carry out federally-related administrative responsibilities for the UHI program, such as determining budget requirements for tax-supported UHI benefits and establishing procedures for determining the eligibility of the poor and near-poor.

*State responsibilities*

Each state should establish or designate an independent agency responsible for ensuring the effective administration of the regulatory process under the UHI program. This agency should be specifically prohibited from serving as either a purchaser or provider of health services.

State-level functions can be accomplished in a variety of ways and through different organizational structures depending on individual state procedures and preferences. However, each state should implement measures to ensure the quality of health services, planning and capital development of health resources, effective operation of prepayment plans and private health insurance companies, and the reasonableness of the rates for health services, all in a manner consistent with federal standards and guidelines. All the state agency's proceedings should be conducted within the usual requirements of due process through the establishment of appropriate mechanisms for both administrative and judicial appeals by those adversely affected. All existing and new regulations developed by or under the control of the state agency should be carefully assessed for their cost effectiveness.

**Summary**

*Principles and goals*

- Good health for all persons is fundamental to the best interests of our nation. Our nation's health and the health of all individuals reflects the combined efforts given to various elements, including the direct provision of health services, as well as adequate housing, proper nutrition, environmental hazard controls, public health measures, and personal choices of lifestyle.
- Financial, material, and human resources are limited, and one of the most difficult tasks facing the nation is the selection and support of an appropriate mix of available means for attaining and maintaining an acceptable level of health for all citizens.
- The maintenance of good health is the responsibility of each individual. However, health services should be made available to all individuals and should be so organized as to be readily accessible to all, but use of services should be based on need.

*The delivery of health services/health manpower*

- The system for the delivery of health services should have as its ultimate goal the best possible health services for all persons.
- The health delivery system should provide as comprehensive health services as possible within available resources, should focus on individual needs, be personalized through the skills and compassion of health personnel, and should recognize the dignity of the individual. Providers should meet generally accepted standards of effectiveness, quality, and efficiency.
- No single way of organizing medical and health care services can be developed for application to all communities. In fact, the diversity and adaptability of our current health delivery system is a strength that should be built on as the system evolves in the future. Innovation should be encouraged, and the benefits of alternative choice through a multiplicity of health care providers with varied types of organizational forms, sponsorship, and ownership should be preserved.
- Hospitals, as a key organizational component and resource for the delivery of health services to the community, should be involved in the coordination and implementation of changes in the system with or without UHI legislation. Effective steps should be taken now by hospitals to create appropriate changes in the system.
- Physician leadership and participation is essential in planning and developing new health delivery systems and innovative changes in hospital services.
- Whenever comprehensive health delivery systems are able to provide more accessible and effective delivery of health services, they should be encouraged. Such changes in the delivery system should be coordinated and implemented by health care providers, the patients served by these providers, and the community.
- A coordinated health manpower program provided through private sector leadership is necessary to ensure that competent health manpower with the required skills is available in sufficient number in the right setting to provide necessary medical and health care services at a reasonable cost.

*Financing health services*

- The financing program should reflect an equitable sharing of the cost of health care among all persons, recognizing differences in family income and eliminating for the poor and near-poor the financial barriers to the acquisition of good health care. Individuals who are able should contribute toward the cost of their care.
- Health care financing should promote a more effective means of allocation and more efficient use of resources in the delivery of health care through appropriate incentives for consumers, providers, insurers, and government.
- The financing program should support a viable and strong pluralistic health care delivery system for the nation by providing adequate financing to ensure the availability of good quality health care services.
- Multiple sources of financing should be used, including both private and governmental sources. Expansion of health insurance benefits should be phased in to gradually achieve more comprehensiveness. Government, at all levels, should not promise more than what can realistically be financed or delivered.
- Governmental contributions should be made through the purchase of basic health insurance benefits from prepayment plans and private health insurance companies for the aged, the disabled, the unemployed, and the poor and subsidization of the cost of insurance for the near-poor.
- The federal government should require employers to purchase a basic set of private health insurance benefits for their employees and their dependents, with appropriate employer/employee sharing of premium costs.
- Prospective payment methods, in conformance with federal standards, should be developed and implemented at the state level for determining rates of payment to qualified providers. Federal standards should (a) require that providers be approved in accordance with regulations for quality and adequacy of services to be eligible for payment; (b) define the adequacy of institution payment, as measured by the fiscal solvency of efficient and effective health care institutions, in accordance with the principles expressed in the AHA statement on the *Financial Requirements of Health Care Institutions and Services;* (c) permit physicians to be compensated by various methods of payment, such as fee for unit of time or service, capitation, salary, salary plus incentive, or combinations of these; (d) provide incentives for the use of that component of care that is most appropriate under the circumstances to provide the care economically; and (e) encourage providers to participate in comprehensive health delivery organizations.

*Regulation and controls*

- Government must place greater emphasis on developing a more coordinated, equitable, and cost-effective regulatory process for health services. The development of an improved regulatory system should be built on the existing structures at the state level.

- An independent regulatory agency, separate from the DHEW, should be established to separate the federal government's role as purchaser of care for specific population groups from its general responsibilities for regulating health care services in the public interest.
- This independent body should serve as the nation's primary agency responsible for the continuing assessment, surveillance, and policy development of the UHI program. Its authority would incorporate that of the existing federally-mandated bodies charged with those responsibilities.
- The DHEW should not have regulatory authority, but should continue to have programmatic responsibilities for such health-related activities as health manpower and training assistance, biomedical and health services research and development, public health, and certain additional administrative responsibilities for the UHI program.
- An independent agency at the state level, responsible for the effective administration of the federal regulations and guidelines, should be established or designated. This agency should be specifically prohibited from acting as either a purchaser or provider of health services.
- The state agency, within federal guidelines, should implement and conduct measures to ensure the quality of medical and institutional health care, planning and capital development of health resources, effective operation of prepayment plans and private health insurance companies, and the reasonableness of the rates for health services. Due process should be guaranteed through the right to both administrative and judicial appeals.

## GLOSSARY

*Aged*—individuals who are age 65 or over and are entitled to retirement benefits under the Social Security program or under the railroad retirement system.

*Allied health personnel*—those persons who support the work of physicians, dentists, and registered nurses in the areas of patient care, public health, health research, and environmental health. These persons may function in professional, technical, or supportive positions.

*Appropriate*—suitable to the particular conditions.

*Benefits*—those medical and health care services for which payment will be made, in whole or in part, by qualified prepayment plans and health insurance companies. The benefits included in the UHI legislation are described as the "basic set."

*Capitation*—the method of paying for a comprehensive or specific set of medical and health care services through a prenegotiated and fixed periodic payment made by or on behalf of each person or family unit enrolled in the plan.

*Comprehensive health care services*—provision of health maintenance, primary care, specialty care, restorative care, and health-related custodial care in order to meet the total medical and health care needs of the patient.

*Comprehensive health delivery system*—a system capable of providing comprehensive medical and health care services to a defined population group (refs. 2, 4).

*Cost*—the expenditure of resources.

*Credentialling*—the formal recognition of professional or technical competence involving the processes of accreditation of educational programs, the certification of individuals by a nongovernmental agency or association, or the licensure of an individual by an agency of government.

*Disabled*—individuals under age 65 who have been entitled for not less than 24 consecutive months to benefits under the Social Security program or under the railroad retirement system on the basis of a disability.

*Disadvantaged*—those individuals or groups who face inequity in access to medical and health care services, which may be due to, but are not limited to, such factors as: race, ethnicity, sex, age, religion, education, economic status, type of diagnosis, mental or physical handicap, language, geographic residence, or a combination of these factors.

*Ensure*—to make sure or certain that a task or function is carried out according to predefined and agreed-upon standards without necessarily directly carrying out that task or function.

*Equitable*—impartial, fair, or reasonable in judgment or dispensation.

*Good quality*—fully conforming to professional standards of medical and health care practice.

*Health*—a state of competence—of emotional, mental, and physical strength—enabling a person to set goals, investigate alternatives, make decisions, and take action to control his environment within the sphere for which, by nature and circumstance, he or she has been fitted (ref. 10).

*Health care corporation*—a comprehensive health delivery organization, franchised by state government, required to provide comprehensive health care services on a fee-for-service or capitation basis to individuals and their families who reside in the franchised geographic area and choose to register with the corporation (ref. 9).

*Health care institution*—establishment with permanent facilities and with medical services for patients, including inpatient care institutions and outpatient care institutions with organized medical staffs and home care institutions.

*Health care provider*—a comprehensive health delivery system, a health care institution, group, physician, or other individual providing personal medical or health care services.

*Health education*—the planned process that entails the joint identification of needs, the exchange of knowledge and concerns, and the clarification of personal responsibilities for health—all designed to encourage positive health practices and to improve the delivery of health care (ref. 5).

*Health maintenance organization*—a comprehensive health delivery organization providing comprehensive health care services on a capitation basis to individuals and their families who voluntarily choose to enroll with the organization.

*Health professionals*—those persons in health care occupations, as defined in the National Labor Relations Act, who have completed a prescribed course of specialized intellectual instruction and study over a prolonged period in an institution of higher learning or a hospital.

*Health services research and development*—the systematic process of adding to useful knowledge about the relationships between health resources and the health care of the population, either through discovery of new knowledge (research) or through new applications for existing knowledge (development) (ref. 7).

*Hospital*—an establishment that provides, through an organized medical staff, permanent facilities that include inpatient beds; medical services; continuous nursing services; and diagnosis and treatment, both surgical and nonsurgical, for patients who have any of a variety of medical conditions (ref. 1) and an organizational unit that brings together the special qualities of knowledge, skill, and community awareness of its governing board, the organizational expertise and management skills of administration, the medical knowledge and skill of its medical staff, and the professional capabilities of trained personnel (ref. 3).

*Medical and health care services*—the direct efforts of physicians, dentists, nurses, and other health professionals, regardless of the setting—institutional or noninstitutional—to meet the emotional, mental, and physical needs of people in obtaining or retaining health.

*Poor and near-poor*—poor refers to those persons and their families who, on the basis of national standards giving consideration to income, family composition, and living costs in a given area, will qualify for total support for health insurance and health care costs from government funds; near-poor refers to those persons and their families who, on the basis of similar national standards, will qualify for partial support for health insurance and health care costs from government funds.

*Postpayment*—method by which a patient's contribution toward the cost of medical or health care services is paid to his or her prepayment plan or private health insurance company after the care has been provided.

*Prospective payment*—the rates of payment for services are determined and agreed upon prior to rendering services.

*Rate of payment*—price or charge for medical and health care services.

*Regional planning*—the process by which community-related health goals are established and continually reevaluated by providers, purchasers, consumers, and public officials. Alternative methods for achieving these goals are identified, and assistance in the achievement of the goals through the most effective means possible within the limits of available resources is given. The process encompasses the activities of both private and governmental agencies, and advisory as well as formal regulatory functions (refs. 6, 8).

*Unemployed*—persons and their families who are receiving benefits under any federal or state unemployment compensation law.

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Senator KENNEDY. Thank you.

We welcome your comments.

You pointed out areas of agreement and areas of difference, and we want to explore both with you.

As I understand, in the United States, we average about 350 days of hospitalization per 1,000 population; is that approximately right?

Mr. MCMAHON. Yes, maybe a tad higher than that.

Senator KENNEDY. Do you know what the prepaid Kaiser-Permanente averages?

Mr. MCMAHON. Yes.

The Kaiser system, I think, gets down to somewhere in the 500 days of care per 1,000 range. We continue to look at that. We think the existence of that kind of prepaid health system has tended, in areas where it has existed—I do not know about the situation her in Denver—to have a restraining influence on the rest of the system, causing the traditional system to take a sharper look at itself to see how those days of care and, of course, the attendant costs, can be reduced.

Senator KENNEDY. We have in our own State of Massachusetts 11 HMO's, and there are about 450 to 475 days of hospitalization per 1,000. We have a very dramatic difference in some of the different delivery systems, from an average of somewhat 850 under the fee-for-service program, to anywhere from 450 to 500, for the basis of this discussion, in other programs, Kaiser-Permanente and HMO's. That is about a 35- to 40-percent reduction in the amount of hospitalization.

When you figure that 40 cents out of the health dollar is hospitalization and we are spending $160 billion. We are talking about 40 percent of that is hospitalization. When we see where today in a number of different delivery systems, the reduction of hospitalization by 30, 35, 40 percent, we are talking about potential savings of billions and billions and billions of dollars.

We just want to say that we look forward to working with the American Hospital Association on ways of trying to achieve those kinds of savings in the future, because it means taxes to consumers; it means premiums to those involved in paying for it, and it is an extremely important issue. It can be done.

We look forward to working with your association in finding ways of doing it.

Mr. MCMAHON. Clearly, a reduction in the rates of hospitalization has several advantages. There is a cost advantage. There is also a feeling we have that people do not really want to go to a hospital unless they have to. If we can take care of them as we have previously, if we can take care of them better on an outpatient basis, that is a very sound way to go; and I think the existence of some of these alternative systems are pointing out ways that we can indeed reduce the cost of the health care system.

Senator KENNEDY. Well, we will look forward to working with you on this, because we have seen where these other delivery systems outside the fees for service have meant very substantial savings to consumers. We are talking about millions of dollars.

Mr. MCMAHON. It also had an effect on the traditional system if you look at what has happened in Minneapolis-St. Paul. You find that the existence of HMO's there has brought about reductions in days of care in the traditional system.

Senator KENNEDY. The problem that we have had, quite frankly, within the medical profession of even adopting an HMO proposal when the impact of HMO's just on the health care system involves billions of dollars. We will spend about $28 million or $29 million this year in helping to start HMO's, $28 million or $29 million. But the potential savings are in the billions of dollars.

We fight that battle year after year with many of the different groups in our medical system who oppose, and oppose strongly, the development of competition within the health care system.

We welcome any final comments, but you and I can go on for a good deal of time. We will go to our final witnesses.

We have two final witnesses. Barbara Nichols, president, American Nurses' Association, and Teddy Langford, acting dean, School of Nursing, University of Colorado.

## STATEMENT OF BARBARA NICHOLS, PRESIDENT, AMERICAN NURSES' ASSOCIATION

Ms. NICHOLS. I am going to speak first. I am Barbara Nichols, president of American Nurses' Association.

Senator KENNEDY. We are very glad to have you here. [Applause.] That ought to warm you up a little bit on a cold day.

We have heard your organization speak for years on matters affecting nurses. We have worked very closely with your association in the past and look forward to that association in the future.

We are very mindful that you speak for a very important and significant element in the whole health care system. The nurses in many respects are closest to the patients. They have a very professional perspective on these issues. We are particularly grateful. I want to hear from you.

Ms. NICHOLS. Mr. Chairman, my remarks today will speak in support of the national health insurance principles you recently outlined.

As nurses, we see and experience in our daily work the results of the lack of an adequate health care system. This is why as an organization we support the concept that the goal of public health policy must be to make adequate health care available to all. [Applause.]

Ms. NICHOLS. As you know, and as you stated yourself, but I will reiterate, approximately 25 percent of the poor and near poor are not covered by any medicare or medicaid. The unemployed and newly employed often are without health insurance. Health services for many rural and inner-city residents are minimal, or nonexistent, and some of the testimony of the witnesses here today bore that out.

Other groups are discriminated against in various ways under the present insurance plan.

Divorced women, for example, frequently must pay disproportionately high premiums for their own health insurance, as so many divorced women stay at home with young children or work part time in one of many places that offer no fringe benefits as such to employees.

Many health insurance plans do not cover newborn infants. We heard that over and over today, particularly during the first 1 or 2 weeks after birth which, in fact, is the most critical time for the new born. This fact can result and does result in astronomical bills if the child should require intensive care or special procedures of any kind.

The American Nurses Association believes that a national health insurance program is essential in order to guarantee that all U.S. residents will in fact have access to full comprehensive health services.

Mr. Chairman, we refer to a health care system, but the system we have is not a health care system. It is a medical care system, an acute care system which focuses on trying to cure people after they become ill or patch them up after they have been injured or, God forbid, if you are old, relegate you to a nuring home. In other words, our present delivery system is focused on acute and chronic care, which relies primarily on the most expensive health care setting, the institution, and the expensive health care practitioner, the physician.

We believe that no national health insurance plan can be successful that does not make substantial changes in the present system. This would include changes in reimbursement policies to encourage alternative care settings. I am glad to hear Mr. McMahon say he believes that as well. We believe there must be much greater use of registered nurses and other nonphysician health care personnel.

We are pleased to note, Senator Kennedy, that the outline you have provided on national health insurance specifies comprehensive health service, including inpatient services, physicians' services, in and out of hospital, home health services, X–rays, lab tests and specified mental health benefits. We urge that the plan also include coverage for the following additional services:

Twenty-four-hour emergency care, rehabilitative care, full mental health benefits, dental care, nutrition services and supportive care—health teaching, counseling and health education, maintenance care. [Applause.]

Mr. NICHOLS. These services, for the most part, are not medical services, but are integral to the delivery of comprehensive preventive health care.

Additionally, the Kennedy plan, as outlined, makes no reference to nursing services as a covered benefit. You have said, and we agree, that nursing care is a key element in the delivery of health care in all settings. We believe that any comprehensive national health insurance plan must recognize registered, professional nurses as providers and must include nursing services as a benefit, regardless of the setting for that service; that is, home, clinic, hospital, school, nursing home, et cetera. [Applause.]

Ms. NICHOLS. The American Nurses Association has just concluded a series of public hearings across the country on the unmet needs of children and youth. These brought out most forcibly the "gaps" that exist in our health care for the young.

For example, one witness from the U.S. Public Health Service testified on the problem of adolescent pregnancy. He reported that each year in the United States, 1.1 million teenagers, ages 15 to 19, become pregnant.

In just one State, Georgia, there were almost 30,000 adolescent pregnancies in 1977, the majority of which were unwanted. It is estimated that 38 of every 100 12-year-old girls in Georgia in 1976 would have a live birth before she reached her 20th birthday, 1 out of 6 before age 18.

These pregnancies are associated with higher rates of complication due to anemia, toxemia, and caesarean sections. Teenagers have a 60-

percent greater chance than older women of dying as a result of pregnancy. Another tragic result is the higher rate of child abuse among teenage mothers because of the stresses associated with early childbearing. The abortion rate among teenagers is high.

Undoubtedly, one cause of this problem is the lack of health education for teenagers. Health education is an integral part of the nursing role. Regrettably, there is little emphasis on it in our present health care delivery and reimbursement system.

Another health care gap in this country relates to the care for mothers and infants, particularly among the poor and minorities. Eleven countries have a lower infant mortality rate than the United States.

A number of studies and experimental projects have demonstrated the impact of nursing care on infant mortality. For example, infant mortality has declined as a result of a maternal and child health project started by the University of Utah College of Nursing at the Shiprock, N. Mex., Indian reservation at the request of the Indian Health Service.

The infant mortality rate was dramatically reduced in a Mississippi county by the introduction of a program that used nurse midwives to manage normal obstetric patients and their babies. The mortality rate was reduced from 39.1 per 1,000 live births to 21.3. The neonatal mortality rate, which also was high, was reduced from 23.4 per 1,000 to 8.5.

Use of nurse midwives in a project in California resulted in a reduction in neonatal mortality from 23.9 per 1,000, to 10.3 per 1,000. The prematurity level dropped from 11 percent to 6.4 percent. Yet, reimbursement for nurse midwives continues to be an issue.

In these examples, and they are repeated in many other locations throughout the country, the key element is that care was made available where little or no care existed before. It shows that nurses can provide primary care, much of it preventive in nature.

Care of the dying has been receiving increasing attention. Ida Martinson, R.N., Ph. D., who has done outstanding research in this area, has investigated the concept of home care for the dying child.

The study was designed to identify the needs of the child and the parents during endstage cancer. The findings indicated that most children desire to be at home and most parents accept the home care concept and show that they can care for the child at home under the direction and with the support of a professional nurse.

In addition, analysis of costs in the study showed an estimated average of $1,200 for care at home, compared to costs for a similar group of children who died in the hospital whose average final hospitalization cost was $13,000. This certainly has implications for the health care delivery system and coverage by third-party payers.

Mr. Chairman, for all these reasons, we feel there is a need for comprehensive national health insurance. We applaud your concept in the national health plan and look forward to seeing the full details of your proposal.

I thank you for this opportunity to appear here today.

[Applause.]

[The prepared statement of Ms. Nichols follows:]

Testimony of

AMERICAN NURSES'ASSOCIATION

on

National Health Insurance

Denver, Colorado
November 29, 1978

Mr. Chairman, I am Barbara Nichols, president of the American Nurses' Association. I am director of inservice education at St. Mary's Hospital Medical Center in Madison, Wisconsin.

ANA is the professional association of registered nurses with some 200,000 members. As nurses, we see the results of lack of adequate health care. We see the gaps -- sometimes they seem more like chasms - in our present health care system. Perhaps this is why as an organization, we support the concept that the goal of public health policy should be to make adequate health care available to all. We were one of the early supporters of Medicare. We believe that only through a comprehensive national health insurance program can we hope to provide all Americans access to health care services of an acceptable quality.

By conservative estimates, at least 20 million Americans have no health insurance. Of those that do, an estimated 65 million lack adequate protection against the costs of long-term illness and other catastrophic expenses. The rapidly growing elderly population will intensify the demand for the full range of health services--from home care to institutional care. Perhaps a quarter of the total aged population requires some type of care for chronic illness.

Approximately 25% of the poor and near poor are not covered by Medicare and Medicaid. The unemployed and newly employed often arewithout health insurance.

The maldistribution of health care services has added to the nation's problem, although recent federal efforts in this area are beginning to show progress. Health services available to many rural and inner city residents are minimal or nonexistent. Efforts to implement the Rural Health Clinics Amendment have been frustrated by long standing barriers to access and the predominately illness and acute care focus of the health care system.

In a paper presented recently before the American Academy of Nursing, Elaine McCarty, a Family Nurse Practitioner in rural Maine, noted that the "uninsured are relatively young, low income, poorly educated, and urban. This is the group that is less healthy, pays more in out-of-pocket expenses for health care, and has a higher number of hospitalizations."[1]

Other groups are discriminated against in various ways under present insurance plans.

Divorced women, for example, frequently must pay disproportionately high premiums for their own health insurance, as so many of these women must stay at home with young children or work part-time in one of the many places that offer no fringe benefits to such employees.

Many health insurance plans do not cover newborn infants for the first one to two weeks after birth. This is a most critical time and can result in astronomical bills if the child should require intensive care or special procedures of any kind.

The American Nurses' Association believes that a national health insurance program is essential in order to guarantee that all U.S. residents will have access to health care services. It should provide coverage for full comprehensive health services for all U.S. residents.*

*Attached are ANA Resolutions (1974 and 1978) on National Health Insurance.

Accessibility of health care is, of course, a key element. Ease of access is determined by several factors. Most pertinent are physical access, including flexibility in the scheduling of times to accommodate the client and locations that the client can reach; and financial access permitted by the system. Insurance defines both physical and financial access to the provider. If reimbursement for services is limited to one group of health professionals, this obviously limits access by excluding other health professionals, such as nurses, who can and do provide services in a variety of settings--schools, neighborhood health centers, public health departments, and the home.

Mr. Chairman, we refer to a "health care system," but the system we now have is not a health care system. It is a medical care system - an acute care system which focuses on trying to cure people after they become ill or putting them back together after they have been injured, or, if they are older, putting them in a nursing home. In other words, it is focused on acute and chronic care and relies primarily on the most expensive health care setting, the institution, and the most expensive health care practitioner, the physician.

We believe that no national health insurance plan can be successful that does not make substantial changes in the present system. This should include changes in reimbursement policies to encourage alternative care settings and much greater use of registered nurses and other non-physician health care personnel.

We are pleased to note that Senator Kennedy's national health insurance plan would provide comprehensive health services, including in-patient services, physician's services in and out of hospital, home health services, x-rays, lab tests and specified mental health benefits. We would urge that the plan also include coverage for the following additional services: 24-hour emergency care, rehabilitative care, full mental health benefits, dental care, nutrition services and supportive care (health teaching, counseling and health education, maintenance care). These services, for the most part, are not medical services, but are integral to the delivery of comprehensive preventative health care.

Additionally, the Kennedy plan, as outlined, makes no reference to nursing services as a covered benefit. Nursing care is a key element in the delivery of health care in all settings. We believe that any comprehensive national health insurance plan must recognize registered, professional nurses as providers and must include nursing services as a benefit, regardless of the setting for that service, i.e. home, clinic, hospital, school, nursing home, etc.

In most hospitals, nursing service is an income producing department. However, nursing service costs, as well as certain other service costs, have traditionally been lumped in the multi-purpose category of routine operating costs of institutions. This practice has prevented true cost accounting and is one factor hampering the development of a financially responsive health care system. We believe that separate identification not only would provide a more accurate financial picture but would enable the consumer to better evaluate nursing care. It would also serve to increase the nurse's sense of accountability to the patient, encouraging the nurse to see herself as a provider of nursing care for the patient rather than a provider of nursing service for the hospital.

We urge that attention be given to providing that insurance programs clearly spell out covered health care services and allow the consumer to choose and have access to services of nurses and other health care professionals. Nurse providers, whether they are self-employed or employees of an institution or agency, can authorize appropriate nursing services. Insurance programs should not require the payment of a fee to a physician for signing a claims form for reimbursement of services which are provided by nurses with nursing authority.

We recognize that there can be different approaches to reimbursement for nursing services depending upon the variety of settings or organizational arrangements (i.e. hospital, home care agency, independent group practice, HMOs, etc.).

We also applaud the Kennedy plan's emphasis on preventive care. Access to preventive care services can eliminate the need for later, more acute care, with tremendous savings in terms of human suffering as well as dollars.

The American Nurses' Association has just concluded a series of public hearings across the country on the unmet health needs of children and youth. These brought out most forcibly the "gaps" that exist in our health care for the young.

One witness from the U.S. Public Health Service[2] testified on the problem of adolescent pregnancy. He reported that each year in the United States, 1.1 million teenagers, ages 15-19, become pregnant. In just one state, Georgia, there were almost 30,000 adolescent pregnancies in 1977, the majority of which were unwanted. It was estimated that 38 of every 100 12 year old girls in Georgia in 1976 would have a live birth before she reached her 20th birthday, one out of six before age 18. These pregnancies are associated with higher rates of complication due to anemia, toxemia and caesarean sections. Teenagers have a 60 per cent greater chance than older women of dying as a result of pregnancy. Another tragic result is the higher rate of child abuse among teen age mothers because of the stresses associated with early childbearing. The abortion rate among teenagers is high.

Undoubtedly, one cause of this problem is the lack of health education for teenagers. As the witness at our hearing said, "We have failed to influence our youth on the health issues associated with sexual activity. They are poorly educated and not trained in the decision process necessary to lead healthy lives. Many have passed decision points in their lives without an awareness that a choice existed."

Teenage drinking and alcoholism is another increasing health problem among youth. A witness at our hearings[3] cited one recent survey of teenage drinking among students in grades 7 through 12. It showed that 74 per cent of the teenagers were drinkers - 79 per cent of the boys and 70 per cent of the girls. Among this group of drinkers, 19 per cent were experiencing alcohol-related problems. Approximately 3.3 million of

the 17 million youth in the 14 to 17 age range are having adverse effects from their drinking. Combining alcohol with other drugs is part of the problem. Suicide is the second leading cause of death among adolescents, and there is a strong correlation between alcohol use and suicide. Alcohol can cause birth defects and behavioral impairment in the offspring of mothers who drink excessively during pregnancy.

One witness at the ANA hearings challenged nursing to take a leadership role in dealing with these problems. She said:

"Nurses have entree into almost every setting necessary to effective prevention, early intervention, treatment and rehabilitation: the home, schools, business and industry, the community, clinical settings, etc.; you are in an ideal position to assume a leadership role."

We would agree. Health education is an integral part of the nursing role. Unfortunately there is little emphasis on it in our present health care delivery and reimbursement systems.

As noted by the witness at our hearings, the professional nurse is in a key position to promote the development of health education programs in industry, health maintenance organizations, hospitals, nursing homes, physicians' offices, out-patient clinics, home health agencies, public health departments, schools. We would urge that this present and potential contribution not be overlooked in the formulation of new health policy directions.

Another gap in health care in this country is for mothers and infants, particularly among the poor and minorities. Eleven countries have a lower infant mortality rate than the United States.

A number of studies and experimental projects have demonstrated the impact of nursing care on infant mortality.

Infant mortality has declined as a result of a maternal and child health project started by the University of Utah College of Nursing at the Shiprock, New Mexico Indian reservation at the request of the Indian Health Service.

The project was to demonstrate that primary care for women and children can be provided by nurse practitioners. An initial staff of three nurse midwives was employed. The project director attributes the success of the project to the fact that the certified nurse midwife fits in well with the lay midwife of the Navajo culture as well as a policy that was adopted allowing Indian agencies to take over project functions as soon as they were able to do so effectively.

Present staff includes 43 nurse midwives, pediatric nurse specialists, family nurse practitioners, obstetricians, pediatricians and other health care workers. The nurses provide preventive care, well child checkups, family planning assistance, and follow up care after hospitalization. They manage normal labor and deliveries and minor health problems and refer serious cases to the IHS medical team.

The infant mortality rate was dramatically reduced in a Mississippi county by the introduction of a program that used nurse midwives to manage normal obstetric patients and their babies. The mortality rate was reduced from 39.1 per 1,000 live births to 21.3. The neonatal mortality rate, which also was high, was reduced from 23.4 per 1,000 to 8.5.

Use of nurse midwives in a project in California resulted in a reduction in neonatal mortality from 23.9 per 1,000 to 10.3 per 1,000. The prematurity level dropped from 11 per cent to 6.4 per cent.[4] Yet reimbursement for nurse midwives continues to be an issue.

In these examples, and they are repeated in many other locations throughout the country, the key element is that care was made available where little or no care existed before. It shows that nurses can provide primary care, much of it preventive in nature.

Much of it also is supportive in nature, and one way to prevent future difficulties is to correctly identify the need for care at given times. For example, the critical time for a young mother may not be during the immediate prenatal and postpartal periods when health care services tend to be concentrated, but during the first month at home with the new baby. It can be critical to the healthy development of both the family and the infant. It is then when few have contact with any health care professionals that the family need for support and guidance may be acute. This gap in care was investigated in a recent study.[5] Frequently, public health nurse referrals are made only for "problem" patients while the mothers in the study were considered "normal." Only 8 of 40 mothers in the study were visited at home by a public health nurse.

Care of the dying has been receiving increasing attention. Ida Martinson, R.N., Ph.D., who has done outstanding research in this area, has investigated the concept of home care for the dying child. The study was designed to identify the needs of the child and the parents during end-stage cancer. The findings indicated that most children desire to be at home and most parents accept the home care concept and show that they can care for the child at home under the direction and with the support of a professional nurse. In addition, analysis of costs in the study showed an estimated average of $1200 for care at home compared to costs for a similar group of children who died in the hospital whose average final hospitalization cost was $13,000. This certainly has implications for the health care delivery system and coverage by third party payers.

The present system of reimbursement does not encourage home care. Certainly, restrictions on payment for home health visits by nurses constitute a weakness in the present reimbursement policies. For example, Medicare provides payment for only ten days of care for cataract surgery patients. This, in effect, covers medical care. It provides little recognition of the fact that cataract patients, usually elderly people, may require assistance once they have returned home. They may live alone and be unable to administer prescribed eye drops. Physical disabilities may prevent them from carrying out other prescribed procedures or to care for themselves in other ways.

One Visiting Nurse Service reports the instance of a cancer victim patient who was discharged home after surgery. The physician ordered dressing changes of the surgical wound three times a week. The man could not change his own dressing which was on his back. His wife had severely limited vision and could not change the dressing. The physician asked the VNA to handle the case. The insurer deemed the three dressing changes medically unnecessary and denied payment to the VNA for two dressing changes. If the dressing changes had been performed in the hospital they would have been reimbursable.

Home visits by nurses must be approved by a physician to be reimbursed. In this case, even the physician's order was not approved. If the VNA itself determines that a person requires nursing visits, insurers will not reimburse.

Follow up home care is often essential to the recovery of patients. Home care often can prevent the need for older patients to go into nursing homes.

However, our present wasteful reimbursement policies give little attention to these realities.

We strongly support the inclusion of home health services as outlined in the Kennedy plan.

As I mentioned in the study of care of the dying child, the most humane care may also be the most cost effective.

There have been a number of recent research projects on the cost effectiveness of nursing care. One program of patient care research conducted by Jean E. Johnson, R.N., Ph. D., Wayne State University School of Nursing, showed that a nursing therapeutic intervention can significantly reduce the time required for recovery from illness, increase the probability of obtaining optimum results from medical procedures and reduce patients' negative emotional response to those procedures. The theory is quite simple. The nurses simply help the patients to understand what is going to happen to them, what sensations to expect and the order and time of activities. Among patient subjects of the research were children having an orthopedic cast removed and adults receiving gastrointestinal endoscopy examinations.

In the case of abdominal surgical patients, for example, it was shown that patients given this kind of preoperative information were judged by their surgeons to be ready for discharge from the hospital significantly earlier than patients in control groups. They also returned to usual activities earlier than the control groups.

The Medical Care and Research Foundation here in Denver has conducted studies comparing the delivery of primary care by physician only (control) and by the adult health nurse practitioner/physician team (experimental). Results showed the greater achievement of health care goals per dollar expended was in favor of the experimental pattern particularly for the homebound elderly. The mean cost per patient for the homebound elderly was $2,473 under the experimental project and $4,017 under the control program.

In the control pattern (physician only) the patients' health care goals were achieved through greater use of hospitalization, diagnostic procedures, consulting physicians, surgery consultations and supportive services from community agencies. In the experimental pattern (adult health nurse practitioner/physician team), the patients' health care goals were achieved through greater use of primary care visits and therapies. The number of nursing home days was slightly higher in the experimental pattern.

We commend the inclusion of mental health benefits in the Kennedy plan. In this area again, we find that current law limits not only the types of professionals providing care but also the settings in which such care is delivered. Consequently, services of qualified psychiatric-mental health nurses and other qualified mental health practitioners are severely restricted. The result is that mental health services are unavailable to many who need them.

We think that provisions comparable to those for physical illness should be made for psychiatric-mental health care, ending the present discriminatory treatment in public financing against people with mental disabilities.

We are concerned that there seems to be insufficient provision in the Kennedy plan for informing the public of the availability of covered services. We suggest that the final bill provide some guidance with regard to informing the public of the benefits available and of the procedures to be used in securing them.

It is encouraging that the Kennedy plan incorporates existing mechanisms of peer review and health planning. These mechanisms should be developed into a more comprehensive system which will provide for active participation in the decision-making processes by nursing and other health professions.

The nursing profession is committed to the establishment of peer review systems whereby providers of nursing care services can be held accountable by consumers and third party payors for the effective and appropriate utilization of nursing services of high quality.

The American Nurses' Association supports the concept of health care cost containment. The current system, with its overreliance on hospitals and its emphasis on acute care has proved enormously expensive. One proper response to skyrocketing health care costs should be a shifting away from the use of expensive, in-patient facilities and toward the imaginative use

of less expensive ambulatory services which are very often more appropriate delivery mechanisms in the first place. We share Senator Kennedy's concern that savings not be made at the expense of wage increases for low paid, non-supervisory health care workers who only now are beginning to achieve parity with comparable workers in other sectors. (Recent HEW figures show clearly that wage inflation in the health care sector is well below the inflation in other health care sector costs.)

In addition, we believe the following factors not evident in the Kennedy plan should be considered in designing a cost containment system:

1. Voluntary cost controls should precede any mandatory controls.
2. Hospitals should be classified according to size and geographic location.
3. Cost controls should be extended to the suppliers of the health care industry, i.e. manufacturers, utilities, vendors, and to all providers and insurance carriers.

We thank you for the opportunity to appear here today and we would be happy to answer any questions.

NOTES

1. McCarty, Elaine Edith, Primary Care By Nurses: Sphere of Responsibility and Accountability. American Academy of Nursing, paper presented at Annual meeting, Washington, D.C., September 17-19, 1978, p. 10.

2. McCarthy, Brian J., M.D., HEW, PHS, Center for Disease Control, "Unmet Needs of Adolescents...Adolescent Pregnancy;" Testimony before the ANA, Oct. 10, 1978, Atlanta, Georgia.

3. Archer, Loran, Acting Director of the National Institute on Alcohol Abuse and Alcoholism; paper presented at ANA Youth Health hearings, Nov. 14, 1978, Washington, D.C.

4. Levy, B.S. et al. "Reducing Neonatal Mortality Rate with Nurse Midwives," American Journal of Obstetrics and Gynecology. Vol. 109, 50-57.

5. Gruis, Marcia. "Beyond Maternity: Postpartum Concerns of Mothers." The American Journal of Maternal Child Nursing (May/June 1977), 182-188.

#53

AMERICAN NURSES' ASSOCIATION

RESOLUTION TO REAFFIRM THE 1974 ANA HOUSE OF DELEGATES

RESOLUTION ON NATIONAL HEALTH INSURANCE

WHEREAS The House of Delegates of the American Nurses' Association has repeatedly called for the enactment of a national health insurance program, and

WHEREAS The American Nurses' Association has for many years worked for a national program providing universal coverage for comprehensive health care services, and

WHEREAS The American Nurses' Association has for many years called for a national health insurance program that would guarantee to all people access to health care services of an acceptable quality as a basic human right, therefore be it

RESOLVED That the 1978 ANA House of Delegates reaffirm the Resolution on National Health Insurance adopted in 1974, and be it

RESOLVED That in order that urgent health care needs of people be met the association work for early congressional action to provide for a humane and rational system of health care services, and be it

RESOLVED That the national health policy of the United States of America should include an integrated system for delivery of health care services that recognizes nurses as essential providers of care, and the services of nurses as an essential benefit of the system, and be it further

RESOLVED That the national health policy of the country recognize the authority of nurses for nursing practice, and the delivery of nursing services.

Adopted by the 1978 House of Delegates

HOUSE OF DELEGATES
RESOLUTION
NATIONAL HEALTH INSURANCE

WHEREAS: health, a state of physical, social and mental well-being is a basic human right, and

WHEREAS: government at all levels must act to insure that health care services are provided for all citizens, and

WHEREAS: there is a need for integrated systems to deliver comprehensive health care services that are accessible and acceptable to all people without regard to age, sex, race, social or economic condition, and

WHEREAS: there is a need for a national program designed to correct serious inadequacies in present health care delivery systems, and

WHEREAS: nursing care is an essential component of health care; therefore, be it

RESOLVED: that the American Nurses' Association aggressively work for the enactment of legislation to establish a program of national health insurance benefits, and be it further

RESOLVED: that the national health insurance program guarantee coverage of all people for the full range of comprehensive health services, and be it further

RESOLVED: that the scope of benefits be clearly defined so that they can be understood by beneficiaries and providers alike, and be it further

RESOLVED: that the national health program clearly recognize the distinctions between health care and medical care; and that the plan provide options in utilization of health care services that are not necessarily dependent on the physician, and be it further

RESOLVED: that nursing care be a benefit of the national health program, and be it further

RESOLVED: that the data systems necessary for effective management of the national insurance program protect the rights and privacy of individuals, and be it further

RESOLVED: that the plan include provisions for peer review of services that will protect the right and the responsibility of each health care discipline to monitor the practice of its own practitioners, and be it further

RESOLVED: that there continue to be a system of individual licensure for the practice of nursing, and be it further

RESOLVED: that provision be made for consumer participation in periodic evaluation of the national health insurance program, and be it further

RESOLVED: that the national health insurance program be financed through payroll taxes or payment of premiums by the self-employed, and purchase of health insurance coverage for the poor and unemployed from general tax revenues, and be it further

RESOLVED: that ANA strongly urge the designation of nurses as health providers in all pending or proposed legislation on National Health Insurance.

Adopted by ANA House of Delegates
June 10, 1974

# Summary of
# Testimony of
# AMERICAN NURSES' ASSOCIATION

on

National Health Insurance

Denver, Colorado

November 29, 1978

Mr. Chairman, we speak in support of the NHI principles which you recently outlined.

As nurses, we see the results of lack of adequate health care. We see the gaps - sometimes they seem more like chasms - in our present health care system. Perhaps this is why as an organization, we support the concept that the goal of public health policy should be to make adequate health care available to all. We were one of the early supporters of Medicare. We believe that only through a comprehensive national health insurance program can we hope to provide all Americans access to health care services of an acceptable quality.

Approximately 25% of the poor and near poor are not covered by Medicare and Medicaid. The unemployed and newly employed often are without health insurance.

The maldistribution of health care services has added to the nation's problem, although recent federal efforts in this area are beginning to show progress. Health services available to many rural and inner city residents are minimal or nonexistent. Efforts to implement the Rural Health Clinics Amendment have been

frustrated by long standing barriers to access and the predominately illness and acute care focus of the health care system.

Other groups are discriminated against in various ways under present insurance plans.

Divorced women, for example, frequently must pay disproportionately high premiums for their own health insurance, as so many of these women must stay at home with young children or work part-time in one of the many places that offer no fringe benefits to such employees.

Many health insurance plans do not cover newborn infants for the first one to two weeks after birth. This is a most critical time and can result in astronomical bills if the child should require intensive care or special procedures of any kind.

The American Nurses' Association believes that a national health insurance program is essential in order to guarantee that all U.S. residents will have access to health care services. It should provide coverage for full comprehensive health services for all U.S. residents.

Mr. Chairman, we refer to a "health care system," but the system we now have is not a health care system. It is a medical care system - an acute care system which focuses on trying to cure people after they become ill or putting them back together after they have been injured, or, if they are older, putting them in a nursing home. In other words, it is focused on acute and chronic care and relies primarily on the most expensive health care setting, the institution, and the most expensive health care practitioner, the physician.

We believe that no national health insurance plan can be successful that does not make substantial changes in the present system. This should include changes in reimbursement policies to encourage alternative care settings and much greater use of registered nurses and other non-physician health care personnel.

We are pleased to note that Senator Kennedy's outline for national health insurance provides for comprehensive health services, including in-patient services, physician's services in and out of hospital, home health services, x-rays, lab tests and specified mental health benefits. We would urge that the plan also include coverage for the following additional services: 24 hour emergency care, rehabilitative care, full mental health benefits, dental care, nutrition services and supportive care (health teaching, counseling and health education, maintenance care). These services, for the most part, are not medical services, but are integral to the delivery of comprehensive preventive health care.

Additionally, the Kennedy plan, as outlined, makes no reference to nursing services as a covered benefit. Nursing care is a key element in the delivery of health care in all settings. We believe that any comprehensive national health insurance plan must recognize registered, professional nurses as providers and must include nursing services as a benefit, regardless of the setting for that service, i.e. home, clinic, hospital, school, nursing home, etc.

The American Nurses' Association has just concluded a series of public hearings across the country on the unmet health needs of children and youth. These brought out most forcibly the "gaps" that exist in our health care for the young.

One witness from the U.S. Public Health Service testified on the problem of adolescent pregnancy. He reported that each year in the United States, 1.1 million teenagers, ages 15-19, become pregnant. In just one state, Georgia, there were almost 30,000 adolescent pregnancies in 1977, the majority of which were unwanted. It was estimated that 38 of every 100 12 year old girls in Georgia in 1976 would have a live birth before she reached her 20th birthday, one out of six before age 18. These pregnancies are associated with higher rates of complication due to anemia, toxemia and caesarean sections. Teenagers have a 60 per cent greater chance than older women of dying as a result of pregnancy. Another tragic result is the higher rate of child abuse among teenage mothers because of the stresses associated with early childbearing. The abortion rate among teenagers is high.

Undoubtedly, one cause of this problem is the lack of health education for teenagers. As the witness at our hearing said, "We have failed to influence our youth on the health issues associated with sexual activity. They are poorly educated and not trained in the decision process necessary to lead healthy lives. Many have passed decision points in their lives without an awareness that a choice existed."

Another gap in health care in this country is for mothers and infants, particularly among the poor and minorities. Eleven countries have a lower infant mortality rate than the United States.

A number of studies and experimental projects have demonstrated the impact of nursing care on infant mortality. For example, infant mortality has declined as a result of a maternal and child health

project started by the University of Utah College of Nursing at the Shiprock, New Mexico Indian reservation at the request of the Indian Health Service.

The infant mortality rate was dramatically reduced in a Mississippi county by the introduction of a program that used nurse midwives to manage normal obstetric patients and their babies. The mortality rate was reduced from 39.1 per 1,000 live births to 21.3. The neonatal mortality rate, which also was high, was reduced from 23.4 per 1,000 to 8.5.

Use of nurse midwives in a project in California resulted in a reduction in neonatal mortality from 23.9 per 1,000 to 10.3 per 1,000. The prematurity level dropped from 11 per cent to 6.4 per cent. Yet reimbursement for nurse midwives continues to be an issue.

In these examples, and they are repeated in many other locations throughout the country, the key element is that care was made available where little or no care existed before. It shows that nurses can provide primary care, much of it preventive in nature.

Care of the dying has been receiving increasing attention. Ida Martinson, R.N., Ph. D., who has done outstanding research in this area, has investigated the concept of home care for the dying child. The study was designed to identify the needs of the child and the parents during end-stage cancer. The findings indicated that most children desire to be at home and most parents accept the home care concept and show that they can care for the child at home under the direction and with the support of a professional nurse. In addition, analysis of costs in the study showed an estimated average of $1200 for care at home compared to costs for a similar group of

children who died in the hospital whose average final hospitalization cost was $13,000. This certainly has implications for the health care delivery system and coverage by third party payors.

The Medical Care and Research Foundation here in Denver has conducted studies comparing the delivery of primary care by physician only (control) and by the adult health nurse practitioner/physician team (experimental). Results showed the greater achievement of health care goals per dollar expended was in favor of the experimental pattern particularly for the homebound elderly. The mean cost per patient for the homebound elderly was $2,473 under the experimental project and $4,017 under the control program.

In closing, I would just like to mention several factors not evident in the Kennedy plan which we believe should be considered in designing an NHI cost containment system:

1) Voluntary cost controls should precede any mandatory controls.

2) Hospitals should be classified according to size and geographic location.

3) Cost controls should be extended to the suppliers of the health care industry, i.e. manufacturers, utilities, vendors, and to all providers and insurance carriers.

I thank you for the opportunity to appear here today, and I would be happy to answer any questions.

Senator KENNEDY. Wonderful. In the meantime, we can work on reenacting the nurse training amendment. [Applause.]

Ms. NICHOLS. We will look forward to your support of that endeavor.

Senator KENNEDY. You have it, on that and on these other areas.

Very constructive comments.

We will now hear from Dr. Teddy Lanford.

## STATEMENT OF DR. TEDDY LANGFORD, ACTING DEAN, SCHOOL OF NURSING, UNIVERSITY OF COLORADO, REPRESENTING THE COLORADO NURSES ASSOCIATION

Dr. LANGFORD. I am Dr. Teddy Langford, acting dean of the school of nursing at the University of Colorado. I am here today representing the Colorado Nurses Association.

Mr. Chairman, we are truly delighted that you have come to Colorado to receive input regarding the need for comprehensive national health insurance programs.

The State is a good example of both urban and rural health needs. As a result of our geography and population distribution, we have developed some innovative health care delivery programs.

These programs can be used as illustrations of the major points I would like to emphasize today. One of those points is that one important aspect to be considered in any planning of a national health insurance is provision of preventive health services and the development of incentives for provision and/or utilization of those services.

This is borne out by McClure's anaylsis that for any form of national health insurance to be successful in promoting changes in health economically, it must produce changes in the structure and incentives of the system which provide care.

Clearly, preventive care can be promoted through nursing, a practice discipline which has long had a concern with the promotion of the health and comfort of individuals and families.

You are aware, I know, that the first practitioner program was begun at the University of Colorado some 10 years ago. While it was very controversial at the time, the concept has now been greatly accepted nationwide.

In this connection, I would like to say that nurse practitioners do not replace physicians. There seems to be some confusion about this. But by more effectively using the skills of nurses and physicians working as colleagues, the public will receive better health care.

The nurse role and the physician role are not merely greater or lesser degrees of a single role, but are complementary in providing high-quality primary health care.

Each role constitutes a different emphasis of practice. The nurse's best emphasis is on preserving and promoting wellness no matter where he or she practices, in acute care or primary care. However, it is in primary care, such as in the nurse practitioner role, that the nurse can have the greatest impact on promoting self-care and perhaps ultimately a change in the health status of citizens.

Nurse practitioners deliver care in a variety of settings including but not limited to homes, ambulatory care centers, health maintenance

organizations, schools, industries, and physicians' offices. One primary focus of activity of nurse practitioners is in the care of children. This is the key target group for preventive care.

The future of the country's population is dependent on the health care delivery system's capacity to identify and prevent and treat health problems of our Nation's youth. Yet there is overwhelming evidence that, despite our sophisticated health technologies, the needs of children are not being adequately met.

The suicide rate among adolescents is increasing alarmingly. The accidental death rate, which is the No. 1 killer of youth, continues to climb.

Child abuse incidents abound, although much has been done to identify the characteristics of the potentially abused and the abuser. I might add this effort has been assisted largely by the National Center for Child Abuse here in Colorado.

Veneral disease and teenage pregnancy rates are all on the increase. Immunization programs today are inadequate, so that we are beginning once again to see the crippling effects of preventable childhood diseases such as measles and polio.

Identifying and dealing with such problems before they become acute is largely ignored in current health care financing systems. Preventable health care problems in children cut across all income levels.

Judith Igoe, project director of the school nurse practitioner program at the University of Colorado, states that:

> Money alone will not solve the problem of nonutilization of traditional health facilities for preventive purposes * * * unfortunately, most families in most serious financial need view preventive health services as a luxury they neither understand or cannot afford in terms of time, energy, and transportation costs.

Preventive services for children are not limited to an annual physical examination, immunization update, and medical followup, but include dental health services, accident prevention, health, nutrition and family life, education and guidance, and counseling services.

Access to these services is limited by more than just economic status. Prevention seems to be undervalued by a society attuned to the acute care focus of our health care system. School health programs provide a way to change that orientation.

Innovative health programs can and have been implemented in the school systems which will provide comprehensive preventive services.

For example, Deanna Hanna, a school nurse practitioner for the Denver public schools, in her testimony before the American Nurses Association hearings on the unmet needs of youth, said accident prevention for school-age children should be a national priority.

Ms. Hanna proposed a largely school-based program utilizing a multidisciplinary approach. School nurses are in a strategic place to provide preventive services for children and adolescents. These nurses are frequently the child's first contact to the health care system.

Although school health programs have been around for a long time, the effectiveness of these programs is intimately related to the amount of funding available for these services.

When communities cut the school budget, school health services are the first to feel the impact. It is reasonable, therefore, to consider school health services as covered benefits under a national system of health insurance.

Health services should be reimbursed on the basis of service and not the setting or the provider. In this case, delivery of these services can best be facilitated by utilizing an existing structure, the school.

As I mentioned, Colorado, is where the nurse practitioner movement began and today nurse practitioners are providing care in rural areas where little or no care existed before. Passage of the rural health clinics bill, which provides reimbursement under medicare and medicaid for nurse practitioner services in rural clinics is recognition of the importance of this development. It should be recognized in any national health insurance program.

However, it is not only the services of the nurse in primary care which are properly considered for reimbursement, though the nurse practitioner, the primary care nurse, certainly offers services which are quite legitimately reimbursable.

The acute care nurses, those practicing in hospitals and other inpatient facilities, provide key nursing services as well. Among those services are comfort measures, administration of various treatments, patient education and counseling services, to mention a few.

In pursuit of cost containment so vital to the success of any national health insurance plan, it would be an important concept to consider the direct reimbursement of nursing services as an item separate from the basic room rate. [Applause.]

Dr. LANGFORD. In this fashion, the specific types of care thus rendered could be better identified and greater accountability affixed for the rendering as well as the results of these services.

The example I have just mentioned serve to emphasize my first point, that preventive care must be emphasized in any national health insurance plan and that nurses can be a key element in providing that care.

Another major point that I would like to make is that consideration in making the changes in structure and incentives in the system of care should be geared to promoting delivery of care in nontraditional sites.

As mentioned above, schools are one example of such sites. The development of the hospice, a type of care to provide the terminally ill and their families with nonhospital care toward a peaceful death is another.

We have examples of hospices here in the Denver-Boulder area. You have today visited another alternative, the birth center. Nurses there provide safe, effective and satisfying care to child-bearing families. A small group of nurses worked with a group of elderly persons in Brighton, Colo., a rural community north of Denver. That group created their own health promotion center in their senior activities center. Surely each of these is a legitimate health care site for in fact health care can and is being rendered there. I will echo the words of Dr. Ingeborg Mauksch:

> There are many shortcomings in our present system of health and illness care delivery. One is that consumers must go where services are. If services were brought to where people are—factories, schools, residential complexes, old-age communities, industrial areas and so forth—utilization would increase and health care would become more economic.

Certainly, my perspective and that of Colorado nurses is that nursing can and should have a large part to play in improving our Nation's health.

It is unfortunate that President Carter recently chose to veto the Nursing Training Act. That was done in the face of the estimates of need for continuing the present levels of graduation of new nurses, even under the present circumstances.

In the light of the potential passage of some form of national health insurance and resulting role reformulation, there are estimates for considerable increases in need for registered nurses. Clearly, funds to support nursing education will continue to be necessary.

It is our conviction that additional public and private financing of health care services directly will not guarantee that health care is accessible to all.

What is needed is the development of integrated systems to deliver comprehensive health services which are accessible and acceptable to all people.

The traditional modes of health care delivery and the financing of health care services have not been able to achieve this end. We are pleased that your draft legislation emphasizes preventive health care and we are encouraged by your willingness to fully explore the issues and consider nontraditional answers to health care delivery.

I personally would like to thank you very much for a very thought-provoking morning. [Applause.]

Senator KENNEDY. A very helpful statement.

We will have a chance to examine it in greater detail in the record.

We want to thank you for joining with us and being part of this morning's hearing.

We have just 10 minutes left, and we have a series of names on our list. We will take the first 10 names on the list and give each one a minute. That is the way we will have to do it.

The ones that do not have a chance to testify, if they will just take a moment and write to us in the Senate Health Committee, we will include your testimony as a part of this total record. We will keep the record open for 10 days. We will ask you, within the next couple of days, if you will just write down your observations or comments and send them on in and we will make that a part of the record of this hearing.

Your views will be considered and included as a part of the total record of this hearing. I wish we could be able to hear from all of you. I know it is an additional burden to have to write your comments down. But for those that we do not get to, we will let you do that.

The first name on the list is Thomas Allen, Denver Indian Health Board.

## STATEMENT OF THOMAS ALLEN, EXECUTIVE DIRECTOR, DENVER INDIAN HEALTH BOARD

Mr. ALLEN. Mr. Chairman, I have prepared a brief and general statement regarding American Indians in urban areas.

I am executive director of the Denver Indian Health Board, a non-profit community organization, incorporated in the State of Colorado in January 1978.

This organization was formed in the interest of the urban American Indian community of Denver metropolitan area.

The focus of this organization is on the health status of American Indians who have migrated to this urban center for educational, economic, and whatever other reasons a person moves to large urban centers.

The goal of the Denver Indian Health Board is to provide physical and mental health services to both residents and transient Native American people located in the Denver metro area on an outpatient and inpatient basis as funding and facilities shall permit.

Currently, the Denver Indian Health Board is directing its efforts in educating and informing the urban Indians who reside in Denver about the existing public sector health delivery system and how to utilize the same.

The funding for these services is provided by the Department of Health, Education, and Welfare, Indian Health Service. The Indian Health Service has trust responsibility for providing health care to American Indians who through treaties negotiated for these services to be provided by the Federal Government.

These same trust responsibilities have statutes and limitations that exclude a person based on the geographic location in which this person chooses to live. In most cases, this applies to the American Indian who resides in large urban centers such as Denver. Only within the last decade has the Indian Health Service made a major effort to provide health care to the urban Indians by funding projects such as the Denver Indian Health Board.

The recent passage of Public Law 94–437, The Indian Health Care Improvement Act, has allowed the Indian Health Service to provide moneys to urban Indian organizations under title V of that law. Although specifically listed in this law, appropriations for this title are too low to provide adequate care for American Indians residing in urban areas.

American Indians coming to the urban centers are unprepared to assume the responsibility or liability of health care. These actions are based on previous experiences with the Indian Health Service which is entrusted with providing health care to Amercan Indians at no cost. When faced with the prospect of having to pay for these services in urban areas, many Indian people do not seek medical care or are forced to return to their points of origin to receive health care.

National health insurance would provide a positive method for the American Indians in urban areas to obtain adequate health care being provided by the public sector system.

The present Indian Health Service system must be maintained to insure the American Indian is not going to be overlooked in this issue of health care, as they have been in the past. Although entrusted with the responsibility of providing health care to the American Indian, the Indean Health Service has been inadequately funded to do an adequate job.

National health insurance should be used to insure continuance of a health system that has trust and treaty responsibilities to the American Indian, and it should no way be viewed as a method to circumvent these responsibilities.

Senator KENNEDY. We know Dr. Johnson very well, head of the Indian Health Service, and we work very closely with him and con-

tinue to. He actually testified earlier, just about 1 year ago. We are enormously interested in the role of the Indian Health Service in any kind of national health insurance.

Beverly Myers, a staff member of our committee, visited Denver about a year ago and met with a number of different Indian groups. We have met with the National Indian Health Board in Denver and also Pueblo Tribes of New Mexico. We want to work with them and we are very conscious of the special role that the Indian Health Service has.

Our next witness is Charles A. Banderob, of Ballantine, Mont., representing the Montana Senior Citizens Association.

## STATEMENT OF CHARLES A. BANDEROB, PRESIDENT, MONTANA SENIOR CITIZENS ASSOCIATION

Mr. BANDEROB. Mr. Chairman and members of the committee, ladies and gentleman, I am Charles A. Banderob of Ballantine, Mont., a small rural town of 500 people. I am president of the Montana Senior Citizens Association, a statewide organization of senior citizens, and at their annual State convention, the delegates adopted the following resolution:

Whereas, medicare and medicaid do not eliminate the financial burden of senior citizens and;

Whereas, most senior citizens throughout the State of Montana are in financial difficulties;

Be it resolved, that Montana Senior Citizens Association will support and urge passage of the Kennedy-Corman National Health Security Act.

Be it further resolved that MSCA contact all other organizations in the State and urge them for concurrence in this matter.

The above action was taken because of the ever-increasing cost of health care, to the point to where is it a constant threat to the well-being of not only the senior population but also to a high percentage of the entire population.

This constant insecurity is due to the high cost of health services and insurance, to where it has become one of the major causes of the poor health conditions of our Nation.

Every local chapter of the Montana Senior Citizens Association has not one or two cases, but many cases where families have had health conditions develop, due to no avoidable fault of their own, which has caused them to lose their homes or has caused them bankruptcy, or near so.

This is a sad state of affairs, for a Nation which professes to be as intelligent and wealthy as we do.

I have also submitted some attachments to my written statement.

[The prepared statement of Mr. Banderob with accompanying attachments follow:]

Ballantine, Montana
Nov. 1978

TESTIMONY FOR A NATIONAL HEALTH SECURITY ACT.

Senator Kennedy, members of the committee, ladies and gentlemen, I am Chas.A.Banderob of Ballantine, Montana a small town on the The Huntley Irrigation Project, the first Federally developed irrigation project in the nation, to be completed. 1904 to 1907.

The inflated cost of health services and or care, and the lack of addiquate insurances or the prohibitive cost of adiquate health insurance coverage, has become a scurge that threatens far to high a percentage of our population, and under recent inflation it has become a real night-mare that haunts many of us day and night.

Harry Boulion of Acton,Montana had a modest wheat farm, a wife and stepsons, he was stricken with a stroke, and spent many long years in a hospitial, it took his home, and farm, his wife died over the ordeal, and he spent his last several years in the county hospital, at local tax payers expence, something he had spent much of his time and tallent attempting to avoid happening to anyone.

Just recently a family in the Huntley community had health conditions develope with one of their youngsters, with unsuremountable doctor and hospitial bills, and the community had to solisit funds to help out, but not enough. This area has had to try on several occations, to raise funds to help out some unfortinite family, others are struggeling under doctor bills and hospitial bills that may yet take their farms or homes.

Any type of insurance system that may become a part of A National Health Security system, should be a non-profit cooperative system that is owned and opperated by the clients. The others have been at this all these years, and look at the insecure health state of affairs we are in as a nation.

I am attaching several attachments dealing with this issue.

Signed: Chas. A. Banderob

Attachment no. 1

11-26-78

# Medical bills stagger families

By JEANNIE CROSS
Gazette State Bureau

HELENA — This Thanksgiving, Mr. and Mrs. Joe Russell were grateful for two things: their 10-month old daughter is alive and they paid only $5,000 of their own money to keep her that way.

Other Montana families aren't so lucky. One couple has $60,000 in medical bills and a dead child — bills from court-ordered surgery to which they objected.

The names in this article are changed. The facts aren't.

And the facts are:

— Many Montana families don't have sufficient insurance to cover their children's catastophic or chronic ailments;

— Federal medical aid can be used to get people healthy but not keep them that way;

— The state doesn't have the money to bail Montanans out of medical bills that can mount to $400,000.

The results are tragic.

For example, there's a student at Rocky Mountain College in Billings who in January will have to chose between continuing his college education or living. He's a hemophiliac whose blood won't clot, making the slightest cut or bruise a death-defying experience. The federal Supplemental Security Income (SSI) program will pay for the $3,000-$4,000 worth of blood concentrate he needs annually to stay alive — if he doesn't work. But he has to work to come up with next semester's tuition. And he can't work enough hours to pay for both college and the concentrate.

**Nurses help to extend health care — Page 1D**

Another example: Mr. and Mrs. Richard Terry have two hemophiliac sons. One is married and pays his own bills. The other is in eighth grade and requires a minimum of $350 worth of the concentrate a month, according to his mother. This spring he also needed treatment for bleeding in his kidneys and stomach and for a paralyzed arm — all of were caused by an accident in which two older children fell on him.

Terry is a self-employed farmer, his wife works part-time as a hospital aide. They can't get medical insurance that will cover their son's expenses.

"We've tried," Mrs. Terry said. "But it's a big joke."

How do the Terry's pay for their boy's treatment? They don't.

"You just owe," Mrs. Terry said. Currently they have some $5,000 in unpaid medical bills.

Hemophilia, leukemia, respiratory diseases in newborn infants, kidney dialysis — all are expensive to treat; few are covered fully by federal, state or private insurance programs.

"Some of these bills total more than our entire budget," says Dee Capp, program manager of the handicapped children's bureau with the state Department of Health and Environmental Sciences. "These people need a lot more than they're getting but there's nothing to give them."

The bureau's budget from state and federal funds for 1978-79 is $486,797. There's a Billings baby who's been hospitalized in Denver since he was born prematurely in

(More on Medical, Page 1D)

## Medical

FROM PAGE 1

April weighing one pound. The child's bills already total $400,000, Capp said — and the family's insurance company pulled out in August.

"The system doesn't work," Capp said.

One of her pet peeves is the SSI program. Not only does it require a recipient to be poor, it pays only for critical medical care. This means hospitalization is covered, but not medication that could prevent a person from having to be hospitalized.

Insurance coverage is similar. An insurance company will pay for round-the-clock care in a hospital, but nothing for a nurse in the home. So a parent either keeps her child in the hospital or quits work to stay a home and play nurse or hires a nurse out of her own pocket.

And many families have no insurance, Capp says — particularly the ones who most need it.

The SSI and insurance exclusions are counter-productive, many feel. One parent noted that if insurance covered the concentrate needed by her hemophiliac son, he wouldn't be crippled and need braces and physical therapy — much more expensive items that are covered by the insurance.

Some Montana families faced with these problems have been asked to submit testimony to U.S. Sen. Edward Kennedy, D-Mass., who will hold a hearing Nov. 29 in Denver on his nationl health insurance plan. A Kennedy aide said some families may be flown to Denver to testify in person if their plight is great enough.

Attachment no. 2 Banderob*

Gazette

Thursday
October 5, 1978
Billings, Montana 59103
94th Year, No. 156
Single Copy 25 Cents

# Medics warned: Cut costs or face controls

## Health

FROM PAGE 1

Gov. Judge praised the state's doctors for setting up one of the country's first professional standards review organizations.

He also urged hospitals to submit rate increases to the Montana Hospital Rate Review Commission and abide by the commission's decision as to whether the increases are justified or not.

Nationally, hospital costs rose 16 per cent in 1976-77, well ahead of the rate of inflation. Wednesday's speakers said they hoped a combined effort among providers would slow the health cost increase to 13 or 14 per cent this year.

A sense of combined effort was, in part, the point of the conference. It was an unprecedented attempt to get the different members of the health industry to unite against the threat of national health insurance.

The increasingly controversial role of nurses in the medical picture was discussed in a speech by Lucie Kelly, a New Yorker representing the American Nurses Association.

Nurses, buoyed by the women's rights movement, are exchanging their "not-too-bright-but-kind" image, Mrs. Kelly said, for one of independent professionals who can deliver the kind of primary care once given only by a doctor.

Health costs could theoretically drop if doctors let nurses take over some primary care duties.

"Unfortunately," Mrs. Kelly said, "some physicians see the new nursing role as an economic threat, and harass both individual nurses and physicians and nurses in joint practice."

Another speaker, W. Daniel Barker, president of the American Hospital Association, said that hospitals, under pressure to lower rates, are in a squeeze between the government, the insurance companies, and the doctors.

Barker partly blamed the growing numbers of elderly — who demand a proportionately large amount of medical care — for rising costs. He also said that federal regulation itself added $15 billion to annual medical costs.

Dr. James Cope of Forsyth, president of the Montana Medical Association, delivered the strongest invective of the day against federal intervention in the medical field.

"Irresponsible ideological zealots such as (Sen. Edward) Kennedy and his lot" should not be allowed to bring in national health insurance, Dr. Cope said.

He argued that high quality, high technology health care is expensive, and he called it "a bargain" compared to what the public spends on tobacco, alcohol, and toiletries.

"Unless there is a radical change in the political climate," Dr. Cope said, "all signs point to more, not less, controls."

By KERRY PECHTER
Of The Gazette Staff

Rampant costs in the health industry were the theme of a parade of speakers in Billings Wednesday, as nurses, doctors and health administrators from around the state gathered for the First Montana Health Congress.

The convention crowd, including several hundred nurses, and the speakers, including Gov. Thomas Judge, agreed that the nation's medical costs are too high. But there was wide disagreement about why.

The dominant note was general resentment of federal intervention in the form of the new Health Systems Agencies (HSA) and a feeling that Montana's private "health providers" could put their own house in order if the bureaucrats would only leave them alone.

But Governor Judge warned the medical fraternity that time was running out.

Noting that Montana hospital operating costs increased 75 per cent between 1971 and 1976, compared to 70 per cent nationally, the governor said:

"Either we succeed in cutting those costs or the growing anger and frustration of the people of America — and of Montana — will result in more regulations."

Judge urged less hospitalization and more home health care, greater awareness by consumers of personal health, and warned that the tax reform movement will mean fewer state Medicare dollars in the future.

(More on Health, Page 12A)

ATTACHMENT
NO. 3

| Companies selling Medicare Gap Insurance Policies | Ratio of losses to premiums earned |
|---|---|
| **ABOVE 50%** | |
| Guardian Life Insurance Company of America | 88.51 |
| West States Insurance Company | 79 |
| Inter-Ocean Insurance Company | 69.4 |
| ITT Life Insurance Corporation | 67 |
| Banker's Multiple Line Insurance | 63.7 |
| Mutual of Omaha Insurance Company | 61.4 |
| Aetna Life Insurance Company | 58.9 |
| Industrial Life Insurance Company of Dallas, Texas | 54.84 |
| Colonial Penn Group, Inc.* | 52 |
| **BELOW 50%** | |
| United Equitable Life Insurance | 43.9 |
| Federal Life and Casualty Company | 43.7 |
| Old American Insurance Company | 41.55 |
| Continental Life and Accident Company | 38.2 |
| Constitution Life Insurance Company | 35.4 |
| Cosmopolitan Life Insurance Company | 28 |
| National Home Life Assurance | 31.83 |
| Mutual Life Insurance Company of New York | 29.4 |
| New York Life Insurance Company | 28.1 |
| American National Insurance Company | 26 |
| Medico Life Insurance Company | 22.76 |
| Pacific Mutual Life Insurance Company* | 21.6 |
| Beneficial Standard Life Insurance | 16.8 |
| Pennsylvania Life Insurance Company | 16.5 |

Editor's note: Companies surveyed by Senior World were limited to those collecting $50,000 or more in premiums. In the case of companies which sold multiple lines of Medicare gap policies, loss ratios were recorded for the highest-selling policy. Most loss ratios filed with the insurance department are based on nationwide sales; companies marked by * indicate loss ratios for California alone.

Attachment no. 4

5-7-79

# State lacks funds for implementing health options

By JEANNIE CROSS
Gazette State Bureau

HELENA — The Montana Health Systems Agency (MHSA) wants to increase the alternatives to nursing homes and expand medical in-service training, but it has no money to do so.

Established in 1976 under federal public health laws, MHSA is charged with annually reviewing Montana medical services, identifying public health improvement projects, and helping fund those projects.

MHSA has just completed its first such review and project plan. Its seven proposals would cost an estimated $20,000 to implement. But federal Area Health Development Funds, which are supposed to fund agency proposals, aren't available and MHSA has no idea when or if they will be.

In the meantime, MHSA may seek grants from the Old West Regional Commission and federal Rural Health Initiative program.

Here's a summary of MHSA's seven proposed projects for 1978-79:

- Encourage the Richland County Health Department in Sidney to expand its home health care services to include such things as advice on nutrition, social and homemaking services, pharmacy services, and speech and physical therapy.

- Encourage the Yellowstone City-County Health Department to geographically expand the range of home health services it now provides to Yellowstone, Carbon, Stillwater, Big Horn, Mussellshell, and Golden Valley counties.

- Conduct a feasibility study of building "personal care homes" for the elderly in Richland and Custer counties. The homes would not provide any nursing services, but would help residents with meals and personal care, such as washing and dressing. MHSA will work with the state Department of Social and Rehabilitation Services (SRS) on this project. SRS currently is planning a number of additional alternatives to nursing home care.

- Activate Health Learning Centers in Sidney and Great Falls to serve eastern and north central Montana, respectively. During 1978-79 each center would provide four programs on health issues and techniques for area doctors, nurses, and other health personnel. Each state hospital district has a learning center, but only those in Missoula and Billings are really active,according to MHSA. MHSA says the Sidney and Great Falls centers could supplement these.

MHSA has found the following institutions eligible for funds by virtue of poor layout or outdated facilities: Cooney Convalescent Center, Helena; Sweet Grass Community Hospital, Big Timber; Toole County Hospital and Nusing Home, Shelby; McCone County Hopital, Circle; Garfield County Hospital and Nursing Home, Jordan; Madison Valley Hospital, Ennis; Granite County Memorial Hospital, Philipsburg; and Big Sandy Medical Center.

July 5-14-79

## Deaconess room rates rise

On July 1, rates at the Billings Deaconess hospital were increased an average of 14.5 percent.

That means the daily semi-private room charge has risen from $87 to $104; the private room from $92 to $109; and the private deluxe room from $97 to $114.

The Montana Hospital Rate Review System Board of Directors, with Ella Mae Cromer as chairman, examined financial and statistical information for the hospital before the new rates received approval.

Inflation in the cost of personnel and supplies and increased services were the major contributing factors to the increased rates, the chairman said.

# Primary care an unmet need in U.S. — study

WASHINGTON (UPI) — To meet America's shortage of primary health care physicians, an Institute of Medicine committee Wednesday called for financial incentives to encourage more doctors to enter the field and the underserved rural areas.

The panel said the supply of doctors is increasing rapidly in the United States and may be 60 percent greater in 1990 than today. But it said too many will be specialists and not enough will provide the basic, personal, relatively low-cost care most people need.

Only 44.8 percent of today's doctors provide primary services.

To induce more doctors to provide primary care, the committee recommended that physicians be paid the same by insurors for similar services whether they are general practitioners and family physicians or specialists such as cardiologists and general surgeons.

Dr. E. Harvey Estes, the committee chairman from Duke University, said at a news conference many specialists now enjoy both roles — providing specialized services as well as primary service. He said the panel recommendation would force a doctor to choose one role or another.

Estes said, for example a family physician might charge $20 for stitching a child's minor leg laceration while a plastic surgeon might charge $100 for the same care.

Senator KENNEDY. Thank you very much. We will have that for the record.

Bernie Tessler, Denver, Colo., Mountain Plains Congress of Senior Organizations.

## STATEMENT OF BERNIE TESSLER, MOUNTAIN PLAINS CONGRESS OF SENIOR CITIZENS, DENVER, COLO.

Ms. TESSLER. You mentioned the low number of doctors who accept assignment of medicare and medicaid in many States. The number of doctors who accept assignment is very low in this region. In Wyoming it is only 17 percent, South Dakota is 32 percent, and North Dakota is 25 percent.

My question is: If we are going to keep medicare in place under national health insurance, what can we do to raise the assignment rate for medicare, part B, or how can we make it mandatory?

Senator KENNEDY. What we are going to do is, we improve the benefits and we require the payment in full for the acceptance of the program. That is the only way we will be able to do it. That is the only way we are going to be able to do it. This has to be an essential aspect of it. Otherwise, it is a partial Band-Aid solution to it.

We will be comprehensive and deal with principle kinds of concerns that elderly people have in both inpatient and outpatient facilities. We do not get into the long-term extended care for the elderly, which is a very important problem. We are going to have to deal with that at some point down the road.

With regard to medicare, we improve significantly the benefit package and mandate that they have to take the payment in full.

Next, let me ask Dr. Roman Hought.

## STATEMENT OF DR. ROMAN HOUGHT, NEUROSURGEON, BOULDER, COLO.

Dr. HOUGHT. My name is Dr. Roman Hought. I am a local neurosurgeon from Boulder, Colo.

Recently, I finished 3½ months in Great Britain where I worked in a hospital over there, hand in hand with surgeons. I know a minute is not very much time.

I would like to point out what their chief complaint with the national health insurance system is. They say that due to the bureaucratic redtape involved with implementing necessary health care situations in the hospital—namely, lack of personnel and lack of necessary equipment that they cannot get because of redtape—there is a decrease in the quality of health care in that system. It makes the physician, the surgeon, the dentist, much more aware of the quantity that is forced upon them. In their opinion, it decreases the quality of health care.

My fear is, if this health care system is initiated in this country, the excellence of health care that we do have in the United States will be decreased.

Thank you.

Senator KENNEDY. Thank you.

Next is Marilyn Baise.

## STATEMENT OF MARILYN BAISE

Ms. BAISE. I wanted to make a statement.

I certainly share the need to provide adequate health care for all people. I think we would be shortsighted to sacrifice the quality of the present medical and acute medical care system. We do not have a Massachusetts General, Houston Burns Center, et cetera, across the border.

I would like to point out the obvious need to involve other medical care providers in the development of a national health care plan.

Senator KENNEDY. Good comment.

Don Ballard.

## STATEMENT OF DON BALLARD

Mr. BALLARD. Speaking as a person who has twice had to pay medical expenses for my son, I think I can congratulate the Canadians a great deal on the apparent excellent care they are getting.

The problem that I want to address is this: Our son has a lung disease for which we have tried to get insurance. We realize that we will not be able to provide coverage for it on our own plan where I work. What is he going to do when he becomes 5, when, the doctor says, he will probably have a very severe emphysema?

This, to me, points up the need for a plan.

I want to congratulate the Canadians for the good plan they have.

Senator KENNEDY. Elizabeth Powell.

## STATMENT OF ELIZABETH POWELL

Ms. POWELL. I was quite amused when the nurse made the comment concerning people being patched up. I have been patched up for years and I am still going.

One of the questions I wanted to ask Senator Kennedy is, will this be a mandatory law on national health insurance?

Senator KENNEDY. Will it be mandatory?

The answer is, it will be universal, it will be.

Ms. POWELL. Then you are in trouble from me.

Senator KENNEDY. Just like social security.

Ms. POWELL. I have got news for you right now. I will take you to the Supreme Court. I do not believe in things being shoved down my throat. I am an American citizen. I pay my way. I have a right to choose what I want. I do not want you to shove it down my throat. I don't care who you are. You can be the King of Siam for all I care.

My next question is: How will national health insurance be paid? How are you going to finance it?

Senator KENNEDY. By an earnings base premium.

Ms. POWELL. On the young people——

Senator KENNEDY. Employee and employer, yes.

Ms. POWELL. You are going to burden the young people again. I worked for 40 years.

Senator KENNEDY. Every one of the witnesses that we had up here worked and they are paying their share.

Ms. POWELL. I am not popular and I know it. I just wanted to say my piece.

Senator KENNEDY. Fine.

Ms. POWELL. I feel we have too much Government as it is. I am an American citizen and I have a right to speak.

Senator KENNEDY. You certainly do. We are glad to have your comments.

Wonderful.

Ms. POWELL. I have said it.

Senator KENNEDY. Next we will have Robert B. Sawyer, M.D.

## STATEMENT OF ROBERT B. SAWYER, M.D., PRESIDENT, COLORADO MEDICAL SOCIETY

Dr. SAWYER. I am Dr. Sawyer, Senator. I am president of the Colorado Medical Society. I appreciate the chance to say something.

We have submitted written testimony.

I would like to point out some reasons that we think it is a little unique from the other ones you have heard. I know you usually get the usual medical rhetoric.

We pinpointed some individual things where we go around the State. We do believe this is more a State than a national issue.

I understand the general concerns that you have and things of that nature. Let me speak on the physician's problem.

He looks at the bureaucratic redtape and the impact that this will have on the people and himself. We know that you as a Senator do not have a heck of a lot of control over what those bureaucrats do.

The bottom line has been the experience with all the other Government programs which all of us are faced with, the overwhelming interference in the way it is run by nonelected officials.

Thank you, sir.

Thanks for coming. You have made our whole day. [Applause.]

Senator KENNEDY. One point is that it would be administered completely by the State, through the State, at the State level. We hope you get a look at that——

Dr. SAWYER. The initial impetus comes from the top, from the Department of HEW, just like the other things, just like medicare, and medicaid, and all these problems, but people are not getting a fair shot——

Senator KENNEDY. I completely agree they are not getting a fair shot.

Dr. SAWYER. People understand that the medical care system is expensive, but the political things are expensive, too.

Senator KENNEDY. Fine. That is true.

John Cox, and then Mr. Reed, and that is the end, I am afraid. That will be 10 people.

## STATEMENT OF JOHN COX, M.D.

Dr. COX. My name is Dr. Cox. I practiced for 5½ years in Ontario, Canada, where I believe you visited a couple of years ago. I must disagree entirely on the situation in Canada.

I believe that we definitely need a health care program, but to model it after the Canadian plan would be catastrophic, not only on the quality, but the accessibility and the economy.

Dr. McHugh[?], Treasurer of the Canadian Government, has worried about the spiraling health costs. Since 1960, health care costs in Canada have gone up 424 percent and in the United States has only gone up 324 percent.

The average hospital stay in Canada is 1.8 days per average citizen, and in the United States it is 1.2. This is in spite of the extensive home care programs that they have in Canada.

I realize there are problems, but for the Government to run it would be catastrophic. It should be done at the local level.

When it was run on our county medical program, our overhead was 20 cents on every premium dollar, and with the Provincial government, it ran 80 cents on every premium dollar.

They are closing down hospitals, rural hospitals, and limiting the number of ambulances available and eliminating the number of renal dialysis machines, and they are rationing health care in an attempt to cut costs.

Thank you for the opportunity to speak.

[Applause.]

Senator KENNEDY. Mr. Reed?

## STATEMENT OF JOE REED, CARTEZ, COLO.

Mr. REED. Mr. Senator, I am Joe Reed from down in the southwestern part of Colorado.

We have heard much this morning about the cost of medical care. I am greatly concerned about the cost of it, but there is something worse: when you have no medical care, such as we have in rural areas.

The people in our county 3 years ago elected to build a county hospital to try to straighten out our medical problems in that area. It is controlled by two groups of doctors which will not let new doctors come into the area. They are denied hospital privileges.

The people in Delores County, some 50 miles away—understand in this area our towns are 50 or 75 miles apart—the people in Delores County got together and, through some health care, got some help and set up medical clinics. The local doctors in the area will not even help staff that clinic on one afternoon a week. A doctor has to come from Durango, Colo., some 80 miles, for that. So I certainly believe, Senator, we need to go just a little farther perhaps than national health insurance. We need national health care.

Thank you. [Applause.]

Senator KENNEDY. Very fine.

We will ask the others to submit their testimony.

[The statements referred to follow:]

Colorado Congress of Senior Organizations
910 Sixteenth Street
Denver, Colorado 80202
303-892-5672

December 14, 1978

Senate SubCommittee on Health
United States Senate
Suite 2227
Washington, D.C. 20510

Gentlemen:

Enclosed you will find written testimony on health costs submitted by two Program for Local Service Vista volunteers, affiliates with our organization. These volunteers were unable to be in Denver on November 29, 1978 when the Committee held its hearings.

Would you please submit this testimony into the record for the November 29th hearings.

Thank you for your consideration.

Sincerely,

Carole Baker
Executive Assistant

CB:ds
Encls.

TO: Senate Sub Committee on Health
U. S. Senate
Suite 2227
Washington, D.C.

A lady 67 years of age - multiple health problems
Artificial hips (2) A heart pacer
Arthritis, Diabetis - Insulin Hypodermic

| | |
|---|---|
| INCOME | |
| Social Security | $ 147.00 |
| Interest | 30.00 |
| | $ 177.00 |
| MONTHLY EXPENSES | |
| Federal Housing rent | $ 47.00 |
| Blue Cross/Blue Shield | 40.00 |
| Car insurance | 29.00 |
| Telephone | 5.65 |
| Medication | 55.00 |
| Groceries/incidentals | 60.00 |
| | $ 236.65 |

This lady does babysitting and housekeeping chores for persons who have medical problems, both elderly and those in need, to supplement her income, when she is able. She has a 1963 automobile which she uses to get around in. She was taken to the hospital Oct. 2 with hi-sugar (350) unconscious - was in intensive care under oxygen four days and continued oxygen for another week; hospitalized a month. By mid-November she was asking me to find places for her to work. The Congregate Meals Project needed volunteers (Title VII) _ she helped a week and got her meals for this. Then she went to care for two children in a home whose parents needed to be away for a short time. This lady just won't give up. The small amount of money she gets interest from keeps her from getting old age pension and medicaid ($229.00 per mo.) When she was able she was one of the most helpful volunteers. A divorce put her in great financial need. Her recent illness has really caused her to be in a bad financial situation.

Guidotta Bates
815 Edmunds
Brush, Colorado 80723

Senate SubCommittee on Health
U.S. Senate Suite 2227
Washington, D.C.

1. Approximate income of family less than $ 200.00

2. Insurance coverage None

3. Medicals bills per day in nursing home 27.50

4. Had some savings but soon that will be gone.

Both are in their 80's

He must travel to Grand Junction to see her (252 miles round trip)

Lucile Lieber

Box 66

Eagle Colorado 81631

November 27, 1978

Senator Edward Kennedy
United States Senate
Washington, D.C.

Dear Senator Kennedy:

On approximatley November 15, 1978 at 11:15 A.M. a Mr. Walter Sharadon called me stating he was calling from your Washington office. I expressed my concern regarding Health Issues as they effect a single person household. He remarked he was very interested in my views. He also informed me that on November 29, 1978, I would be allowed to express my concerns at St. Thomas 22nd and Dexter.

Recently I read in the local newspaper that for the November 29, 1978, 5 families from Colorado have been selected ~~in~~ addition to five families from Canada.

I do not believe this selection reflects a well rounded picture of Health Issue in the United States.

I am willing and able to address the health issue as it effects single person households, plus elderly single person households.

Thank you for your attention,

Ann Caldwell

Ann Caldwell
3425 Dahlia
Denver, CO 80207

cc: Gary Hart

UNIVERSITY OF COLORADO
MEDICAL CENTER

CONTAINER C287
4200 EAST NINTH AVENUE
DENVER, COLORADO 80262
(303) 394-7435

SCHOOL OF NURSING & SCHOOL OF MEDICINE
CONTINUING EDUCATION SERVICES
SCHOOL NURSE PRACTITIONER PROGRAM

INFORMATION ON SCHOOL NURSE PRACTITIONERS

It has long been accepted that health care for the school-age child ideally should be provided by the child's primary physician with the school physician, the school nurse, and other health professionals in the school serving as additional resources. Over the past five years, we have been able to demonstrate that much of the care and many of the services required by school-age children can be given by school nurse practitioners. Utilization of these specially educated and highly qualified health professionals can serve as one of the most direct and feasible means of adding to the quality, availability, and continuity of health care for children.

In many school districts, school nurses have become secretaries with nursing degrees, spending much of their time on clerical work such as keeping children's medical records up-to-date. Many school nurses spend only about one-fourth of their day in delivering direct health care to children. With problems such as these, more and more schools are turning to school nurse practitioners for comprehensive health care delivery. The school nurse practitioner has advanced skills in school health nursing and is able to provide quality care for children in the school setting.

With their advanced training, school nurse practitioners are able to:

Prepare a health history with information provided by the child and those responsible for the child, i.e., parent or other relative.

Conduct a comprehensive physical exam including neurological testing and laboratory tests.

Provide immunizations.

Test and evaluate the child's physical, cognitive, social and emotional development.

Diagnose and treat children who are ill or injured while at school (in more severe cases, the school nurse practitioner will refer children to physicians).

Provide health education for children, teachers, and parents. The thrust of the school nurse practitioner's health education efforts with children is to encourage them to take responsibility for their own health care.

Monitor the school's physical plant to see that is is safe for children, teachers, and staff. The school nurse practitioner checks such items as sanitary conditions in restrooms, locker rooms, food preparation, and eating facilities; classroom lighting and seating; and playground conditions.

Provide evaluative, rehabilitative, and counseling services to physically and mentally handicapped children and their families. This is particularly important with increased numbers of physically and mentally handicapped children being integrated into regular schools across the nation.

Work with other professionals in helping children receive quality health care and health education. These professionals include teachers, school administrators, physicians, dentists, nutritionists, hearing and speech therapists, learning disabilities specialists, school psychologists, social workers, and counselors.

In addition to the services of a school nurse practitioner, a school health aide (or aides) is an important part of the program. An aide does clerical work and is trained to administer minor first aid. This frees the school nurse practitioner to deliver direct health care to children. High school students with career interests in health are serving as aides in some schools.

School nurse practitioners are trained not only to deliver health care but to offer health education programs as well. In some districts, this may mean directing the total health education program or planning health education classes to be taught by classroom teachers. Or it may mean actually teaching health subjects in a classroom when called upon by the teacher. Health education with children and parents regularly occurs on an informal one-to-one basis at the school health clinic.

Encouraging and teaching children to take part in their own health care is the major educational aim of the school nurse practitioner program. Children in the lower grades are taught to prepare their own immunization charts, while older children are taught to prepare their own health histories for their personal physicians or the school nurse practitioner. Children are taught appropriate first aid measures such as how to cleanse and care for their own injuries at school, and high school students are taught how to manage their own minor illnesses.

## SUMMARY

There are more than 50 million school children in the United States and 30% of them never visit a doctor's office, clinic, or hospital except for extreme illness or emergency care. Many of these children do not have a basic health care source and even when personal physicians, hospital-based clinics, neighborhood health centers, or other health facilities are available, the children are not brought to them for the care they require. Many children have emotional disturbances, perceptual handicaps, disorders of speech, or other difficulties, but because of the lack of early assessment and care of physical, emotional, and learning disorders, the children develop progressively more severe problems which may go unrecognized and adversely affect their health and ability to learn.

Since children between the ages of 5 and 18 years are readily accessible in the school, the school can serve as a site where a more complete picture of an individual child's health and educational problems can be ascertained and more responsible evaluative and preventive services can be provided by well-trained health professionals under the overall supervision of physicians. More extensive use of the school as a setting where health care is provided would significantly increase the likelihood that the health needs of school-age children are met.

Testimony for the Nov. 29 sub-committee hearing in Denver, Colorado

Yesterday, I attended Sen. Kennedy's sub-committee hearing on N.H.I. After the testimony from the six Colorado families and the six Canadian families, Sen. Kennedy asked if we had any questions to ask the Canadians about their health delivery system. I stood up and raised my hand, but he said he only wanted to hear what the Colorado families who had testified thought, that I would be given an opportunity to speak later. He then held a short recess for the twelve families to leave before he heard the additional testimony.

I had two questions to ask the Canadian families: Who pays for this 'cradle to grave' health care? And who paid for the Canadians trip to Denver?

I was under the impression that congressional sub-committee hearings are to hear testimony on all points of view concerning the issue. The twelve families who testified clearly represented one side. Shouldn't there have been time for some critics of the Canadian health delivery system. I have heard some very very alarming things that have happened to the quality of care and abuse to the system!

I believe Sen Kennedy is sincere in his backing of N.H.I. but I think he is being misinformed. His charts comparing Canadian expenditures to the U.S. were misleading, and I wonder if he realizes that the Canadians pay substantially less for aid to other countries, national defense, space programs, etc. and yet their taxes are higher than ours and their dollar is worth less! He also mentioned that rising costs in physicians fees and hospital co sts can only be controlled by mandatory caps. He must realize the three primary reasons for this rise is labor, materials, and the cost of the red tape connected to complying with the federal regulations we already have. Surely without controlling the labor and material costs, the quality of medical care will go down and rationing of health care would occur!

The gaps should be filled in so that catestrophic illnesses won't totally wipe out a family financially. It can be done at the local level. Please don't take away our right to choose what kind of health care we want.

I also deeply resent, as a tax payer, paying for this N.H.I. publicity campaign!

Sincerely,

Roberta R. Urban

Roberta R. Urban
5170 So. Alton Way
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# MPCSO

TESTIMONY PRESENTED BY THE MOUNTAIN PLAINS CONGRESS OF SENIOR ORGANIZATIONS TO THE SENATE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH.

The Mountain Plains Congress of Senior Organizations (MPCSO) is a six state senior citizen advocacy group in federal region VIII. MPCSO is comprised of the six state based senior citizen membership organizations, (Colorado Congress of Senior Citizens, Montana Senior Citizens Association, North Dakota Seniors United, South Dakota Association of Senior Citizens, Utah State Coalition of Senior Citizens and Wyoming Senior Citizens, Inc.)

The MPCSO Board of Directors comprised of senior citizen representatives throughout the region, recently attended the National Health Insurance hearings held in Denver, Colorado. Following the hearing the Board of Directors voted to support the concept of National Health Insurance as proposed under the Kennedy plan.

Health care has been a primary concern of MPCSO since its inception. The organizations advocacy thrust has previously addressed generic drug reform, Medicare Supplemental insurance problems and hospital cost containment issues at the state and national level. The Kennedy Committee's proposal for National Health Insurance is based around the current Medicare system, a system in drastic need of reform.

MPCSO's recent scrutiny of the Medicare system revealed three major problem areas which are seldom addressed: the refusal of physicians to accept Medicare assignment; regional and state variations in Medicare reimbursement fees; and an increasing dependence on private health insurance to supplement Medicare. The following testimony addresses these specific inadeqacies of Medicare.

(1) Non-Acceptance of Assignment

Under the regulations for Medicare Part B, which is the voluntary part of Medicare paying for doctors' and related services for older and disabled people, doctors can accept an "assignment" of the medical bill or not as they so choose.

If the doctor does accept an assignment of the bill, he agrees to accept as payment in full the amount that the disbursing agent or "intermediary" says is a "reasonable"

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charge. The intermediary usually is Blue Cross/Blue Shield or a private insurance company appointed by Social Security to handle claims in a specific area.

If the doctor refuses to accept the assignment he can charge what he wants and the patient himself must apply for reimbursement. The fact is that only about half the Medicare claims now are accepted as assignment by doctors, and patients often receive only half or less the amount the doctor charges.

The refusal of the majority of doctors to accept assignment and the resultant higher cost to Medicare patients has become the most bitter medical grievance of senior citizens.

The problem is growing. In 1970, nationally about 65% of all Medicare claims were accepted. Each year since then the proportion has declined until it reached 50.5% in 1977.

But the regional variations are even more striking and seniors and their families in regions with low acceptance rates are becoming increasingly resentful.

The assignment rates for the nation (by region) are as follows:

| Region | Assignment Rate |
|---|---|
| Boston | 67.6% |
| New York | 50.2% |
| Philadelphia | 60.9% |
| Atlanta | 49.1% |
| Chicago | 46.8% |
| Dallas | 51.0% |
| Kansas City | 39.3% |
| Denver | 40.2% |
| San Francisco | 52.9% |
| Seattle | 32.5% |

Even more astounding is the fact that the assignment rate varies considerably within a given region. The Denver region has the following assignment rates by state. (1977 data).

| State | Percentage |
|---|---|
| Colorado | 51.7% |
| Montana | 21.6% |
| North Dakota | 31.6% |
| South Dakota | 30.3% |
| Utah | 42.9% |
| Wyoming | 17.7% |

The truth is that Medicare doctor-bill insurance cannot be considered a uniform system. Whether you or an elderly or disabled relative get full reimbursement depends to a large extent on which doctor you use and where you live.

Everybody pays the same monthly fee for this voluntary part of Medicare, but not everybody gets the same benefit.

The following example outlines the extent to which non-acceptance of assignment can financially impact an older citizen. The 1978 Medicare reimbursement rate for extraction of a lens (cataract removal) was $600.00 for Colorado. If a physician charges $800.00 for the procedure, Medicare will reimburse $480.00 and the senior citizen is responsible for $320.00. This is based on Medicares 80% reimbursement of the allowable charge (80% x $600 = $480). The Medicare beneficiary pays the required 20% of the allowable charge (20% x $600 = $120) in addition to the $200 overcharge.

Whatever the reason for the significant variation in reimbursement rates between and within the federal regions, it is unfair to ask the elderly to pay higher out of pocket medical expenses based on a poorly designed Medicare system.

(2) Regional Variations of Medicare Reimbursement Fees.

The regional variation in levels of assignment acceptance is directly correlated to Medicare variations in reimbursement rates. While MPCSO concedes that reimbursement fees should reflect the geographic differences in the cost of living, the Department of Health, Education and Welfare has allowed the situation to become extreme.

The following chart indicates the severe fluctuation in Medicare allowable reimbursement rates for two surgical procedures. (1978 data).

PREVAILING FEE SCHEDULE

| Extraction of Lens | | Prostatectomy | |
|---|---|---|---|
| State | | State | |
| Alaska | $1,009.60 | Alaska | $ 960.00 |
| New York | 814.20 | New York | 1,085.60 |
| Illinois | 800.00 | Illinois | 860.30 |
| California | 787.50 | California | 1,153.45 |
| Georgia | 590.30 | Georgia | 607.00 |
| Wyoming | 562.70 | Wyoming | 613.90 |
| Delaware | 494.10 | Delaware | 518.40 |
| Utah | 426.00 | Utah | 355.00 |

The inexplicable geographic differences in fees and the fact that a large number of physicians are receiving fees substantially below the national average suggest the need for a general reform of physician reimbursement practices which would eliminate the differences and lead to a more consistent and equalized system.

For a detailed explanation of the prevailing reimbursement system, see appendix #1.

(3) Medicare Supplemental Insurance Problems.

Based on Medicare gaps and the unpredictable circumstances surrounding physician refusal of Medicare assignment, the majority (55%) of older citizens purchase one or more Medicare supplemental insurance policies from private insurance companies. This type of coverage becomes increasingly popular in relation to the declining protection of Medicare.

However, Medicare supplemental policies are not the solution to fill the Medicare "gap". This is easily proven by the fact that supplemental policies collectively cover just over 5% of the total health care cost of older people. The Federal Trade Commisison has recently prepared reports presented to congressional committees on the improprieties of this type of insurance.

MPCSO has also researched this subject by reading/analyzing over 100 policies and surveying 15,000 elderly. The research indicated the following major problems: low loss ratio figures (poor return on investment); lack of comparability between policies; fear-oriented sales practices; lack of policies that cover Part B of Medicare; a complete absence of policies

to address the aforementioned assignment problem; rampant and excessive purchasing of policies; and the sale of single-oriented policies (i.e. cancer etc.). MPCSO is continuing to work with State Insurance Regulatory divisions on this problem and have assisted in the development and passage of three Colorado legislative bills to establish a 60% loss ratio , provide for senior citizen education, and mandate disclosure forms with sale of policies. However, the solution lies in Medicare reform to alleviate the reliance on supplemental policies.

Recommendations

National policy decisions which serve to perpetuate the current inadequacies of the Medicare system will only strengthen the arbitrary and discriminatory features which desparately need reform. MPCSO advocates health care reform for older citizens which either completely transforms the current Medicare program or totally replaces the program with a workable/predictable system.

To this goal, MPCSO offers the following Medicare reform recommendations.

(1) Older citizens need access to basic consumer information that facilitates knowledgeable and predictable medical decisions as to cost of service. This requires public awareness of Medicare reimbursement levels and the availability of consumer lists of physicians who agree to provide services at the allocated Medicare reimbursement rate. Whereas H.E.W. has this data readily available, it is their responsibility to implement this aspect of consumer awareness and education. The physician community would, over time, begin to correct some of the current dis-functions. Additionally, consumers would be able to begin to make educated decisions as to how the health system operates.

In conjunction to increased consumer awareness, physicians need an educational program which will instruct them as to the functioning of the Medicare system. Physicians also must be made to realize the financial burden placed on their geriatric patients when Medicare assignment is not accepted.

(2) A mandatory Medicare system in which physicians either agreed to accept Medicare as total payment or did not participate would benefit older citizens. A mandatory system cannot be initiated under the current Medicare program. MPCSO suggests two primary changes as prerequisites to the establishment of a mandatory system: (1) elimination of the current prevailing reimbursement method which financially encourages physicians to charge current higher fees in order to boost the following years prevailing fee schedule. (2) The implementation of a set fee schedule based solely on (a) comparisons to other primary insurance reimbursement levels, (b) geographic variations in the Consumer Price Index, and cost of malpractice insurance. (3) The availability of physicians to a community. These changes would assist in developing a set fee schedule which would be

acceptable to the physician community as well as the Medicare beneficiary.

The Mountain Plains Congress of Senior Organizations lends its support to the Kennedy National Health Insurance proposal.

MPCSO has offered this testimony to benefit the Senate Subcommittee on Health in designing a Natinal Health Insurance plan which adequately protects older Americans.

APPENDIX 1

The Medicare program uses a method based on "actual," "customary," "prevailing," and "reasonable" charges, which is similar to the "usual and customary" system.

Although the statistical computations used to generate a fee by the "usual and customary" method vary from program to program, the Medicare "reasonable charge" system is typical: (1) First, the average of all "actual" fees charged by an individual doctor for a procedure, called the "customary" charge, is determined. (2) The "prevailing" charge is the charge which is below the highest 25 percent of the customary charges of all the doctors in the local area but above the lowest 75 percent; i.e., it is set at the 75th percentile of all customary charges. (3) The physician cannot be paid more than his customary charge or more than the prevailing charge, if it is lower than the customary charge. Whichever is lower is called the "reasonable" charge.

Under some private insurance plans and under Medicare, physicians can agree that the third party reimbursement will be payment in full for their services, i.e., that they will not attempt to collect additional payment from the patient. Under Medicare, this is called "accepting assignment." More than half of all Medicare doctors now refuse to accept assignment. If a physician not on assignment charges a fee higher than the reasonable charge, he can collect the reasonable charge from the Medicare carrier and bill the patient for the rest.

Prevailing charges reflect what physicians in the area have actually been charging. If a significant proportion of physicians raise their fees for a particular procedure, then the prevailing charge for the subsequent year will be higher. Though prevailing charges do not reveal what individual doctors are charging in particular cases, they are statistically based on an aggregation of individual fees and therefore reflect the general level of physician fees in the area, at least for Medicare patients.

The physician's financial incentive under such a system is always to charge more than both his customary charge for the previous year and the area prevailing charge. His customary charge will then stay above the prevailing charge and the next year's prevailing charge will be higher (assuming other physicians in the area behave the same way). The only limitation on increases in prevailing charges is an overall "Economic Index" which now allows prevailings for fiscal 1977 to be no more than 27.6 percent higher than fiscal 1973 prevailings. In fact, for about 70 percent of all Medicare claims, physicians charge more than the prevailing charge. The amount billed is typically 20 to 25 percent higher than the prevailing charge.

If the physician also refuses assignment and the patient can afford to pay, he can collect amounts in excess of the reasonable charge in the current year. This approach increases the physician's income at the expense of the taxpayer and frequently the patient.

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STATEMENT

OF THE

COLORADO MEDICAL SOCIETY

TO THE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
COMMITTEE ON HUMAN RESOURCES
UNITED STATES SENATE

ON

NATIONAL HEALTH INSURANCE

BY

ROBERT B. SAWYER, M.D.

NOVEMBER 27, 1978

STATEMENT

Of The

COLORADO MEDICAL SOCIETY

To The

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
COMMITTEE ON HUMAN RESOURCES
UNITED STATES SENATE

On

NATIONAL HEALTH INSURANCE

By

ROBERT B. SAWYER, M.D.

November 27, 1978

MR. KENNEDY AND MEMBERS OF THE COMMITTEE:

For reasons given by your staff, it appears that the Colorado Medical Society will be unable to present verbal testimony at your Health and Research Subcommittee hearing to be conducted November 29 in Denver. Consequently, I appreciate the opportunity of providing you our thoughts in writing on your Preliminary Plan for the Health Care of all Americans (dated October 2, 1978).

After careful review, three main themes seem to prevail: (1) the delivery of quality care; (2) containment of the costs of health care; and (3) access to health care by all citizens.

Needless to say, the physicians of Colorado are also concerned about these issues, and I would like to inform you how we are addressing them.

1. Quality of Health Care for Colorado Citizens: Over the past years, we have felt so strongly about this important issue that in June, 1970, our House of Delegates organized the Colorado Foundation for Medical Care (CFMC) for

the primary purpose of providing a statewide mechanism for reviewing patient care and assuring that it would be maintained consistently at a high level. Of course, we have been reviewing patient care via audits for some time, but not on a structured statewide basis.

In 1973, our Foundation was designated as Colorado's Professional Standards Review Organization (PSRO) providing concurrent as well as retrospective review of Medicare, Medicaid and Title V patients receiving care in the hospital setting. We were the pioneers of statewide PSRO's and served as the model for many others for our innovative approach to review of patient care.

Just recently, our Foundation has contracted with the Health Standards Quality Bureau to provide review of care rendered Coloradans in the long term care setting. The Foundation is also working with private insurers in providing review of patient care in the ambulatory and hospital setting.

I am especially pleased to report that, although many PSRO's have been criticized for their lack of effectiveness, Colorado's has been cited by several groups, including the Office of Planning, Evaluation and Legislation (OPEL) as doing an outstanding job. This is not to say that we have reached perfection; however, we seem to have a good program developed in this area. Our Colorado physicians provide the quality assessment.

II. Containment of Health Care Costs: Certainly, in these days of inflation, the cost of health care is a deep concern for us all. Numerous studies have been conducted to identify factors contributing to this problem and I'll list just a few which have been identified by our national organization - AMA.

--Unstable world-wide economic conditions

--High labor costs

--Government deficit spending

--Devalued currencies

--Government programs (Medicare, Medicaid) and the cost of government regulations

--Expensive new technology and equipment

--Payment by insurance companies or government for various medical items that have removed incentives for economy

--Overtreatment

It seems that now is the time to implement mechanisms to deal with issues. Of course, I'm sure that's what you are trying to do in your proposal, however, if what we are doing in Colorado is successful, it should obviate the need for your proposal.

We have supported passage of legislation creating the Colorado Hospital Commission and now all Colorado hospitals must submit their budgets to this Commission for review and approval. We have actually carried this effort one step further with the creation of a state Voluntary Effort (VE) committee involving physicians, hospital administrators, and the community. At our September Annual Session, our House of Delegates voted to support the national voluntary effort to cut the rate of physicians' fee increases by 1% each over the next two years. We also have worked together with other providers of health care in (1) tightening utilization review procedures used by hospitals and medical staffs; (2) improving internal management and financial controls and (3) expanding the concept of shared hospital and physician services. Obviously, the results of these efforts will not be evident overnight. We're hopeful that the results will be carefully reviewed and considered before the federal government intervenes.

One last, and perhaps most important point, on this issue is that the whole community must be involved; hospitals and physicians cannot solve this problem alone. The patient must be made aware of the role he plays in the health care system, e.g., maintenance of good health, proper utilization of the system; and accept his share of the responsibility to make it work well.

III. ACCESSING THE HEALTH CARE SYSTEM: We are well aware of the problems some of our citizens have in accessing the delivery system, but we feel that a preconceived budget for health costs will inevitably result in limiting the availability of services.

In Colorado, the majority of workers either provide their own health insurance or it is provided by their employers. The Medicare population is, in our estimation, being well served and, in fact, may be overutilizing the system. Medicaid recipients do have problems, but we are working with the Colorado Department of Social Services and the Colorado Legislature to resolve those problems.

One of the alternatives suggested in your proposal is indeed working in Colorado, namely, Health Maintenance Organizations (HMO's) - there are five in the state. We firmly believe that this alternative should be available, but you should be aware of the fact that HMO's will not always lower the cost of health care, and also have accessibility to quality care problems.

Our experience has shown that the most economical way of meeting patient's needs is in the doctor's office.

Accessibility to health care in some rural sections of our state is a significant problem. We have identified those areas having a shortage of primary care physicians. That report is attached (Addendum I) for your information.

Resolution of the physician distribution problem will be achieved when rural citizens provide incentive in their individual communities; this cannot be accomplished by the federal government. In the meantime, we are working closely with the Governor's Office on Rural Health and the University of Colorado Medical Center to address the problem and to resolve it in the future.

Through the assistance of your brother, John F. Kennedy, Colorado was one of the first states to establish a neighborhood health care program (March 1966). This is an excellent example of federal, state and city governments working together to solve the problem of providing care to those who need it regardless of their ability to pay. I've recently talked with the Director of the Denver Neighborhood Health Program (which also serves the entire state) who informs me the program is working quite well.

SUMMARY: We all are striving for the same end result - access to quality care at reasonable costs. In Colorado, we are addressing the issues:

1. Our Colorado Foundation for Medical Care is providing review by physicians to assure that quality care is rendered in the proper setting through concurrent and retrospective review. This is being done for federally funded and private pay patients.

2. The physicians of Colorado, individually and through the Colorado Medical Society are working to provide the best care for reasonable charges. This includes working with other health providers, business and the community in maintaining costs at reasonable levels.

3. The Colorado Medical Society recognizes there are problems accessing the health care system and is working with the appropriate groups for local solutions.

In summary, what we really desire is more help from the people of Colorado in resolving these problems and not additional governmental intervention.

Our experience with government health programs has proven that they are expensive, confusing to both the patient and provider and, in the end, do not achieve the result sought.

There are many specific issues in your proposal which we feel would best be addressed by our personally discussing them with you and your committee rather than in this document. We look forward to having that opportunity at some time in the immediate future. We would like to work with you in keeping our health system the best in the world.

ADDENDUM I

Primary Health Care Needs of Colorado: Primarily a Rural Problem

The following report has been generated by the Committee on Medical Manpower so that Colorado Medical Society members might have a better understanding of primary care physician distribution and needs in Colorado

Data were obtained from Physician Resources in Colorado: An Analysis by Heinz F. Mueller, Barbara M. Bryan and Cathleen A. Saidy and Patient Flow Patterns In Hospital Service Areas in Colorado by Heinz F. Mueller. Committee members modified data about their representative areas.

The Committee does not claim that the following need assessment of recommendations are totally complete but would consider them general guidelines that should be helpful in understanding physician distribution and needs. Primary care practitioners population ratios were generally considered adequate if they were 1:1500. However, these recommendations are also affected by the total number of physicians in a given area and travel time between health care facilities. Primary care physicians or generalists are considered to represent the specialties of family practice, internal medicine pediatrics and obstetrics-gynecology.

This document does not address the financial aspects of patient care from the physician's standpoint nor the financial barriers to medical care that still exist today for some population groups. Both should be considered for effective health care planning.

I. Health Systems Agency (HSA) 1.

A. Rural Northeast Colorado. The greatest need for primary care physicians or other primary care practitioners is in Region 5: Cheyenne, Elbert, Kit Carson, and Lincoln Counties. The population of this area is generally older and financially poorer than the state average. Lincoln County with Limon and Hugo has one generalist per 2400 population, Elbert County has none for a population of 5200, although this County is the closest to the Denver metropolitan area. It is also supplied with a physician assistant in Kiowa working under the direction of physicians from Arapahoe County. However, the adjoining County to the West, Douglas, is also very short of generalists, but has a recently established emergency room in Castle Rock as an extension of Swedish Medical Center in Denver. Only Cheyenne Wells appears to have an adequate generalist distribution - one per 1150 population. The Burlington area is the most populous in Region 5 with 7500. The next most needy area in the rural area of HSA-1 is Region 1 containing Logan, Morgan, Phillips, Sedgwick, Washington and Yuma Counties. Washington and Yuma Counties have one generalist per 5000 population and one per 2100 respectively. The communities of Ft. Morgan, Holyoke, Brush, Julesberg and Sterling are somewhat adequately supplied and serve as resource areas for the surrounding countryside. Some physicians in these communities are nearing retirement and shortage may occur in the future.

Region 2, containing Larimer and Weld Counties also appears, in general, to be well supplied but most of the physicians are located in Ft Collins and Greeley. Citizens of the northern parts of both counties have considerable travel time to the larger metropolitan areas.

In summary, the Committee would recommend that the Kit Carson, Lincoln, Washington and Yuma Counties be focused on for planning efforts to supply more primary health care practitioners. Health care teams could be created out of larger centers such as Sterling and Greeley to provide the adjacent plains areas with greater availability of health care. Smaller population areas might be supplied with nurse practitioners or physician assistants with visits by a physician on a regularly scheduled basis and a good transportation system to carry the more ill patients to the physician and hospital as is presently occuring in Kiowa.

B. Denver Metropolitan Area. The Metropolitan Denver Area, having half the state's population, also has the greatest concentration of specialists and generalists. The generalist population ratio is one per every 1350 citizens not counting physicians in training.

Central Denver is in no need of a generalist, having a ratio of one per 880 population. Generalists have not left the central city to move to the suburbs, probably because of location of hospitals and consulting specialists in the central area. In the last few years there has been a trend for new generalists to establish practices in outlying suburban areas since central Denver hospitals have established satellite clinics or full hospitals in these areas such as Aurora and the northern part of the metropolitan area. This trend has not hurt the central city ratio, however.

If there is any need for generalists in the Denver metro area, it is in the Adams and Douglas County areas. Adams County has one generalist per 3000 and Douglas one per 3600 population. Adams County is an industrial-agricultural, generally lower income area which recently has been aided by the addition of St. Anthony's North in addition to Valley View Hospital in the area. Douglas County, to the southeast, is generally rural and somewhat underdeveloped but appears to be a future residential area for the Denver metro area as growth occurs. As mentioned above, Swedish Medical Center has established an emergency facility in Castle Rock. However, present need for primary health care services for Douglas County will increase in the future. The Aurora area is also growing rapidly as a residential community; and because of the presence of Aurora Community and Presbyterian Hospitals, more physicians are practicing in this area. The Broomfield area between Denver and Boulder is also short of generalists, but this area is thought to be close enough to Boulder and Denver as not to be considered an area of great need. Lafayette and Louisville also have few generalists but these communities are fairly close to Boulder and Longmont.

II. HSA II:

A. Rural Areas of HSA II. In Region 6, which is essentially the Arkansas River Valley, there is one generalist for every 2000 citizens. The main medical centers in this area are the Otero County Medical Center in La Junta, Pioneer's Hospital in Rocky Ford and Prower's Medical Center in Lamar. Otero County Medical Center seems to be foremost in becoming the regional referral center. The Counties of Bent, Crowley, Kiowa and Prowers are in need of more generalists. National Health Service Corps physicians have helped supplement physician numbers in these counties but there are still needs. Geographic distances are fairly far between small communities. Conceivably these smaller communities could be served by para-professionals as part of health care teams as discussed above for Northeast Colorado. There are many low income citizens in this area including migrant farm workers, the care for whom might be aided by more supplemental funds

from state or federal government.

Region 8. The San Luis Valley is in need of generalists except for Alamosa and Rio Grande Counties. Conejos, Costilla, Mineral and Saguache Counties are in need of more primary health care services. Again, Health Corps physicians have served this area but there has been little retention from this program. Many low income citizens of this region, the poorest in the state, are served under a Community Health Center Grant which provides them with health insurance in order to receive care from existing health care resources in the valley. However, there is a need for more health resources. Again, in this area where travel times are long, physicians with satellite clinics and assistants could be helpful.

Trinidad, in Las Animas County, has recently had a large influx of both National Health Service Corps physicians and physicians entering private practice. However, the sparsely populated eastern half of the county is very far from these services in Trinidad. Huerfano County appears adequately supplied and is, except for the mountainous region of this county, not far from either Pueblo or Trinidad.

Lake, Park and Teller Counties, west of Colorado Springs, are in need of more generalist services. Lake County has a generalist for every 2600 people, Park, one for every 2600 people and Teller, one per every 5400 people. Although some distance apart, Fairplay and Leadville could be linked in a cooperative effort to function from the hospital in Leadville. However, the geographical barriers in the winter and the commercial trade patterns would make this recommendation difficult to implement. Cripple Creek surely could be equipped with a summertime physician and/or health practitioner working with some central resource in Colorado Springs.

B. Urban Areas in HSA II. El Paso County appears well supplied with both primary and specialty care services. However, Pueblo is in need of generalists, having one every 2200 citizens. To a large extent, this community has a fairly large population of low income citizens being served by a federally funded neighborhood health care clinic system.

III. HSA III

A. Rural Areas of HSA III. Fifty percent of the population of HSA III lives more than thirty minutes from a hospital or other source of medical care. There are also several small communities in this area without a hospital or physician that are isolated because of mountain terrain. The greatest area of need seems to be in the far southwestern part of the state where there are many geographical barriers and a rather poor economic base. Archuleta County with Pagosa Springs, is in need of a least one more generalist, presently having one per 3,000 population. La Plata County, with Durango, seems to be well supplied with physicians. However, Montezuma County, Cortez ,is in need since the present ratio is one generalist per 2300 people. Dolores County, north of Montezuma County, with Dove Creek, is also in need of medical care service. There has been a Health Corps Nurse Clinic in this area for a few years with good acceptance by regional physicians and citizens. Within Miguel San Juan, Hinsdale and Ouray Counties, Telluride, Silverton and Lake City are only short

distances apart but are separated by high mountain ranges and have long travel distances between them. The Delta, Gunnison and Montrose areas are better supplied than the far southwest part of the state. There are no apparent problems in Pitkin, Mesa, and Garfield Counties, except Rifle which is in need of generalists. Eagle County could be better supplied but there are some physicians who drive from Glenwood Springs to help that area. However, in the winter the travel conditions are sometimes quite prohibitive. In the northern part of the region, Jackson County is in need, having only one generalist per 1900 population. Moffat and Rio Blanco Counties may receive much energy development growth and it is projected that their needs will increase dramatically in the next few years. Meeker is already short staffed, presently, with one physician.

B. Urban Areas in HSA III. The only urban area is Grand Junction, and it appears to be well supplied with both generalists and some specialists. This community will surely be an educational resource center in the future and should be the medical referral area for the western slope.

SUMMARY. The areas in need of more primary care services are the far eastern plains, both north and south, the southwest corner of the state, San Luis Valley, some scattered areas in the central mountains and two rural counties near the Denver metro area. Pueblo is the only metropolitan area in need of more services.

Some areas could be supplied by satellite clinics and para-professionals, closely guided by physician supervisors who would be located in a more central community, usually near a hospital. In other areas this model would not apply because of geographic barriers. These communities would require separate systems consisting of both hospital and physician services.

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CLEAR CREEK VALLEY MEDICAL SOCIETY

# COST CONTAINMENT REPORT

Cost Containment Committee

D A. Berg, D. O., Chairman
Frederick Brandenburg, M.D.
Richard Cohen, M.D.
N. Kenneth Furlong, M.D.
Charles Gartner, M.D.
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# THE COST CONTAINMENT COMMITTEE--CONCEPTION AND PURPOSE

D. A. Berg, D. O.
Chairman

A Gallup Poll survey taken in June, 1977, revealed that 67% of Americans believe that national health insurance is necessary because of the high cost of health care. This clamor for national health insurance represented a majority opinion in every population group in America.

It perhaps becomes a moot point whether or not this changed attitude toward America's health care system is the result of the ten years of intense political propaganda mediated through the mass media or whether this socialistic change in attitude is merely a product of the new "social awareness" of our times. In any case, it is inescapable that the political leaders of our country would take maximum advantage of this citizen "underdog" vs "rich doctor" perception, a political issue made to order for the politicians of our times.

It may not even be possible now to retrospectively survey the real cause of health care [illegible] such as inflation fueled by government excesses and deficit spending by our "socially oriented" congressmen. It may not be possible for the average citizen to reflect on the tremendous inflationary impact of a coal settlement that will add 37% to the manpower costs of this basic industry in just three years--an industry so basic that virtually everything America buys will be cost impacted by this skyrocketing inflationary settlement. Perhaps most Americans have forgotten how our nation acquired most of its excess hospital beds via federal tax dollars received under grants through the Hill-Burton program.

But the greatest distortion in the medical market place came in 1965 with the sudden injection of billions of dollars into the health care system through the Medicare and Medicaid program. Prior to 1965, the Consumer Price Index and Hospital Price Index ran nearly parallel but after the infusion of massive federal dollars, hospital costs zoomed upward. Why shouldn't it? Can you imagine what would happen today to the price of any other American commodity if the federal government should go into the market place, buy billions of dollars worth of the commodity, and pass it out free to certain groups in our country or to other members of our world society. Remarkable, the government is now paying 40% of health care costs according to a report issued by the Department of Health, Education, and Welfare entitled, "Health, United States, 1976-1977."

So far we have said nothing about the cost to hospitals of minimum wage laws in an industry that is as labor intensified as is the hospital industry, nor have we mentioned the cost of unionizing the hospital labor force which is directly or indirectly encouraged by the government.

THE COST CONTAINMENT COMMITTEE--CONCEPTION AND PURPOSE, D. A. Berg, D.O.

So the government created the problem--but the health industry is charged with solving the problem, under threat of more government intervention. Bills before Congress, including Representative Paul Rogers' (D., Florida) hospital cost containment bill and Representative Dan Rostentowski's (D., Ill.) bill for a standby federal control plan, stand ready for passage if voluntary efforts fail. The American Medical Association has accepted the challenge to work out cost control measures and has created the "Commission on the Cost of Medical Care" headed by former A.M.A. President, Max Parrott, M. D. Their report has been published and has drawn considerable fire for its bureaucratic type solutions but, in defense of the report, the Commission was obviously faced with the dilemma of offering remedies to a bureaucratic health care nightmare that had already inflicted a deadly wound on the traditional health care system as we have known it. They were left with "doctoring" the health care system as already disrupted by the federal government and its bureaucracy.

The American Medical Association has also joined with the American Hospital Association and the Federation of American Hospitals to sponsor a Voluntary Cost Containment Program and this effort is underway.

In a memorandum issued by the A.M.A. January 12, 1978, local and state medical societies were urged to establish joint medical-hospital associations to attack state and local level cost containment problems.

The Clear Creek Valley Medical Society Cost Containment Committee, appointed by our Society President, functions under this mandate.

It is the intention of the Committee to study and evaluate medical care cost containment problems from our perspective in the health-care area of the Clear Creek Valley Medical Society.

"Hospital regulations. You gotta wear the straps while I read the bill."

"Say, nurse, I wonder if you could tell me why hospitals always require patients to have their charges sitting down?"

# REASONS FOR RISING COSTS

R. L. Weiss, D. O.

There are several broad categories of costs unique to the health care industry. These are the labor intensive wage structure, expansive technology, the third party reimbursement system, malpractice and the changing attitude towards medicine.

## Labor Intensive Wage Structure

A highly service oriented industry (services account for up to 70% of a hospital's costs), it has recently experienced two periods of catch up wages, during the late 60's through the early 70's and after the termination of wage controls in 1974.

Physicians' fees have escalated at about the same rate as hospital wages. This may be attributed partially to maldistribution. Some areas are still experiencing shortages, and while medical schools are admitting more students yearly, this causes oversupply in the cities. Again, the health care system violates the economic rules of supply and demand. The increase in supply of physicians tends to make fees rise.

## Expansive Technology

The health care field is simultaneously praised and criticized for the rapidly changing medical technology in which new diagnostic and therapeutic techniques and expensive techniques are centered in the hospital. Suppliers' prices have been escalating at a much greater rate than that of the rest of the economy. Construction costs have been extremely high, as have the costs of borrowing capital.

Government agencies have attempted to limit the amount of duplicative facilities and technologies-which in itself is a costly procedure. It does not necessarily control the costs. Along with this type of control over services are other regulatory agencies. There are well over 100 regulatory agencies that every hospital must deal with. Usually technology advances, because where health is concerned, "everyone deserves the best."

## Third Party Reimbursement

The method of payment of medical services has recently come under fire as a catalyst in rising health costs. Private insurance policies generally have a low or nonexistant deductible. While the insurance companies recognize the relationship of low deductibles to costs, they are reluctant to change because consumers want this type of coverage. Governmental coverage, such as Medicare and Medicaid, greatly increase the availability of health care, but also encourage unnecessary medical care. Third party insurers have also been slow to realize the cost benefits of outpatient coverage. Some insurance plans are now covering

outpatient diagnostic services, but there is more room for improvement. Bad debts are also high in hospitals, a cost which must be passed on to consumers. Hospitals have traditionally been viewed as charitable organizations and are slow to adopt business office techniques. Hospitals extend more credit voluntarily than any other industry. From all the points mentioned above, it is easy to see why demand for health care is unlimited. The public views health care as a right.

Inflation

Inflation accounts for 53% of the hospital cost increase. Medical goods and service costs rise faster than consumer items. Especially high are the rapidly escalating energy and malpractice insurance rates.

Malpractice

Malpractice is rising in what is termed "the litigious society of the 70's." Again, the phenomena results as a public perception of a perfect medical world where mistakes are unforgivable.

What is Being Done

Many changes have begun to control the rate of increase in hospital costs. Most have not had a significant effect because the causes as previously mentioned are basically uncontrollable.

Length of Hospital Stay

A recent effort has been launched by government to limit the length of stay of hospital patients. Like the chicken and the egg, it is difficult to say if intensified services or a shorter length of stay come first. Ultimately, the total cost of a hospital stay is less, although the per diem rate is higher, a statistic which is more often quoted.

Outpatient Services

Insurance policies are beginning to cover outpatient diagnostic services, a change which theoretically lowers total health costs. However, utilization is increasing.

Government Control

The most significant change has come with governmental agencies. Again, a question arises as to whether the agencies control and reduce costs, or just incur new costs.

Government agencies now are involved with licensing, PSRO's, utilization review, fire and safety standards, expansion and purchase of new services, and other elements of health costs. While intentions are good, it is often questionable whether the results are truly cost effective.

What Should Be Done

There doesn't seem to be any choice of whether something should be done about costs. The question is whether the health industry will be allowed or forced by government to control their own costs.

Physician-Hospital Relationship

Increasingly, physicians will need to work with the hospital in order to bring about cost containment measures. It is estimated 80% of the hospital dollar is controlled by doctors.

In fact, if voluntary rationing of services is not initiated now, it is possible governmental control, through national health insurance, will force rationing of services. The medical staff must have a greater interest in clinical progress of the hospital, and the hospital of the needs of the medical staff.

Legislation

The health care industry has become a strong lobbying party in face of government intervention. The AMA, AHA, and FAH are working together to represent our views in order to protect the present free enterprise system. The voluntary effort represents an unprecedented demonstration of unity on the part of various entities of the health care industry. The National Steering Committee on Voluntary Cost Containment is the industry's answer made to a challenge of Senator Rostenkowski. Hopefully, support of this effort on all levels will forestall government intervention.

Good Health

Of course, the ultimate answer to control of health care costs is good health. It is unfortunate we do not have a system that rewards the healthy, but regardless, good health should be encouraged. Health, as a result of exercise, proper diet, rest and relaxation, and avoidance of harmful agents is a right of everyone, or more properly termed, a responsibility. Cost containment needs to be encouraged from the roots up.

Thus, we can better answer the question of whether health care is a right or a privilege, and hope that it will continue to be a right.

Enclosure: "Positions and Policies - Federation of American Hospitals."

# ROLE OF GOVERNMENT IN RISING HEALTH CARE COSTS

Kim Sleichter, Supervisor, Travelers

While the federal and state governments have had various health programs for a number of years, perhaps the most important and far-reaching legislation enacted by Congress in recent years has been the National Health Planning and Resources Development Act (P.L. 93-641 of 1974).

The functions of P. L. 93-641 involved the following: (Footnote 1)

1. Develop guidelines for National Health Planning policy with various state and local agencies created under the Act.
2. Establish Health Service Areas throughout the United States.
3. Issue regulations governing implementation of the Act.
4. Designate Health Service Agencies in each Health Service Area.
5. Provide technical assistance to Health Planning and Development Agencies at the state and local levels.
6. Provide financial support to state and local planning agencies.
7. Designate State Health Planning and Development Agencies.
8. Review Health Plans produced by state and sub-state agencies.
9. Approve most federal assistance plans and project grants.

This Act was created out of necessity for a realignment of the nation's Health Planning and Development Programs, and to create "A single set of structures at the State and Regional levels to deal with planning, resource allocation, and regulation in the health field.". (Footnote 2)

The Health Planning process is designed to help contain the inflationary spiral of health care costs. In 1975, health care costs rose 10.3% compared with a 7.7% increase in the Consumer Price Index. Total expenditures on health care exceeded $118,000,000,000 in 1975. (Footnote 3)

Possible explanations as to why health care costs continue to rise concern the "growth in health care prices and spending due to such factors as improved and complex medical techniques and equipment, the labor intensive nature of hospital care, general inflation, and the unprecedented demand for health care services created by government programs and the spread of private health insurance. To a large degree, however, the inflation also stems from serious deficiencies in the way health care services are organized and delivered. In many areas there is an excessive supply of hospital beds and unnecessary duplication of other costly services and facilities. Hospitals, by and large, have been reimbursed for whatever they spend. Medically acceptable outpatient care, as an alternative to costly hospitalization, has not been sufficiently encouraged. Overall, incentives on the part of the providers and patients alike to economize have been lacking inasmuch as so much of the nation's health care bill is paid through third party mechanisms. It is clear that medical care eludes most of the normal influences of the marketplace. It is not practical for the consumer to comparison shop for price or quality. A greatly complicating factor, too, is the phenomenon of "defensive medicine" whose full dimensions are yet unknown, practiced by physicians fearful of malpractice suits." (Footnote 4)

ROLE OF GOVERNMENT IN RISING HEALTH CARE COSTS, Kim Sleichter, Travelers

The passage of P. L. 93-641 was a major step towards containing health care costs. The Health Service Agencies created by this Act have as a goal the achievement of the proper balance, within the community, of demand and supply of health care resources and preventing further unnecessary duplication of hospital beds and other expensive technologically specialized medical equipment.

The Health Service Agencies themselves must be comprised of providers and consumers, with a consumer majority. Under this Act providers include physicians, dentists, health care institutions, health care insurors, health professional schools, and allied health professions. The Health Service Agency itself performs planning and development functions as well as regulatory activities to and for the state regulatory agencies.

A brief analysis of P. L. 93-641 and its effect on health providers is described in a release from Ernst & Ernst in 1975, which states:

> "We expect P. L. 93-641 will effect the health care industry no less than Medicare has. This new health planning legislation appears to be paving the way for National Health Insurance and could provide a framework for price controls. Even though numerous implementing regulations are yet to come, it is clear that health care providers will have to deal constantly with new planning agencies. These agencies are to be governed by a cross section of their communities, emphasizing the consumer."

1. It establishes nationwide regional health planning agencies and processes, revising and replacing the existing planning agency approach.

2. It gives the new planning agencies greater authority over areawide planning and involvement in federal funding programs than that of their predecessors.

3. It requires the new agencies to carry out a periodic review and evaluation of all health services offered by hospitals.

4. It calls for the government to develop uniform systems for cost accounting, rate setting, reporting, and for determining provider classifications.

5. It requires certificate of need legislation in all states.

6. It provides funding for seed money projects to implement areawide health plans.

Health care providers will have to justify, with comprehensive documentation, the demand for and financial feasiblity of any planned and desired new services in order to support the applications and obtain required approvals. In a similar vein, providers will likely need to justify with documentation existing services in response to the review of "appropriateness" by the various agencies. (Footnote 5)

This Act obviously has direct impact upon the physician, who has the dominant role with respect to the problem of the cost of care. This is due mainly because physicians control the total process of medical

care. "Typically, this process begins when a patient seeks help. From then on the initiative passes to the physician, whose decision significantly influences the quantity, type, and cost of service utilized. The physician is gatekeeper to the production of medical care. The actual delivery of care is frequently in the hands of other health professionals, but they take their instructions from the physician and report back to him." (Footnote 6)

The role of government in containing health care costs is, of course, faced with the dilemma of achieving costs savings or reductions at the expense of quality medical care. The Act does not have to result in a sacrifice of quality care, but rather, through its implementation and participation by the community providers and consumers, should result in a more comprehensive health planning function leading to the more efficient and effective utilization and allocation of delivery of medical care services.

The Health Planning and Resources Development Act is by no means the only case in which the government has become involved in the health care area. It is, however, perhaps the most important health legislation passed since the advent of Medicare. In a $200,000,000,000 a year industry, one can expect the government to take an active role, since much of the total cost outlays for providing medical care reimbursement are through federally funded programs. Whether one agrees or disagrees with the government involvement, one can say with certainty that the government's role is here to stay, and its role will most certainly increase unless providers and consumers work together to make sure that the existing health programs are workable and can accomplish the bills set forth.

Footnotes:

1. National Health Planning and Resources Development Act, James R. Kimmey and Assoc., Madison, Wi.
2. Ibid
3. Health Planning Commentary, HIAA 9-24-76
4. Ibid
5. Ernst & Ernst, Cleveland, Ohio
6. Who Shall Live - Health, Economics and Social Choice, Victor Fuchs, p. 57

# HOSPITAL COSTS

D. A. Berg, D. O.

Hospital costs constitute the largest share of the medical care budget of the U. S. Of 139.3 billion spent for health care in the year ending June 30, 1976, 55.4 billion went for hospital care. Cost of hospital care has escalated more rapidly than other segments of health care largely because hospital service is labor intensified and labor costs have soared. But other factors contribute greatly to increased hospital costs including general inflation and increased utilization.

Since 1965, total health care expenditures in this country rose from 38.9 billion to 139.3 billion in 1976. Much of this increase has been due to increased utilization. Between 1960 and 1975, the U. S. population increased from 179.9 million to 213 million; physician visits per person per year increased from 4.5 in 1965 to 5.1 in 1975; the average daily occupancy rate in hospitals increased from 477,000 to 701,000 in 1974, and the number of hospital outpatient visits doubled from approximately 125 million in 1964 to more than 250 million in 1974.[1]

Thus, over-utilization contributes significantly and is being addressed by utilization review boards. The problem, also, is being successfully curtailed in some programs by eliminating first dollar coverage in favor of patient co-payment, e.g. the Coors Brewing health program.

The concept of full service hospitals with all skilled care beds is under challenge. Centralized surgi-centers utilized for the more bizarre surgical procedures requiring specially skilled teams are under study because this approach would eliminate the need for the existence of such costly facilities in all the general full-service hospitals. Thus, one or two surgi-centers per each large service area would eliminate millions of dollars of equipment costs to other nearby hospitals.

On the other side of the spectrum, graduated care centers starting with sleep-in diagnostic centers and resembling motels could provide the patient and physician the convenience of a rapid diagnostic work-up with access to the necessary diagnostic facilities if the sleep-in center was part of a hospital, for example. After all, it is often much more practical to remain in house for 2 to 3 nights than to spend a couple of weeks migrating from x-ray, to lab, to specialist, etc. The time loss to the physician and patient plus the poor quality of the work-up may offset slightly additional costs for boarding in but why should "boarding-in' rooms be charged with the cost of a surgical suite for by-pass heart surgery?

If graduated hospital care was available, physicians could refer patients for the proper level of care at the appropriate price. Thus, the concept of graduated care centers versus the existence of great number of full-service hospitals is gaining favor.

1. American Academy of Family Practice, Reporter, Volume 5, No. 2, P.3

# HOSPITAL COSTS IN THE CCVMS AREA

A. C. Lotman, M. D.

After compiling lists of various costs at different hospitals, I have summarized those that I think would be most significant to the members of the Society. Also enclosed is a summary of x-ray examinations performed in emergency rooms, indicating the percentage of normal examinations. It was impossible to determine what relative increase in cost of medical care was produced by the prepondérance of normal examinations.

| | | | |
|---|---|---|---|
| Costs: | 1) Operating Room | Cost per ½ hour | $125.00 |
| | 2) Room Rates per Day | Semi-private | 105.00 |
| | | Private | 125.00 |
| | | ICU/CCU | 275.00 |
| Medication Costs: | | | |
| | 1) Percodan | | .50/tab |
| | 2) Dalmane 30 mg | | .50/tab |
| | 3) Diuril 50 mg | | .25/tab |
| | 4) Digoxin .25 mg | | .25/tab |
| | 5) One gram IV Keflin | | 12.00 |
| Ambulance Costs: | | | |
| | Once the ambulance leaves the station | | 70.00 |
| | If oxygen is used, add | | 10.00 |
| | If lights and siren are used, add | | 10.00 |
| | If patient is defibrillated, add | | 20.00 |
| | If IV is started, add | | 10.00 |
| | Permile charge additional, add | | 2.00/mile |
| | Ambulance Cab for routine transfer from nursing home to hospital and back approximately | | 18.00 |
| Cost of Electrocardiogram: | | | 20.00 |
| Routine Visit to the Physical Therapy Dept.: | | | 7.00/visit |
| Cost of a 4" Ace Bandage: | | | .75 |
| Food Cost per Day per Patient: | | | 8.75 |

## RELATIVE COST

Charles Gartner, M. D.

Much unfavorable publicity has been generated regarding physician income, fraud, abuse, rapid escalation of cost in the health field and related matters. As a result, forests of paper and oceans of ink and countless person' hours of labor have been expended trying to devise ways of containing cost. The work of this Committee is another such attempt and cannot hope to compete with the massive funding and sophisticated studies which have been performed on a national level. This section of the report focuses on the concept of relative costs and their causes. I can not hope to propose any solutions to the problems, although some solutions may be apparent, but the first step in solving any problem is to define it--is there a problem and if so, what exactly is the problem?

In current government parlance, the "health care industry" must be considered a labor intensive industry. The equipment, no matter how sophisticated, does not run itself but must have constant attention by personnel, and the care of the sick patient must go on 24 hours a day, and 7 days a week. Thus very few other industries compare to medicine. Perhaps an analogy can be drawn to the air transportation industry, however, which also functions 24 hours a day and 7 days a week utilizing much skilled and unskilled labor to safely provide services which risk human life; utilizing complex and expensive equipment; providing a service to a segment of the population which varies from time to time; and exhibiting a high cost (and which is prone to institute legal procedings if things go less than well). Accordingly it would seem reasonable to compare some costs in terms of personnel income in this area. United Airlines recently advertised for maintenance personnel to clean aircraft at a starting salary of $3.00 to $3.50 an hour. Hospital housekeeping personnel start at a comparable salary in one local hospital of $3.19 an hour. Obviously because of the nature of the problem, the number of housekeeping personnel per patient is much greater in a hospital than the number of similar personnel per passenger on an airline, so that comparable volume of service requires a much higher outlay of labor. To take another example, a nurse's aide is paid at approximately 75% of the pay rate of the stewardess. While the stewardess' job is considered extremely glamorous and exciting, the nurse's aide job is considered to be drudgery. The salary of an intensive care nurse of approximately $14,000 per year starting salary compares most unfavorably with that of an air traffic controller, who has similar job pressure in terms of acuteness of attention to detail and critical responsibility with regard to safety of human life. The average annual salary of a physician as reported in 1977 (1976 income) by Medical Economics of $55,000 a year compares with that of a captain of an airliner. However, the average airline captain flies approximately 55 hours per month while the average physician (based on the same survey) works 55 hours per week in providing direct patient care services. A $500 per month medical assistant with training in laboratory, injections, x-ray, insurance, reception, and scheduling can be compared to a $700 per month typist or a ticket clerk for an airline (and compares even more unfavorable with a $400 per week topless dancer). 13

RELATIVE COST, Charles Gartner, M. D.

This analogy could be continued ad infinitum to multiple jobs in multiple industries but these simple and easy to understand figures hold true generally across the board. Despite the low pay of medical personnel relative to their counterparts in industry, it must be emphasized that the labor cost of providing medical care is a critical factor in the escalation of cost. Salaries of non-physician personnel have risen from unconscionable low levels to levels that are at least compatible with the maintenance of a decent standard of living for persons in these occupations. This has been particularly true in the last five years and reflects the correction of a long standing wrong. Nonetheless when these increases are figured in to the costs of health care and compared to the standard inflation rate it makes it appear that the increase in medical care cost is out of line with the rest of industry. It should rather be considered that the basic salaries are now beginning to catch up to those of other areas of the economy. As an aside, one physician, a member of our Society who has been in practice for many years, said that he parallels his office visit fee to the postal rate times a factor of one hundred. (This should be self explanatory, needs no further elaboration, and is provided for information.)

Another area that I wish to touch upon in this section of the report is some of the proposed mechanisms for decreasing the cost of medical care. It has been argued that a prepayment capitation system, such as Kaiser, or prepayment fee for service discounted system, such as Comprecare, may offer substantial savings to the patient as compared with traditional fee for service practice. It is impossible to refute this claim or to substantiate it, since no available cost factor figures are openly available as to these two plans. Admittedly their overall costs are lower, perhaps because of under utilization rather than because of quality medical care. To analyze cost of a comparable service it was decided to utilize figures from three different sources for a simple uncomplicated outpatient visit, without lab work, for an established patient. The Department of Health and Hospitals of the City and County of Denver charge $25.70 for a routine service "intermediate examination, evaluation and/or treatment, same or new illness." A hospital outpatient department basic charge is in the order of $15.00 for the room and $15.00 for the physician for a minimal service type of visit. Comparable fees in a private office are in the range of $10.00 to $15.00 with the median fee in the Denver area now being approximately $12.00. Thus it would appear that the administrative overlay of any large organizarion would increase, rather than decrease, the cost of medical care and that the traditional "cottage industry" type of approach to medical care is indeed the most cost effective in treating the simple uncomplicated illness. Similar analogies have been drawn by other authors with regard to the cost of such things as obstetrical care or major surgical procedures. However these studies have been attacked on the grounds that (1) There is a cost of training personnel in such institutions, and (2) that patients who present to such public institutions or emergency rooms or the V. A. system are in more advanced disease states and are in less good general health, thus requiring an increased expenditure. While this may be true (except for the V. A. system - I doubt that it is true), it nonetheless remains that the simple uncomplicated services are orders of magnitude more expensive.

RELATIVE COST, Charles Gartner, M. D.

As an aside, looking now to the British Health Care system (which is commonly widely quoted as a model system in terms of the number of operative procedures done) it should be noted that in England the waiting list for elective surgery such as herniophery, hemroidectomy, hysterectomy, joint replacement and other similar procedures, is three to five years, depending on the section of the country, yet our health planners say that the fact that we are doing more surgery than the British indicates we are doing too much surgery.

In summary, it would appear that the reasons for the current outcry regarding medical cost are as follows:

(1) Due to a catch-up factor (and relative also to this catch-up factor is the fact that physicians' fees were frozen for two years after the remainder of the nation was freed from wage and price controls during the Nixon Administration) the increase in the price of medical care is indeed rising at a rate faster than that of the consumer price index, but that this is a temporary adjustment and will not continue to do so as personnel costs again come into line with the general need.

(2) We are comparing modern medical technology and modern medical services against the standards of a much less sophisticated technology. The gains in terms of survival and quality of life are tremendous. Suffice it to say that no one attacks the airline industry because jumbo jets cost more than DC-3's, but the medical profession has been attacked because a CAT scanner is much more expensive than a simple x-ray machine.

(3) The increase in costs of raw materials, which are used in vast quantities in this throw-away society, has rapidly escalated the costs of medical care. The materials required for patient care in terms of paper, plastics, and other products which are not normally brought to the attention of the analyst of health care costs, has increased rapidly over the last several years. Obviously plastics and other related materials derived from petro chemicals have more than tripled in price in the last five years. Similarly the cost of forest related products, as we begin to have to rely on commercially grown trees rather than natural growth, has more than doubled in the last five years, and the reams and reams of paperwork being generated in the modern computerized society and the proliferation of myriad forms and more meticulous record keeping in view of the increased legal risks of practicing medicine today have vastly escalated the cost of providing medical services. Whereas twenty years ago a practitioner could perhaps keep 10 years' pertinent medical records on one 5 x 8 file card, today the average simple office visit generates more than half of a page (8 x 11) of data required by modern standards of practice.

(4) The increasing legal costs relate to two areas: (a) An increase in malpractice premium rates of 100% to 1000% depending on what part of the country, which in turn is due to an increase in the litigious nature of our society, and (b) The vast amount of expenditure involved to generate government mandated paperwork. In passing it should be noted that approximately one-third of the total non-physician personnel in any private physician's office is involved solely with processing of paper for 3rd party payers and to meet government regulations, nor is there any end in sight to this burgeoning mountain of paperwork.

# MALPRACTICE AND COST CONTROL

D. A. Berg, D. O.

A plethora of damage suits have been filed against physicians and other professional groups as well as corporations and businesses in the past decade or two. Rising insurance costs for professional and business liability has driven some businesses out of operation. Insurance was so hard to get that it even necessitated government guaranteed insurance for the drug companies who manufactured the swine flu vaccine.

Physicians' malpractice insurance rates have skyrocketed. According to St. Paul Fire & Marine Insurance Company, one out of every 23 doctors in 1967 was charged with malpractice and the average claim was $7,731. By 1975, the average claim rose to $12,266 and one out of every ten doctors was being charged with malpractice. In addition, the number of claims exceeding $100,000 increased 400 percent between 1972 and 1974.

The Ralph Naders and other activist groups whose business it is to generate publicity and "protect the consumer" are partly responsible for the changed attitudes of Americans about suing. The publicity given exhorbitant court settlements by the media has also encouraged the "something for nothing" people. But in the minds of a great number of knowledgeable people, the single greatest cause of the wave of litigation of this decade is the lawyer's contingency fee because the contingency fee rewards the lawyer according to the moeny he can collect for his client, not for justice meted out. Thus, the higher the settlement, the greater the lawyer's fee. Hence, lawyers sue for outlandish sums, encourage clients to run up high medical bills, and disdain reasonable settlements. The system does not guarantee justice for the impoverished--no respectable malpractice lawyer takes a poor person's minor claim but they will all take a [illegible] person's personal injury case if damages seem substantial and they [illegible] take them with or without contingency fees. After all the lawyers aren't going to get paid in most instances until the case is settled and money is available, so why the contingency fee? The reason for a contingency fee system is simply to make it possible for the lawyer to collect 35% to 50% of the injured person's compensation, which is unconscionable. And, of course, the incentive then is for an unreasonably high award so the lawyer can make more money.

The contingent fee system actually imposes a bounty on doctors. The most negligible injury sustained by a patient at the hands of a physician can be blown up to a massive award.

In fact, it was for many of these same reasons that William the Conqueror outlawed contingent fees in England more than 900 years ago. Today, the U. S. is the only country in the world where such arrangements are legal.[1]

In the minds of many, contingency fees are immoral and unjust and actually corrupt our judicial system. They serve no useful purpose but, on the other hand, impact heavily on consumer costs, not only for medical care, but for everything the consumer buys. In the face of the present crisis, isn't it time to abandon a system that the rest of the world turned away from centuries ago as unworkable and unfair?

1. Physician's Management, p. 42, August, 1975

# REGULATING COST CONTROL

D. A. Berg, D. O.

The concept of pre-determining prices outside of the free market place is a foreign intrusion into the economics of this country and has been an abysmal failure in those authoritarian countries where it has been tried, to wit, Russia and other socialistic countries. Food, washing machines and clothes cost two to three times as much in Russia as in western countries, yet transportation and medical care, for example, are incongruously cheap. The supply and demand factors have been largely eliminated so that the central government determines what shall be available and at what price, hence, pre-determining the life-style of its citizens. It is difficult to understand how uninvolved, inexperienced social planners can successfully supplant the financially involved extrepreneur who has to be knowledgeable regarding cost factors and pricing at the risk of financial disaster. Certainly, when the central planners of socialistic countries really need to determine the true value of a product, they always turn to the open market system of western countries and a good recent example of that was the oil market. Since Russia exports large quantities of oil to its eastern satelites, the price of Russian oil was allowed to rise simultaneously with the sudden advance of western oil prices in 1973--cost planners be hanged.

And if government hospitals of today, for example, state, county, and city hospitals and Veteran's Hospitals are any indication of cost savings and efficiencies to be attained by government control and central planning, then we certainly have a foresight of disaster as these institutions are the most inefficient in the nation while, on the other hand, proprietary hospitals in many instances have been the most cost effective of all according to former Rep. Otis Pike.

Maryland was the first state in the nation to mandate hospital rate structure by statute. In an interview June 1, 1978 Francis B. Francois, Councilman at Large of Prince George's County, an attorney and directly involved with the state's hospital regulatory body, stated to me that a saving of five to ten per cent was being effected by the state's imposition of cost control and rate structure but added that the private hospitals were doing as well as the city and county hospitals in cost control and "we need the private hospitals to keep us honest." Or, to put it another way, once could surmise that he meant they needed the private hospitals to determine a true market value.

He was also admitting, in essence, that the competitive system if kept in a free climate of competition was, of itself, a very effective cost control economic structure.

I would submit that the ~~unfiltered~~ unfettered market place, not jostled with government regulation or infusions of government money, and made truly competitive by elimination of all government restraint of trade such as

REGULATING COST CONTROL, D. A. Berg, D. O.

Certificates of Need, would be very effective in lowering costs. Certainly, a scheme that creates a "territorial monopoly" as does the Certificate of Need, does not allow the free play of competitive economic factors. Neither do mandated wage rates as seen in minimal wage laws nor Davis-Bacon Acts which require construction by union contractors. The only thing wrong with free enterprise today is the fact that it isn't being used and hybridizing free enterprise with "central planning" merely creates a monster that nobody can handle. This would be my personal objection to the proposals put forth by the A.M.A. Cost Commission and by the Voluntary Cost Containment Program of the American Hospital Association, the American Medical Association, and the Federation of American Hospitals.

If physicians self-flagellate and undergo the severest kind of cost introspection, a saving of five to ten percent of present health care costs might be effected but this is only the tip of the medical cost iceberg. If we let the social planners do the job for us, we can expect health care costs to sky-rocket as in every government hospital in the land. When Denmark tried it, their costs soared skyward and presently nursing home costs in Denmark are 2½ times the cost per day for the average American nursing home facility.

THE WRONG WAY OUT?

D. A. Berg, D. O.

The federal government has turned to "nationalization" of the health industry as its answer to cost containment in spite of the fact that other countries have tried this and found that costs rose, quality declined, and the supply of health never meets the demand. Supporters of the Kennedy-Corman bill acknowledge that the initial costs of total health care under their bill would be nearly 248.5 billion per year, about twice the present cost of health care. The proposed A.M.A. plan would cost only slightly less at 243.8 billion.

Highly socialized Denmark is now paying $59.37 per day for nursing home care, 2½ times greater than the present daily cost in the United States.[1] In Great Britain, spending on administration is now over half of what is spent on patient care.[2]

The government's estimates of the cost of Medicare, Medicaid, and Veteran's Care has always greatly exceeded expectations. The worst over-utilization in the country is seen in Veteran's Hospitals.

Based on the government's track record of cost control with Welfare, Amtrak, the Post Office, and Veteran's health care, how could we possibly believe government medicine would be cost effective?

Then the matter of accessibility--the other reason for National Health Insurance. Turning again to the original model, Great Britain, the government's own figures show that 700,000 people are waiting for surgery and this is a country with only one quarter the population of ours.

And then the matter of the necessity for a change in the United States health-care delivery system.

Health care needs of the American people are being addressed and effective systems are in place. The economically disadvantaged have Medicaid, the disabled have health care through Social Security, our working labor force is covered with company and/or Union insurance, injured employees are covered through State Industrial Commissions, and the elderly have Medicare. Thus, only a remarkably small segment of American people, generally the low-income, employed groups and those suffering catastrophic illnesses, have sub-par medical care. Throwing out our very effective American system that has evolved over the years to meet traditional and special health-care needs in favor of a very costly socialized system of medicine to reach a very small number of undercared for citizens of our country is an excessive and inappropriate method of reaching these people.

1. Year to Date--Health Care Newsletter, Feb. 28, 1977, p.3
2. Private Practice, June, 1977, p.40



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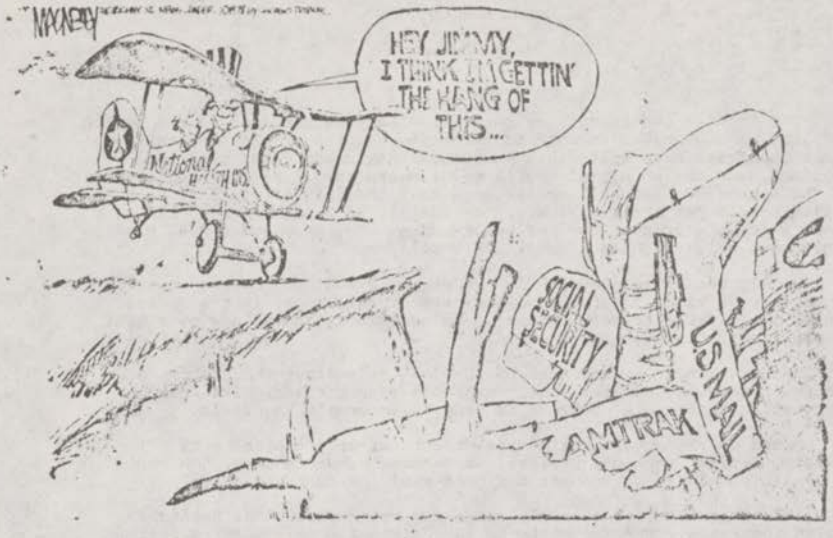
HEY JIMMY, I THINK I'M GETTIN' THE HANG OF THIS...
SOCIAL SECURITY
U.S.MAIL
AMTRAK

# HEALTH CARE DELIVERY SYSTEM IN U. S.

D. A. Berg, D. O.

There is little argument today that America has the best health care delivery system in the world complemented by the best trained physicians and the best equipment. Yet, perhaps due in large part to a drum-beat of adverse government propaganda, 61% of respondents in a recent University of Chicago survey believe there is a "crisis in health care" in the United States. However, 88% of these same respondents were satisfied with the health care they themselves receive.

The same University of Chicago study also surveyed favorable aspects of American medicine and found that infant mortality has dropped 19% in the last five years, 75% of the population and 87% of infants and small children had at least one visit to a doctor in 1976, blacks and low-income Americans have obtained sharply improved access to medical care, 52% of the population had a physical exam in 1976, 63% of people are satisfied with the out-of-pocket cost of care, and 87% are satisfied with the quality of care they receive.[1]

Then, where is the crisis necessitating such drastic action as nationalization of the industry? Ah, it turns out to be a budget crisis. Total medical spending in the nation is projected at 264 billion by 1982, double the current total and six times the total of just ten years ago.[2] Or, stated another way, national health spending per person has more than tripled during the last decade, from $212 in 1966 to $638 in 1976.[3] And when did health care costs begin to make a disproportionate rise against other costs as compared in the Cost of Living Index?

It is interesting to note that during the 20 years prior to 1965, the hospital care price index was lower than the consumer price index; but immediately after infusion of massive federal money into the health care system via Medicare and Medicaid, the hospital care price index started rising much more rapidly than the consumer price index.[4] As more and more federal dollars are pumped into the industry, more and more people attempt to achieve the ultimate in health care, and hospital costs skyrocket. (Hospital costs rose 22% in 1975 e.g.) No market, health care or otherwise, can sustain equilibrium in the face of such sudden and massive infusions of dollars and increased demand. Government, mainly through Medicare and Medicaid, now pays a major share of hospital costs in the U. S. but government has been unable to control the rise in costs. Federal outlays for health care in 1977 were 36 billion dollars but the 1979 budget for federally funded health care is pegged at 47 billion.

The Secretary of H.E.W. certainly has become a monetary czar in our federal government. On April 19, 1978, Secretary Joseph Califano bragged that the budget for his Department alone is larger than the total national budget of any nation in the world except U. S. S. R. [5]

Compare the current federal outlay with the total health care budget of 25,3 billion in 1964 covering all hospital, physician services, drugs, and miscellaneous health care costs.[6] This, of course, was before the advent of major government intervention in the health care field. In that same year, 1964, Americans spent 51 billion for tobacco, alcohol, recreation, and personal care and continue to spend about 30% of the national income on these items each year.[7]

The demeaning of the health care delivery system through an intense attack on integrity of physicians, the rising health care costs, and the purported inadequacy of the distribution of health care all date back to the government's maiden voyage into tax-paid health care delivery. Assuming that this is not a carefully orchestrated propaganda plan by the proponents of government planning for most of life's events, could a better plan be found to inaugurate socialized medicine than by destroying the most respected institution in America, namely, the health care providers. And when traditional system of health care in America is destroyed by government intervention and the costs have become prohibitive because of government policy, can we expect the federal agents to administer a better product for less money?

1. Wall Street Journal, 2-10-78
2. Nation's Business Feb., 1977, p.16
3. Private Practice, April, 1978, p. 44
4. American Family Practice, August, 1977, p. 59
5. Speech by Sec. Califano, April 19, 1978
6. U. S. Dept. of Commerce, Office of Business Economics
7. Ibid, Office of Business Economics, U.S. Dept. of Commerce

CAUSES OF HEALTH CARE COST RISES

D. A. Berg, D. O.

1. General inflation. Basic industries such as coal mining receive 37% increase in wages and benefits over a three year period and the government blinks not an eye. Coal is so basic that its cost ~~affects~~ impacts virtually everything that Americans buy. Sixty percent of the rise in health care costs can be attributed to inflation according to Kenneth Platt, M. D. [8]

James R. Williams, General Manager of the Health Insurance Institute and Vice President of the American Council of Life Insurance, points to the "tremendous changes that have occurred in the health care field since the Medicare and Medicaid Acts of 1965."

He points out that 22.5 million aged and 2.1 million disabled are now enrolled in Medicare and 22.9 million poor are now receiving services from Medicaid.

In fiscal 1975, Mr. Williams says, federal and state payments for health care represented about 42.2 percent of all health expenditures.

"Diffused through taxes, this hidden cost of national health care serves as a far greater catalyst to rising health care costs than private insurance plans." [9]

2. Injection of massive sums of federal dollars into the health care delivery system and at the same time providing a greatly expanded market by providing "free" care to millions of Americans.

3. Increased number of physicians. The ratio of doctors to population has increased to 162 per 100,000 in 1976 from 139 in 1960. Each new doctor generates about $200,000 each year in health care costs aside from charges for his own services. [10]

4. Increased technology. By-pass coronary artery surgery goes for about $25,000 per trip, for example. Prosthetic orthopedic surgery goes for $3,000 to $5,000 and up. The most effective treatment for deep vein thrombosis is newly released streptokinase and urokinase. Thrombo-embolic disease is a very common disease. The cost to the hospitals for therapy with streptokinase runs $200 per day; 12 hours treatment with urokinase is about $3,000. Organ transplant surgery runs into $25,000 to $50,000 bracket. All of these procedures have come into common usage in just the last decade.

5. Government "red-tape". Government imposed controls, regulations, and reporting costs the average patient in the hospital about $22 per day according to a recent study. [11]

CAUSES OF HEALTH CARE COST RISES, D. A. Berg, D. O.

Medical services is not the only industry impacted by government "red-tape". Government rules add $1,500 to $2,500 to the cost of a home, $670 to the cost of a new car. 12

6. Lack of consumer cost constraints. Consumers, especially those represented by unions, have demanded and gotten first dollar coverage. The assurance that someone else is paying the bill eliminates the disincentive for overutilization.

7. Nature of product. Ultimate in medical care is practically unattainable and people continue to die. Yet people obviously strive for unattainable goals - eternal life on earth, hence, the product is almost infinitely expansible. If economic constraints are removed, the insatiable demand for medical service must be controlled by some form of rationing. Life and death decisions must eventually be rendered on a basis of non-biased paremeters administered by dispassionate boards. These decisions relative to access to medical care are a proper government role according to Monte Pascoe, Denver Democratic leader as detailed in his speech to the Denver Medical Society Socio-Economic Committee April 12, 1978.

8 Physicians' attitudes toward exhaustive, "cost be hanged" approach toward diagnosis especially in reference to x-ray and laboratory procedures. It is generally agreed that physicians are the largest single influence on hospital charges and generate 75% of the hospital bill, directly or indirectly. 13

9. Tax deductibility of health insurance as a fringe benefit. Unions helped to persuade Congress that not only the employer's cost for insurance benefits for the entire cost of medical and surgical procedures should be tax deductible but that the benefits should be non-taxable when received by the employee and his family. The combination of employer deductibility and employee exclusion resulted in a benefit being provided which appeared to have no cost to anyone.

The objective of all this was simple--expansion of coverage. And expand it they did. Unions persuaded employers that they got more bang for the buck by picking up the tab for expanded insurance coverage than for the same expenditure in direct wages which would be taxable to the employees. Doctors saw new avenues for having guaranteed payment for a wider range of their services. Insurers saw the possibility of an increasing flow of premium over a wider range of risks.

If this approach is not realistic, might it now be the time for the Congress, employers and employees alike to take a second look at the apparently inexpensive approach to medical coverage provided through nontaxable benefits? Is it unreasonable to suggest that the tax-exempt nature of these benefits has contributed to the lack of cost consciousness which has led us to our present state. 14

10. Hospital unionization. An important portion of the rise has occurred because hospital unionization or the threat of it forced pay scales in hospitals up at a faster rate than the average. Until recently, there has been, in fact, a pay scale lag which was bound to be overcome in time, particularly in a climate of relatively full employment where hospital employees have ample employment options. [15]

11. The blooming (or festering) "malpractice business" has reached an all-time leech effect on the cost of medical care. The American College of Surgeons estimates that close to 900,000,000 - nearly half of the approximate total of 2 billion dollars that all physicians will pay for their professional liability insurance this year (written in 1976) - will go to attorneys for malpractice plaintiffs and defendants.[16]

Or, put in another perspective, one study of legal charges pegs the average gross recovery per case for all lawyers at $22,000; but for malpractice attorneys the average is $81,000.

The fact is that, although the patient ultimately winds up with only 16 cents out of every malpractice insurance premium dollar, lawyers pocket about 52 cents. [17]

The field, of course, has become very economically attractive to the legal profession. At a recent seminar on medical liability sponsored by the Association of Trial Lawyers of America, 288 lawyers attended. Only five had ever tried a malpractice case; the rest were there to learn! [18]

The malpractice risks impact hospitals as well as physicians. The cost of malpractice insurance has gone up more than 750% in the past five years.

While the malpractice suit started out as a means of protecting patients, it developed into a major malady affecting the efficient delivery of health care. Its cost to the consumer (about $6 per patient day according to the American Hospital Association) is way out of proportion to the actual incidence of malpractice. More tests - x-ray, lab, etc. must be done to cover any eventuality that could be brought out in a case in court.

8. C.C.V.M.S. Newsletter, May, 1977
9. Nation's Business, Feb. 1977, p. 18-19
10. U. S. News & World Report, October, 1977
11. Stirring, Volume 1, Number 5, Jan., Feb., 1978
12. Kissinger Letter, April 21, 1978
13. Hospital Medical Staff Advocate, Nov. 1977, p. 1
14.)Heath Larry, President of the National Assn. of Manufacturers,
15.) Jan. 27, 1978
16. Medical Economics, Feb. 23, 1976
17. Physician's Management, August 1975, page 36
18. Ibid, p. 36

# CHAIRMAN'S SUMMARY

D. A. Berg, D. O.

## General Inflation

If general inflation accounts for 60% of the cost rise in medical care and is the single greatest inflationary factor in medical costs today, then addressing this issue first seems appropriate.

The causes of inflation are multitudinous including government policy of fostering inflation by deficit spending, wage hikes exceeding wage earners' increased productivity; scarcity and shortages; government distortion of free, competitive marketing, restraint of trade practices of some businesses; wars; rapid population growth; government pricing policies, for example, farm products; non-monetized currency; tariff regulations; etc. Most of these issues can only be addressed in the political forum, hence, if physicians really want the inflationary spiral curtailed they must perform their civic duties in the political world. If the medical community is a citadel of wisdom partaking generously of the beneficence of America, then the profession also owes the country a measure of political servitude. The impact of a medical profession really turned on for our country versus pure special interest lobbying might have a surprising impact on the politics of this country. Thus, the general control of inflation with its inherent effect on medical costs must largely be a political effort.

1. The issue of general inflation must be attacked in the political arena. The medical profession has a genuine interest in the welfare of this nation and, therefore, must be active in the leadership of this country.

2. Some aspects of health care delivery are outmoded, for example, emphasis on "sick care" versus "well care" and a greater thrust must be made in the direction of preventive medicine. Patients must also be made aware of their role in health care including drinking and smoking restrictions, food selection, weight control, mental health, etc.

3. Full service hospitals with all private rooms, television, electric beds, and gourmet diets are a luxury not necessary in this day of cost control.

4. Payments to physicians based on "usual and customary" or "standard for the area" penalize physicians who practice in the hinterlands where rates based on the above parameters are generally lower. Better physician distribution would occur if the "country" doctor were paid "big city" fees. He is probably more deserving of the higher fees, anyway.

5. Physician's fees rose 9.3% last year--50% more than other consumer prices according to the Kiplinger Letter, March 24, 1978. The Letter

went on to say that, "fee inflation has swelled doctors' incomes to four times that of all other professionals."

The above information probably came from government sources and is unreliable but, nonetheless, physicians could afford to announce a fee moratorium as an example to the rest of the country.

6. Accomodating the government planners weakens our position for freedom to practice and puts us in an indefensible position trying to defend a hybridized (or bastardized, if you please) health care delivery system. Medical societies should improve and defend the present patient-physician health care relationship--not help to nationalize it.

7. Physicians should be in the forefront in an effort to rescue our American judicial system from the excesses of the lawyers. If we don't, we will soon have no civil or criminal justice in this country.

8. Physicians should honor their oath to care for the sick and afflicted. Denying medical service, at least on an interim basis, to anyone requesting it is an affront to the high calling of the medical profession. The late Carl H. McLauthlin, M. D. said it so beautifully when he said, "When a majority of physicians worry more about what they can get than what they can give, we no longer will be a profession." Colorado Medical Society Newsletter, June, 1977, p. 2.

(FOR COLORADO TESTIMONY)

Dear Senator Kennedy,

At your subcommittee in Denver, I was twelfth on your list of one minute comments of which you allowed ten people to speak. I represented the 'Colorado Diabetic Association'. Enclosed are my comments.

I am a dietitian and member of the American Diabetic Association. I will speak today more as a middle-of-the-roader, because I have heard today those groups who appear quite selfish and short-sighted who speak for their groups in favor of the National Health Insurance because as they have cited in their own texts- it means more jobs for their professions.

Recently, one of our state politicians who ran for and won a Republican Senatorial Seat ran on the platform of being a middle-of-the-roader, so too recently did President Carter speak out in favor of Democrats becoming more fiscally minded and taking on a more "middle-of-the-road" approach because our inflationary times demand it.

I think National Health Insurance avoids the real problem with rising health costs and that problem is inflation. Mr. Alfred Kahn, the man appointed by President Carter to curb the inflationary spiral has spoken out repeatedly against American enforcing more governmental controls and has instead, spoken out for free enterprise and the competitive spirit. I am against government control of the public sector whether it be health insurance or the airlines- bananas to it all!

The Health Care Industry is addressing the problem of inflation. In the last seven years that I have worked in the field I have seen many more budgetary checks on hospital budgets. Also much more cost analysis by insurance companies of their services and the need for constant documentation if coverage is to continue is now necessary. Hospital Administrations are looking at what are essential services and what are auxillary services and not including auxillary services as standard services, but let the consumer choose and freely decide what he wants to purchase as health care and what he feels he doesn't need.

Speaking of free enterprise, I am seeing a great increase in Home Health Care Services springing up and the attitude that the family is a viable alternative source of taking care of a majority of health care needs. With free enterprise comes competitive services and competitive prices and if inflation could be curbed, these alternate approaches to keeping health care services reasonably priced could work.

America with our competitive excitement has some of the best medical care in the world. Mr. Kennedy, do you recall two of the six speakers from Canada stated that their doctors had advised that for expert medical treatment, to take them to Seattle and Philadelphia? Do you know why? Unlike Canada, 50% of our good doctors have not left America because in a free society you can be a rich

man, poor man, doctor or Indian Chief. Let's not ruin another one of our competitive forearms of our greatness.

I also advocate preventive measures, both institutionalized ones and competitive ones:

1) Four our children-the Women, Infant and Children Program, School Lunch Program and/or the Breakfast Program-are excellent means of preventing disease in the young.

2) Senior Feeding Program is an excellent social and preventive program that will prolong life and well being to our elderly.

3) More Public Funding to Research to study cancer, heart problems, diabetes and inborn errors of metabolism is greatly needed.

4) More independent genetic counseling firms for families to use on a referral basis so to curb the births of children with cystic fibrosis and other inborn errors of metabolism that make for astronomical medical bills.

Therefore, I am against more governmental control and would prefer to see our competitive American Society have more rein in controlling their own health care problems.

D.J. Looney
4747 E. Miss. Ave #319
Denver, Co. 80222

P.S. I couln't have make it in one minute anyway, this is probably better that I sent my soap-box.

Senator KENNEDY. Before we adjourn, I would like to introduce William Armstrong, father of the new Senator-elect from Colorado. He has been with us all morning during the course of the hearing.

We want to say a word of welcome.

Maybe you would stand up. [Applause.]

Senator KENNEDY. We are delighted with your presence and your attendance here this morning.

We want to thank all of you this morning for coming and being with us.

The subcommittee stands in recess.

[Whereupon, at 12:38 p.m., the subcommittee recessed.]

# NATIONAL HEALTH INSURANCE, 1978

THURSDAY, DECEMBER 14, 1978

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE COMMITTEE ON HUMAN RESOURCES,
*Queens, N.Y.*

The subcommittee met, pursuant to notice, at Italian Senior Citizens, Inc., Italian Charities Building, 83–20 Queens Boulevard, Queens, N.Y., at 10:10 a.m., Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy and Javits.

## OPENING STATEMENT BY SENATOR KENNEDY

Senator KENNEDY. We'll be in order, if we could, please. We'll ask our guests here if they could kindly be seated so we could begin with the testimony.

We've got a very full morning of hearings. We have some very special guests, many of your neighbors and friends who are going to speak with us here this morning. We'd like to get our hearing underway just as soon as we could.

We've got a full meeting hall here, and we're delighted to welcome everyone, but we'll have to be in order in order to hear our witnesses now.

We will be in order. We're going to ask everyone if they'll restrain their conversations so that we can get started with the hearing, please.

We're delighted to have the opportunity to bring the Senate Health Subcommittee back to New York City as a part of a series of field hearings being held all over this Nation on National Health Insurance.

I am particularly pleased that my good friend and colleague, Senator Javits, is with us here today. Over the years, the people of this great city have had no better or more effective advocate than Jack Javits. And over the years I personally have had no better friend or ally in the Congress than Senator Javits. [Applause.]

Now, we don't usually permit the audience to express themselves, but that was a very well-deserved round of applause for a good friend, and I was pleased to join in it.

I look forward to his help as our subcommittee fashions a national health program for all the people of this country.

Contrary to conventional political wisdom, there is a growing grassroots coalition for a national health plan here in New York, as elsewhere across the country. This coalition consists of working men and women, senior citizens, nurses, religious groups of every denomination, minority groups, women's groups, young physicians, interns and residents. I believe the coalition will continue to grow in size as the middle class begins to feel the pinch of rising premiums, increasing deductibles in coinsurance, and diminishing benefits.

There are many in Congress who believe that national health insurance is an idea whose time has come and gone in the United States. I wish they could all be present in this hearing room this morning. They would draw very different conclusions.

For if health insurance is an idea whose time has gone, then he American economy is in grave difficulty, because, left unchecked, health care costs will bankrupt this Nation.

If health insurance is an idea whose time has gone, then millions and millions of Americans will continue to share the plight, the needless suffering and anguish, of those New York families who will testify here today.

If national health insurance is an idea whose time has gone, then 26 million Americans will continue to have no coverage at all, another 18 million will live with totally inadequate coverage, and 52 million Americans will have inadequate health care.

And if national health insurance is an idea whose time has gone, then this great city and this great State will be bankrupted by health care costs.

And we saw, just walking into our meeting here today, those that were concerned about national health insurance and those that are concerned about the plight of the municipal hospitals in your great city—very much the same problems that exist in Boston and many other major cities of this country. We know the extraordinary pressures, financial pressures, which are on the municipal hospitals.

In many instances, those municipal hospitals are providing the only health care for millions of citizens who live in the major urban areas. I'm sure we're going to hear more on that issue later this morning.

Critics say we simply can't afford national health insurance now. The truth is we can't afford not to have it. For if we do nothing at all, and leave the current system alone, this Nation will spend some $252 billion on health care by 1981—and it's important to understand what we're talking about in terms of the cost, because the costs are one of the principal issues that are before the country.

Make no mistake about it, if we do nothing at all, we're going to be spending $252 billion by 1981. Those are Congressional Budget Office figures.

The Congressional Budget Office doesn't support our program or any other program. It just does hard analysis.

So what we need to do is get effective kinds of costs containment and deal with the problem in a comprehensive, universal way. That is what we favor.

In 1968, for example, Canada was spending 6.8 percent of their GNP on health care. Now, in 1978, they're spending 7 percent. And they

now have a total comprehensive program. Because they have prospective budgeting and they have effective cost containment, they've brought those elements together—cost containment and also adequate coverage—and they effectively have a ceiling on it.

In 10 years look what's happened to the United States: 6.5 percent in 1968 and 8.8 percent in 1978. We're finding the costs are going out of control, and you're going to hear the human dimensions of this problem here today.

This is a very real issue and a very real problem. That's why we have to deal with it. We have to get effective cost containment, and we also have to deal with the equity issue. We see other societies in which that is done.

I don't want to give my speech in Memphis again, so I won't. [Laughter.]

National health insurance is about the economic health of this Nation; but, most importantly, it's about people's lives. Every man and woman in this country knows the fear of illness. Everyone in this room has felt it. And that, I think, is really the fundamental and basic issue.

Whether we as a society are going to develop a health care system that is going to free the American people from the latent fear of devastating illness and sickness, even perhaps modest illness and sickness in terms of medical definition—but that is a catastrophe for people, for our elderly people that have to pay the $10, $15, or $20 a month for prescription drugs that they just can't afford.

We want to develop a system that makes the American people free from the fear of illness. It's bad enough to be ill and sick; but it is, I think, unacceptable to have the additional kind of financial burden. [Applause.]

Now, I want to introduce a person that needs no introduction to you.

Just before I do, I want to thank Stephen Framboli [phonetic], who's the executive director of the Italian Senior Citizens Center, who's been extraordinarily helpful to us, and we're very, very grateful for all the kindnesses and courtesies that have been extended. [Applause.]

To Ed Pasano [phonetic], who's been very helpful to us; to all those who were involved in the entire senior citizens center for making this available.

We know what this center has meant to hundreds of people in this community, and the very important life that it has meant to this community. We're enormously grateful for this.

Senator Javits just returned from a very emotional trip, I know, attending the funeral of an outstanding world leader and good friend to the United States, who we certainly all knew and respect, Golda Meier. [Applause.]

He wanted to be here this morning, and went to extraordinary lengths in order to join with us because he cares so deeply about the health care issue.

As I said before, we've worked closely together, as he worked so closely with my brother Bob and President Kennedy. So he'e been a good friend and valued ally. We welcome him here this morning. [Applause.]

PREPARED STATEMENT OF SENATOR JAVITS

Senator JAVITS. Thank you very much, Chairman Kennedy.

We're very pleased to have you in New York, and we're very thankful this hearing should be held in New York in the presence of Governor Carey, and many other distinguished people.

Mr. Chairman, today we receive testimony from citizens of New York regarding the need for a national health plan.

It is proper that we are holding today's hearing in New York City—for this city represents in a microcosm both the achievements and the shortcomings in our health care system.

New York City offers the finest medical care to be found anywhere in the world. The facilities and equipment located here are among the most sophisticated; this city's health practitioners represent the best available in the country; New York's medical and other health professions schools produce superbly trained doctors, nurses, and other health professionals; and this city is privileged to have citizens whose pioneering work regarding such important health-related issues as prevention and occupational health and safety has resulted in widespread recognition of the important role that these factors play in contributing to the health status of all Americans.

The accomplishments of New York City in health are matched, however, by critical problems:

Health care costs in New York are skyrocketing. This year the New York City budget will devote approximately $3 billion to health care this massive support for the city's health care system—which provides (more than 1 percent of the Nation's total health care bill). In spite of health services unequaled by any other American city—adequate health care services are still not equally available to all New Yorkers.

Despite the fact that the city boasts the finest in health care facilities, personnel and equipment in the country, the quality and availability of health services remain widely uneven throughout the city. Today, of the 7½ million people who are residents of New York City, over 2 million live in parts of the city which have been designated by the Department of Health, Education, and Welfare as medically underserved; that is, areas which suffer a shortage of personal health services. Five out of every six New Yorkers who live in medically underserved areas statewide live in New York City.

The working poor face the greatest difficulties in obtaining health care services. Many people with occasional or low-paying jobs have incomes which exceed the medicaid eligibility limits but have no health insurance because their employer does not provide it and they cannot afford to purchase it on an individual basis. The high cost of adequate health insurance to the small employer or the individual consumer continues to present one of the most serious obstacles to universal access to necessary health care services.

These are but a few of the barriers to adequate health services which confront citizens of New York City. The problems which I have described are, however, not unique to New York City. On the contrary, as this subcommittee has seen, they are the same problems which can be found in rural and urban communities across America.

I believe that New York City will continue to assume a major—if not primary—responsibility in solving the problems which face this

city's health care system, but I also believe it is unreasonable to expect New York City to do this alone; for the problems with the care delivery system which we find in this and every major city and many rural communities across this country transcend the ability of any individual community to deal with them effectively. Our city's municipal hospital system, for example, needs and deserves the assistance of the Federal Government.

The solution to these problems, in my judgment, lies in the adoption of a national health plan. While some may fear that adoption of national health plan would prove to be inflationary, the fact is that this country can no longer afford not to adopt such a plan. A recent HEW-funded study estimates that, without substantial reform of our health care system, this country will spend $1 trillion for health care in the year 2000.

Unfortunately, many people view national health insurance narrowly as only a financing mechanism for universal health care services. But a national health plan need not—and indeed should not—be only a financing mechanism. I believe national health insurance should be a vehicle for simultaneously achieving cost containment, overcoming geographic and specialty health care maldistribution problems, reordering priorities to give more emphasis to health care services. This year, elected officials at all levels of government in all corners of the country heard voters call for greater fiscal constraint and improved management of public funds. I interpret those votes as a call to reform and improve the health sector. I view them as a demand carefully review how we are spending our health dollars and to look for ways of allocating our health resources in a more cost-efficient fashion.

Furthermore, most recent polls indicate wide support for the adoption of NHI. Last month, in fact, a poll conducted in New York City by the Daily News showed nearly 8 out of 10 New Yorkers favored the adoption of a national health insurance plan, and exactly half of those polled said they would back the plan even if it meant they would have to pay higher taxes.

Pursuing the adoption of a national health insurance program has, for me, been a lifetime effort. In 1949 I introduced my first national health insurance proposal; since that time I have introduced, on 14 separate occasions, measures aimed at providing health insurance protection to part or all of our population. In the 95th Congress I authored the National Health Insurance for Mothers and Children Act—a bill which would provide comprehensive health benefits to children from birth to age 18, and to pregnant women—which is designed to serve as a first step toward comprehensive national health insurance for all Americans.

Whether it be this approach or some new approach developed in the coming months, I will remain steadfast in my commitment to national health insurance. I believe it is unconscionable for the United States—which is the most able country in the world—to tolerate a health care system with so many deficiencies that many of our citizens are denied access to it at a fair price and on nondiscriminatory conditions. This situation can no longer be permitted to continue.

Today this subcommittee will hear testimony from residents of New York whose firsthand experiences will clearly illustrate shortcomings of our health care system. I welcome each of you and look forward to hearing your testimony.

Thank you very much. [Applause.]

Senator KENNEDY. We welcome the distinguished Governor of the State of New York, who's our first witness here. [Applause.]

As Senator Javits pointed out, we're going to hear about the very heavy financial burdens on the State, as well as the city. And I don't think there are public officials who are dealing with this health care crisis who can speak more eloquently or knowledgeably about these issues than your Governor and mayor.

So, we welcome the Governor here before you.

## STATEMENT OF HON. HUGH L. CAREY, GOVERNOR OF THE STATE OF NEW YORK

Governor CAREY. Thank you very much, Senator Kennedy and Senator Javits.

I need not tell you how warm a welcome we wish to give you in New York here. You received that when you came here and you're going to hear it throughout the day.

I want to move on with my testimony, my message to you, because I'm eager for you to hear from Mayor Koch, from Lillian Roberts, from the people who will testify on behalf of the city, of workers in the health system, those who need the benefits of the health system.

And you are on target, Senator, because, as you portray, the cost patterns that afflict the people and the economy of our country—we're in those things in New York—we have an unchecked, uncontrolled situation. We will be spending money on health, but we will be receiving the benefits of good health care.

And it's on that precise note that I wish to begin, and tell you that here in New York we can prove—we can prove to the people of the United States, as we've proven to the people of New York State, that you can have collaboration and a health system among the workers, those people outside—they worked with us to preserve and maintain what we have of health care in the public health hospital system. The private sector unions as well joined with us to reach wage negotiation patterns and preserve the health system in the private and voluntary sector.

We've done this because we had to do it, we wanted to do it, to have a health care system that would be available to senior citizens, to children, to families; and now we need it as a guarantee our efforts will not be ignored, because we can prove that you can have cost control, and you can have a better health delivery system if there is a commitment by the Federal Government to join with us in what we've been able to do in New York.

We want to guarantee adequate health care for the elderly, and medicaid has gone in that direction—and I was there in the Congress, Senator, as you were, and worked with President Kennedy, President Johnson, Senator Kennedy of New York, Senator Javits, Senator Kennedy, to secure the benefits of medicare and medicaid.

We've learned that the best-perceived programs, in the absence of good management, can fall victim to fraud and abuse, and we have that system here in New York. We moved on fraud and abuse. We're glad our efforts there have been recognized nationally, that fraud and abuse can be eliminated.

And in Congress I've worked, as I've said, and faced the economics of what could be a successful national health care program for us. But theory and philosophy and programs and promises are not all of life. There is a reality—from being a Congressman and dreaming those dreams of what could be done.

I moved to chief executive of this State. Along with the people in the New York City, the mayor, the people and the unions, with those who wanted to save New York City, we ran into a crisis with health before we tempered our dream with reality, and we made programs that began to fail nationally work in New York State.

Based on our experience, we should be able to make these programs work on a national level. It takes work, but it can be done.

Health should be a major concern of any government, but particularly for a Liberal-Democratic administration, it must be open and vigorously seen as a priority second to none. In other words, we must have a nationally organized system of health insurance now—and that's what the message is that I give you this morning. [Applause.]

As Governor of this State, I delivered three state of the health addresses each year in my administration. I'll say it again this year. I will tell the legislature that in New York we've been able to fashion a bipartisan awareness of the health needs of all of our citizens.

Two years ago, we passed an unprecedented number of the Governor's bills—21 out of 22 bills—and we did it on a bipartisan basis, because I believe, Senator, we can prove that health care is not a burden on the national economy. We can make people work in health, and prove to people that by work in health they can improve the national economy.

The day is gone when, in talking about affirmative action programs and how to put people to work in minorities you have to think of pick-and-shovel work. One in seven of our people can productively work in the health system and be part of the improvement of the health economy of our country.

We can take care of the cost of that system and do it by what you would call prospective budgeting and prospective planning. That must be done.

We achieved that goal in a time of fiscal crisis in New York, and it threatened the very survival of this city. We did it. That crisis might have destroyed the pensions of our elderly and the meager savings of the poor.

Yet, even in those darkest days, we never compromised our commitment to meeting the health care needs of our poor and our disabled. Despite temptations to indiscriminately slash budgets, we actually increased the State spending in the human service area while all other departments had to be cut.

It was a long and difficult road. It was a journey that had to be taken.

When I took office, Senator, our health care system was in a state of disarray. Large segments of our population were being denied ac-

cess to the primary health care they needed. Ironically, hospital capacity for inpatient service was far in excess of need. This was a costly and inefficient use of resources.

The cost of health services, especially those publicly funded by medicaid, were seemingly beyond control—certainly beyond the ability of our already-overburdened taxpayers.

Our nursing homes were in the midst of a major scandal with revelations of nursing home operators stealing millions of dollars from our elderly and our infirm. The system was callous, inefficient, unresponsive, lacked accountability—the very regulations of medicaid invited profiteering.

Cost-effective programs in preventive health, such as hypertension, breast cancer, cancer of the cervix, immunizations, and newborn genetic science were not receiving attention.

With the very lives of our citizens at stake, the normal checks and balances of society not in play, the system in disorder, and the cost of health services soaring out of reach, Government had and still has a clear obligation to assure reasonable access to such services and to regulate their quality, quantity, and cost.

There is no need to apologize for active Government involvement. It would have been utterly irresponsible to return to the passive role of the past.

We closed more than 103 nursing homes and 9,000 beds which could not meet State standards or were in excess of needs and in improper places. We did that in collaboration with the unions, with health managers, and the people of the community, so that we're now in a position to state that all of us are trying hard to improve the standards in the homes of the main operation.

We rigorously enforce periodic monitoring so those scandals will never be repeated.

We faced a medicare program which fails to meet the needs of our senior citizens. Medicaid is here. It is not adequate. It does not meet the needs of those citizens who have clear-cut needs. In this State we welcome you because we're a senior State—our senior Senator knows that—we have elderly people in this State far in excess of most other States in the Union.

Those are the New Yorkers we want here. We want to keep them here. We want them healthy. They therefore will be testifying to you today about the need for medicare improvement, despite increased Federal allocations. The elderly pay more out of pocket for health services than they did before medicare.

We will continue to encourage and fight for changes at the Federal level, but we cannot afford to wait. In New York, we've implemented State programs to supplement medicare. In other words, we're going ahead, Senator. We're going ahead because to do otherwise would be to neglect what's happening in New York.

Believe it or not, we have a long list of problems that actually drive families to divorce, destitution, despair, or institutions because of lack of needed health care.

We took a major step forward for the creation of a human, more equitable policy governing medicaid payments for long-term care. Prior to our new policy, the spouse of a person placed in a nursing home

was forced to spend down to the public assistance level—in other words, go on welfare—before the institutionalized husband or wife would be eligible for medicaid, to replace then what I would call the condemnation of marriage by an actual program.

Now, a sliding scale has been established which more realistically reflects the ability of elderly persons living in the community to contribute toward the cost of the care provided to husbands and wives. Compassion and love are not incompatible with good government; they just seem to be overlooked by bureaucracies or the tape in government that stop people from receiving the care they need. We must recognize an individual's need for pride, dignity, and self-worth.

In New York, we have sought to preserve the elderly in their homes and in their communities. Under existing Federal legislation, a family incurs less expense by institutionalizing a loved one than they do by providing home care.

New York has implemented a home health program which allows us to finance less costly nursing care in the home. To further reduce home care costs, New York State——[Applause.]

Senator KENNEDY. Mr. Mayor, we're glad to welcome you here. We'll look forward to hearing from you.

Governor CAREY. Senator, here's an item of cost control. To reduce further home care costs, New York State has also passed the strongest generic drug laws in the Nation. This has dramatically reduced the cost of prescription drugs to all of our citizens, and we're going on with that program.

Because we have this in place, we can now implement a drug insurance program for our elderly with reduced incomes, providing essential and expensive service which medicare fails to provide.

It is satisfying to review the innovative achievements of New York State, but the task of a chief executive is not merely to develop new programs. We have learned the hard lesson that we must never lose sight of the fact that our resources are alarmingly finite. It is our most susceptible populations who pay the greatest bill when the cost of health care escalates without adequate controls.

Cost containment is not an end, but a means to an end, to achieve our health care objectives. If we are to have an effective health care system, it has to be one we can afford.

The combined effects of inflation and Federal program cutbacks are jeopardizing the health care of New Yorkers and all other Americans, increasing the disparity and quality, quantity and accessibility of health care available to them.

Senator, it's affecting a basic civil and human right in this great State, this great city. The human right I speak of is if you happen to be born poor, black or Hispanic, or a combination of those, or you're aging, then I must say that because of the conditions we now face the infant mortality rate is higher, higher than it can be in a civilized human society; and the life expectancy is lower if you're in those categories. That's now addressing human rights, Senator.

So what you're talking about here is the human right of a sound health care system for everyone, to do something about the infant mortality and life expectancy which is not what it should be for those who were born in this city and this State.

Senator KENNEDY. Governor, do I understand then that you are in favor of a comprehensive, universal program, as one of the principal measures that remains on the unfinished agenda of this country?

Governor CAREY. That's correct, Senator, because, as you pointed out, we're going to spend the money anyway, and much of it will be wasted; it won't be aimed in the right direction.

Senator KENNEDY. Do you see this, as I understand it, as a way to get a handle on cost and explosion of health care costs?

Governor CAREY. That's the thrust of my testimony, Senator. We had a cost containment program in New York. We didn't get it by simply taking on the self interest group, the American Hospital Association, and those people. We did it because we collaborated with those people you see picketing outside and those unions, and we collaborated with the labor forces in all of the city and State.

We saw to it that by lobbying for the people we could get cost containment and cost control and then deliver better services in home health care, in services to the elderly.

And with the money we saved, we are now providing more drug services to the elderly on medicare and those who don't receive medicare. So the savings we ploughed back are improving the health system. You can get the savings to put them where the health care system needs them.

In this situation the public shares—this is important—we have the right to call the shots because we're paying for the cost. Health care consumes a major amount of the GNP of the State; and, as you pointed out, an increasing share of the GNP of the Federal Government. So we're paying for this with public dollars.

In our totals, the funding of health, all health in the public hospitals, in the private hospitals, 46.5 percent in 1976 came from government sources—State, Federal and local.

In fiscal 1977, expenditures for health and mental health, including environmental health and health education, accounted for more than $2.5 billion, or some 22 percent of our more than $11.4 billion State budget. It's a major cost area, and it can be contained, and we can improve services.

The cost of medicaid alone represents 30 percent of the State's health care expenditure. In 1969, the New York State medicaid program operated with a budget of $300 million. That has increased to nearly $3 billion, with annual increases as high as 49 percent.

With careful management, we demonstrated that one can control those increases. In 1977, New York State decreased the medicaid budget for the first time that any large State in the Union had reversed the medicaid spiral—and we didn't do it by putting these cost controls on the backs of the poor. We did it, again, by collaboration with the public hospital sector, by the unions—you'll hear that from Lillian Roberts, what they've done in district 37, her union. You're going to hear, as well, from hospital administrators.

But you can't do it in the public sector alone. Since we're paying the tab, Senator, one of the things we're fighting for in this State is full disclosure, full disclosure in the private and voluntary hospitals as well, of how the money is expended so we can curb them in cost control measures. That's the kind of thing we're going to put in place in New York State.

We acted decisively—I want to call this to your attention—management is linked to ways in which we can cause cost control, because that's music to the businessmen and those who may be on the other side of this fight—we've acted decisively to curb the rising cost of medical malpractice insurance which threatened the ability of physicians to practice in New York State and formed them to raise their fees.

Last year, New York was the only State to hold the line on medical malpractice rates—while I might note in comparable States, like California, realized a 100-percent annual rise in rates during the same period.

Some of our highest risk specialists will have a decrease in their rates in 1978 in New York—again, a unique example of how one State, willing to grapple with the complex challenges to the health system, can succeed.

We are seeking to reform a system which covers hospitalization for services that are not reimbursable in the private office or an alternative ambulatory setting. We're seeking a restructured fee schedule which would provide an incentice for physicians to enter areas of need and provide less rewards for those who choose to specialize in our oversupplied fields.

In New York, we've begun this effort. We have selectively increased fees for primary care providers practicing in underserved areas. In other words, we're encouraging people to go into the so-called "ghettos" because that's where medicine and care is needed.

We've increased financial support to hospital-based and free-standing ambulatory care programs, while encouraging the participation of community-based services.

We've established a State funded ambulatory care program aimed at the working poor who are unable to purchase conventional health insurance and who do not qualify for medicaid.

We have established an emergency hospital reimbursement program to help support those inner-city hospitals which must serve the undercovered population. New York looks to the Federal Government for an expansion of the principles embodied in these programs.

The average patient is incapable of judging the acceptability of care or the appropriateness of its cost. It is the undeniable mandate of government to protect the public through the establishment and enforcement of standards and regulations. We have moved to meet this mandate.

Throughout this administration, there has been a streamlining of the regulatory process to resolve State and Federal inconsistencies.

We have initiated an on-site utilization program, which has saved taxpayers more than $50 million in a single year by eliminating unneeded extended hospital stays. Those efforts brought us into direct conflict with Federal regulations that may have been good in theory but were poor in practice.

In New York, we faced reality, and do not believe we should have to fight a Federal bureacracy to cooperate in our struggle to stretch our resources so that the best health care can reach the largest number of people for the last amount of money.

We will continue these efforts and maintain that level of awareness necessary to contain cost and unneeded duplication. We will work in cooperation and in conjunction with all levels of Government and professional and consumer groups to guarantee the quality and efficiency of the health care system.

We must protect our citizens from the financial risks and personal tragedies of catastrophic illness. We might have expected a Federal initiative here but, again, we did not sit idly by and grip in New York. In 1978, New York State passed legislation to authorize catastrophic coverage for those families confronted by unexpected medical expenditures in several pilot areas.

As this program is expanded, we will end the necessity for divorces, broken homes, and bankruptcy to pay for needed health services. We in New York have provided unusual leadership in the development of health care policy. But the challenge is too great for our resources alone.

The Federal Government cannot be permitted to fail to meet its obligations for the provision of health care to the infants, the children, the elderly and the needy.

I was shocked to learn that the Federal Office of Management and Budget may be proposing irrational elimination or reduction of many needed health care programs. This serious and unprecedented action would slash health spending in the current year and in 1980.

At stake in the New York sector is $5 million in comprehensive health grants for preventive care. That means we want help in fighting hypertension, immunization, and venereal disease programs, along with substance abuse and alcoholism funds. They are to be reduced or eliminated. This cannot be tolerated.

Around here——

Senator KENNEDY. This is the money that comes to the State in the areas of hypertension, the real leader in the Senate on that has been Senator Javits, and also the area of the drug and alcoholism program.

Is that being well spent in the State? Because that was initially recommended by the OMB to be virtually abandoned.

Governor CAREY. Senator, it's not only well spent. We'll be fiscal about it and realistic—by hypertension checks in this very center, we've seen blood pressure rising, we've seen cardiovascular disease coming on—it can be checked, it can be handled. We can give them the kind of help they need so they don't have a stroke. We can see the onset of cardiovascular disease.

As far as alcoholism and abuse of toxic substance treatment is concerned, this is where it's at. We have an alcoholism and drug abuse program now in teens and subteens. You take that money away, and you force us into a reverse step. You force us into withdrawing the programs, and we'll have to go it alone.

We'll do our best, but this is no place to cut, this preventive medicine. This will save cost later on, because you have victims going into hospitals and then the cost goes up.

Senator KENNEDY. I'm very hopeful that the OMB and the President will certainly change those priorities.

We can put the rest of your statement in the record, if you'd like to, Governor.

Governor CAREY. All right. Let me just say my last words to Congress and I'll leave it at that.

The Congress must emerge from endless debate and parochial lobbying. We cannot afford a repeat of the senseless delay which led to the death of the Federal hospital cost control bill and a child health assurance program.

Senator, we're going to have the "International Year of the Child" coming up in 1979. Before we get to 1979, I'll depart. [Laughter.]

I want to say this to you—you see here the great mix of New Yorkers, and Ed Koch is coming on behind me, and others are coming on all day long. Their testimony will be the same.

To move on this program now, to put in health cost containment and control—let's fight for that. Let's fight, as well, while we're doing that, so we don't cut the very programs we have proved will work in New York.

We'll cut the cost of hospitalization. We'll give us a health system we can afford, and save lives. Thank you very much, Senator. [Applause.]

Senator JAVITS. Governor, I just have a few questions which I would like to ask.

Senator KENNEDY. We will be in order now.

Senator JAVITS. There is no question about the fact that our main opponent is going to be the problem of—alleged problem—of budget and money. Admittedly, medicaid and medicare, while desirable, are inadequate for the need. What I'd like to ask you about New York's experience is this: Is it a fact that even without a measurable increase in the aggregate expenditure, a remobilization of the resources which are available, based upon cost containment, preventive maintenance, and the use of intelligent cooperation of the workers through their unions and the cooperation of professionals, can vastly improve the degree of health care we can provide.

Governor CAREY. Senator, it need not be and it cannot be if we proceed in an organized way.

Maybe we need domestic SALT talks—we're going to save the salt of the earth, the elderly people, the children—domestic SALT talks to declare an armistice between the health providers who don't want cost control and those of us who knew we need it.

Cost control doesn't mean you're going to slash the budgets that affect the elderly, the children, the home health care, the new ideas. It means we apply the resources we have more effectively in an organized system.

We don't have an organized system now.

Senator JAVITS. May I point out to you, too, that the cost containment bill reported out by the Subcommittee on Health and Scientific Research was not acted on in the last Congress. I believe that this legislation is very important in terms of what can be done without straining the budget.

Governor CAREY. Senator, it died in the Ways and Means Committee, I believe, and maybe I can be of some help there. Now we have Charlie Rangel on that committee from New York and Tom Downey is a new member. We'll do our best to move it through that committee with you, Senator.

Senator JAVITS. Good.

The last thing I'd like to ask you about is this: Isn't it a fact that the whole essence of national health insurance resides in the insurance principle that the more people that are covered the more the burden is mutual and the more economical it is to cover the individual? And, further, that the savings from preventive health care more than makes up for the bulk of the cost of coverage for people that are involved in the system?

Governor CAREY. Correct, Senator. All we need do is destroy some mythologies that should not exist.

There was a mythology in New York that if we legislated maternity health coverage for women in insurance policies we'd drive business out of New York. We legislated that. We have maternity health care right now. It didn't drive anybody out of New York, because we more than compensated for the rising cost of health premiums by having an organized health delivery system.

Governor CAREY. We could afford the good things if we get rid of the fraud and the abuse and the waste.

Senator JAVITS. I'm very pleased to tell you that Congressman Scheuer, another New Yorker, and I sponsored a bill to provide health care for mothers and children.

Governor CAREY. In New York we have moved on teenage pregnacies and taken care of teenage mothers and given them care, to show them compassionate concern. New Yorkers are ahead in that. Make sure you put that in the bill, as well. [Applause.]

Thank you very much.

Governor CAREY. There's a line, Senator, "if you can make it here you can make it anywhere." That's New York. Thank you.

Senator KENNEDY. We'll thank the Governor, and we'll welcome the distinguished mayor of the great city of New York. [Applause.]

Mayor Koch, we were mentioning just as you stepped to the podium that you are probably as close a contact to the day-to-day problems of the people of this city as any public official. You know their problems, and that's why we're looking forward to your testimony.

We know prior to the time that you were mayor, how interested you were in health issues in Congress, and we welcome you this morning. [Applause.]

## STATEMENT OF HON. EDWARD I. KOCH, MAYOR, CITY OF NEW YORK, N.Y.

Mayor KOCH. It's with pleasure, of course, that I appear before this committee to express my full support for the proposed legislation which provide comprehensive health care to all Americans.

In no city or State in this Nation is there a more grim witness than the city of New York to both the human and financial costs of the chaotic means by which we now provide health care to our fellow citizens.

Through mayoral agencies and other mechanisms, such as the Health and Hospitals Corp., New York City spends an astronomical number, $3 billion annually, on health care, of which more than $1 billion comes from city tax levy and capital funds. This money is comprised of the city's share of medicaid payment—nearly $600 million—and some $400 million which is spent on the working poor and illegal aliens who are not eligible for medicaid.

The working poor are called "self pay-no pay" patients because they earn just enough to be above the poverty level, and therefore do not qualify for medicaid. Some have hospitalization coverage through their employers, but absolutely no ability to pay out-of-pocket for ambulatory care.

It has been estimated that we have 500,000 to a million illegal aliens in this city who have no entitlement whatsoever, but, like others, must receive health care. They cannot be turned away.

I'm also deeply concerned about middle-income families, who are the bulwark of this city and our society, who find themselves heavily battered by the escalation in health-care costs. To bring some sense of security to their lives, where a single illness can wipe out a lifetime of work, a national health care program is essential.

Indeed, Senator, if there is a single group that is deprived of health care, it is the middle class, because of not having medicaid. [Applause.]

Not having medicaid, they are the ones who go last to the doctor, because of the enormous expense that's involved, and they are the ones who desparately need the national health coverage which your program would provide.

And, with all the unbearable social burdens this city has tried so hard to bear, we also suffer from a medicaid arrangement which requires us to pay 28 percent of every medicaid dollar. That adds up to the $600 million that I just mentioned.

The rural poverty areas of the South, which surely hold no more misery than Bedford-Stuyvesant or the South Bronx, and have few illegal aliens, are favored with generous reimbursement, while our urban areas receive the bare minimum. And I'm not for a moment suggesting that we should turn our back on the rural areas.

I'm simply saying that it doesn't help this country to turn its back on the urban poor. [Applause.]

We must have relief from all of these inequities. It is no exaggeration to say that the curtailment of this drain on tax levy funds is absolutely essential to the survival of the city of New York.

I want to say to you, Senator, that our deficit, which over the next 4-year period, if we were not to receive city and State and Federal changes in meeting that deficit, our deficit is less than the amount of money expended each year on health care. Imagine that. Our deficit is about $2 billion over that 4-year period. The health-care expense in this city is $3 billion annually.

I have no especially kind words for the poor mangerial practices which helped to create the city's fiscal crisis of 1975 and the grave financial situation we face over the next 3 years.

I have committed, and will continue to commit, a major part of my energy and attention to improving the city's management of its health care activities. We must be certain that we are delivering good quality care for the least amount of dollars. No political considerations will deter me from that course.

Our health and hospitals corporation board is responsible for the operation of its $1.1 billion, 17-hospital municipal system. The State of New York is largely responsible for controlling our voluntary system.

Since the biggest part of our health care dollar goes to inpatient care, both the city and State and determined to reduce the number of

hospital beds to the point where we will be serving our citizens with a lean and yet well-managed hospital system.

To those who are hissing, let me say that it does not help this city, State or the people who need care to have excess hospital beds that serve no purpose other than to drain our dollars.

Some Americans equate having a large quantity of hospital beds with good health care. The contrary is true. Hospital beds which are not well maintained and adequately backed by professional staff are a health care delusion and can be dangerous to patients.

Our present economic peril makes it imperative that once and for all we give up our excess beds and implement a tight, well-managed health care system.

We have to reserve our most expensive resource—the hospital bed—for those who require hospitalization. If we try to maintain the current voluntary and municipal hospital establishment, there will not be enough resources in New York City to support that system.

With all these multiple concerns for delivering care of good quality, we are also preoccupied with our fiscal solvency.

New York City, with the eseential cooperation of the State, will be moving to create a hospital establishment—both municipal and voluntary—which will insure quality hospital care with the least number of hospitals and beds.

Quality care is essential at the least cost to the taxpayer and within the fiscal constraints of this city. This is clearly consistent with the goal of the legislation that you are advocating.

In every corner of my administration, self-help is the watchword. We are not going to look to others to do what we should do for ourselves—and we are not going to do for thers what they should be doing for us. We cannot have placed upon our backs—and it is there now and we cannot continue to have it—the Federal responsibility with respect to health care carried out by New York City. [Applause.]

It's up to the Federal Government to provide a health care system that is responsive to the needs of the citizens of New York City and the needs of this country.

Because, even if we manage to be both efficient and effective and accomplish all of our health care goals, it is quite clear that it is impossible for New York City to go on spending $3 billion annually—which is somewhere between 20 and 25 percent of our budget—on the provision or the providing of health care.

This does not include many billions spent in the voluntary and private sector, as well. We need help from Washington, for example, to provide health care to illegal aliens—which is surely a national, and not just a New York City problem.

It is the Federal Government that has the responsibility of having allow them in, or of taking the necessary legislative—[applause]—of taking the necessary legislative acts to deal with the aliens. They cannot walk away from that problem because humanity requires that, whether you are an illegal alien or a citizen of this city, State and country, that when you are sick you get cared for. [Applause.]

We must not allow mediocrity to overtake the hospitals of New York, which—despite our trobules—number among them some of the finest medical institutions in the country and in the world. We cannot allow this excellence to be destroyed.

However, we must move cautiously and deliberately as we establish a mechnism for implementing national health care insurance. Because, ironically, New York City already has a form of comprehensive health care—we provide health services at Health and Hospitals Corporation facilities to all who need them, whether they can pay or not—and what we have is a system that is wasteful, mismanaged, redundant, and which has the potential for bankrupting the city of New York, and it cannot go on. [Applause.]

We must be certain that what has happened in New York City does not happen throughout the Nation. Adequate controls and incentives for efficient management and reasonable costs have to be built into that system.

We look forward to a national health program with great hope and expectation. Properly organized and managed, such a program could solve one of our city, State and Nation's most difficult social problems.

We trust that you and your colleagues in Congress and the President will move as quickly as possible to establish that system which provides the best medical care at the least cost to the taxpayer. [Applause.]

Senator KENNEDY. Well, you can see from the audience, Mr. Mayor, how effectively you've spoken for the people, certainly in this room, and I think for millions of people in the city of New York. I hope it's a message that we can hear in the Congress and Senate of the United States, because I think you put your finger on a number of the very important items which we're really not addressing and not focusing on.

The fact of the matter is the people who are going to be bankrupted are going to be the middle-income people. They're the ones that are going to find—[applause]—that their premiums are going up and up and up, they're the ones that are going to find, even if they have health insurance, the range of benefits is going to get narrower and narrower, they're the ones that are finding out that even when they have health insurance in the health insurance proposal there's fine print and that it doesn't cover the things which they thought were covered, and they're the ones that are basically taking it on the neck because we have really failed to deal with this in a comprehensive way.

The burden that it is placing on the municipal cities of this country, and on the States of this country, by not bringing a humane and comprehensive program, a universal program, that is providing a very unfair, unwarranted, and unjust burden, I believe, on those that live in the urban areas as well as those that live in rural communities as well.

We've got to bring a rationalization to this system, and I hear you very clearly. I'm just hopeful that there are going to be others in the Congress and Senate that hear you equally as clearly, because this is the voice that should be heard.

Just one question: Why do you think it is that our country, as a society, is so slow in moving and addressing this in the kind of comprehensive way which you've outlined?

Mayor KOCH. Well, I think there is a certain shortsightedness in Washington; and I was there and I fought the battle with you and with Mr. Javits in support of expanding our medical care—not at the cost of the individual, but in some insurance concept way.

Let me put it right on the line: I don't believe that all of the people who are involved in medical care have joined together, and the only voice that is calling out in an effective way happens to be the people. But I don't think the doctors have done their part. [Applause.] I frankly don't think that everyone who works in a hospital is necessarily concerned about the patient. Many of the people [applause], many of the people who are involved in hospital care see it more as a job, whether or not the position is required. I am concerned about this.

I believe that we have to have as our cardinal concept that hospitals are for sick people, that they are not necessarily to provide jobs. They are there to provide people who will attend the sick. [Applause.] That applies to the doctors and the nondoctors, as well. That's No. 1.

Second, I don't believe that the municipalities, as much as we have pressed individually, the mayors of this country, for our own needs—and we have these astronomical needs. As I pointed out to you, next year our deficit is about $500 million, estimated if we were not to get the aid that we hope we will from three entities of Government which will be there, in my judgment. But contrast that with next year we will be spending more than $3 billion annually here in the city of New York out of governmental funds. There is something wrong with that statistic. We cannot bear that.

So I would hope that, somehow or other, the disparate forces that are in this room and in this city and in this country would take the leadership that you two Senators have had over the years, and support your efforts, and make the Congress and the President respond to us. [Applause.]

Senator JAVITS. Mr. Mayor, I'm pleased you understand the bottom line.

I want to pledge to you my efforts and assistance in the unpopular decisions which you may have to make. I thoroughly agree with you, hospital beds which waste money are no boon to the public, and they're no reassurance to sick people. [Applause.]

Now, I'd like to ask you this one question: Don't we also have in our city the grave problem of maldistribution of medical facilities, in the sense that because of a lack of health care personnel in poor areas of the city—you've named two, Bedford-Stuyvesant and South Bronx—people run into the emergency wards of these municipal hospitals when what they need is clinical care and outpatient care of a normal character?

Mayor KOCH. You're absolutely correct. And one of the problems we have is the enormous resistance of the people who live in a particular area not to look at it from the point of view of what is the best facility to provide the best care; but they don't want to give up anything that is there, even if it provides lesser care than that which would otherwise be available.

So it's an educational process that's involved here.

Senator JAVITS. And, also a substitution for a facility which is useful to them, congenial to their needs, and doesn't cost nearly as much?

Mayor KOCH. Exactly, Senator.

Senator JAVITS. I might tell you that we've made some progress with Senator Kennedy's help. We have included a provision in legislation passed at the end of the last session which will enable the Federal Gov-

ernment to give some financing to primary care centers established by hospitals, including municipal hospitals. However, this alone is not enough.

I would like to point this out as well, the United States—and it was a monumental struggle by you, Senator Moynihan, Senator Kennedy, myself, and many others—has agreed to help save New York City from bankruptcy, and yet, by our own actions we are running the city down the drain in a way which is five times more costly than the financing assistance. It's almost unbelievable.

I thank you very much for your sharp statement, and, again, I want to reiterate I will support you in the tough decisions you have had to make and will continue to make.

Mayor KOCH. Thank you, Senator. [Applause.]

Senator KENNEDY. Now, we'll have the following witnesses now and ask them to come up to the stand: Mr. Mark Leavitt, Ms. Elizabeth Fletcher, Ms. Connie Jackson, Ms. Cecelia Merlow, Mr. and Mrs. Edward Carlson, Mr. William Kipp, Ms. Ann Mallon, Mr. Morris Lee, Ms. Carol Horne, and Ms. Jane Hart.

All right. Now we'll get started, and we'll ask if we could have the attention and hear the witnesses here. We will be in order, please.

We have some important stories to hear this morning. We want to give these witnesses the attention that our other distinguished officials received.

Talking about one's illness and sickness is never easy, and sharing that with us is never a pleasant task, but part of the purpose of these hearings is to try and bring this Health Subcommittee around the country and permit people that otherwise couldn't come to Washington to tell us about their story.

What we're seeing is a record that is very similar all over this Nation, in urban areas as well as in rural communities.

Now, our first witness, Mr. Leavitt. If you could tell us, Mr. Leavitt, how old you are?

## STATEMENT OF MARK LEAVITT

Mr. LEAVITT. I'm 29 years old.

Senator KENNEDY. And you have a daughter?

Mr. LEAVITT. I have a daughter, Allegra, right here. She is 3½.

Senator KENNEDY. And you had a tragic occurrence in your family about 2½ years ago, as I understand it?

Mr. LEAVITT. That's correct. My wife died unexpectedly.

Senator KENNEDY. And where did she work at that time?

Mr. LEAVITT. Well, she wasn't working at that time, but previously she worked for the Colombia Trade Development Bureau, a branch of the Colombian Government.

Senator KENNEDY. What type of health attention did she require?

Mr. LEAVITT. Well, she had been hospitalized for 3 years, after we were married, on several occasions for various types of illnesses and conditions.

Senator KENNEDY. And did the health insurance pay for her hospitalization?

Mr. LEAVITT. Well, health insurance—she had health insurance coverage at some points, but it was kind of abruptly and unusually terminated by her employer in a way that we weren't fully aware of, and one of her hospitalizations wasn't covered at all. That was over $2,000.

In the other cases, when she was actually in the hospital, the bulk of her hospitalization was covered, but various other costs—doctors' costs, and certainly out-of-hospital costs—were not ocvered.

Senator KENNEDY. So you had a $2,000 bill out of your own pocket; is that correct?

Mr. LEAVITT. On that one occasion.

Senator KENNEDY. On that one occasion.

How much did you pay out of your pocket for your wife's medical problems, all in all?

Mr. LEAVITT. Well, I paid out of my pocket, over a 3-year period, somewhere in the vicinity of $6,000 to $7,000.

Senator KENNEDY. And what was your income then?

Mr. LEAVITT. Well——

Senator KENNEDY. Approximately.

Mr. LEAVITT. The average income during that period was, I guess, about $12,000 to $15,000.

Senator KENNEDY. And what do you make today?

Mr. LEAVITT. Well, Senator, you've raised one point that I want to deal with, which is as a single parent I feel that I'm discriminated against in at least two ways:

One of them is that I find it very difficult to maintain full-time employment; in fact, I left full-time employment about 5 or 6 months after my wife left, and I have not been fully full-time employed since, although I'm currently regularly part-time employed. I'm a lawyer in housing rehabilitation, and I'm in private practice.

So, on the one hand, I wasn't able to be fully employed because of my situation; and, therefore, didn't get medical insurance coverage as many full-time employed people. And, on the other hand, I'm discriminated against because the rates that I pay are based often on a family which has two parents, even though this family has one parent. And, in fact, now I pay as an individual family about $500 to $600 in health insurance costs, whereas as a two-parent family I found myself paying much less.

Senator KENNEDY. Well, now, what did—your age again is?

Mr. LEAVITT. I'm 29.

Senator KENNEDY. Twenty-nine, young, married, with a small infant, your wife getting a series of illnesses and sicknesses which she died from, enormous personal tragedy at a time when you're just getting started in life and with a young child. There were really significant medical bills of approximately $7,000 even though your wife had some form of hospitalization, drawing down whatever savings that you have. And now you are faced as a single parent with a young child with the complexity in getting coverage and the amounts that you have to pay for it from a part-time job.

And what sort of sense does that make—there are single-parent families that are trying to provide for children that perhaps have not endured the kind of personal tragedy you have—but does that make any kind of sense to you at all, in terms of a human society?

Mr. LEAVITT. Senator, it obviously doesn't.

And another unusual factor is that now, even though my daughter and I are essentially well, between dental costs and what they call well-baby care, and regular checkups for me, I find myself spending upward of $1,000 a year, which is not covered at all by the health insurance coverage I have, even though my daughter and I are well.

Senator KENNEDY. And so the fact of the matter is that the amount of inclusion in the overwhelming number of health insurance does not put a premium of preventive health care——

Mr. LEAVITT. That's absolutely right.

Senator KENNEDY. To keep people healthy, rather than treating them when they're ill and sick; and you're taking those additional steps, which are virtually nonexistent in our nonsystem, and generally do exist in certainly most of the other industrial societies.

Could we move to Mrs. Fletcher.

## STATEMENT OF ELIZABETH FLETCHER

Senator KENNEDY. Ms. Fletcher, could you tell us how old you are?

Ms. FLETCHER. Twenty-three.

Senator KENNEDY. Twenty-three years. And where do you work?

Ms. FLETCHER. I have a part-time job in UCP, which is where my son attends.

Senator KENNEDY. And your husband?

Ms. FLETCHER. He works as a full-time production manager for a printing firm.

Senator KENNEDY. So your husband works full time, you work part time; is that correct?

Ms. FLETCHER. Yes.

Senator KENNEDY. Your approximate income for the family?

Ms. FLETCHER. $20,000.

Senator KENNEDY. $20,000. OK. Now, I understand you have a 2-year-old child who was born in Brooklyn?

Ms. FLETCHER. Yes.

Senator KENNEDY. Can you tell us what his medical condition is?

Ms. FLETCHER. He has spinobifida—which is, his spinal cord was not fully developed when he was born.

Senator KENNEDY. And so he required original surgery and a hip replacement; is that correct?

Ms. FLETCHER. Originally it was his back repaired, and then he had to stop because it was also complicated with hydrocephalus. Also, he had hip surgery, and is waiting for another one.

Senator KENNEDY. Why is he waiting for another one?

Ms. FLETCHER. Because we cannot afford it. Simply, the doctor had suggested after the first hip surgery that it be done within the first 6 months. After that, because we had not finished paying his bill, he has been putting it off, and he has put it off up until now. Now he claims he will be doing it January or February, but we still don't know. We still have an outstanding bill.

Senator KENNEDY. And this is a very serious condition, spinobifida. We had a chance about 10 days ago to face a group of parents in Chicago, all of the children of which had spinobifida, and they have a unit out there at Children's Memorial Hospital. It's an extraor-

dinarily serious ailment for children—and, in fact, a number of years ago, just a few years ago, children died of spinobifida.

Senator KENNEDY. Now they're able to, through new surgical techniques, to keep them alive, but they do need a series of remedial medical procedures, and this is what your child needs?

Ms. FLETCHER. Yes.

Senator KENNEDY. And even though you have, as I understand, a husband who's working full time and you're working part time, making as a family about $20,000 a year, you had some insurance; did you?

Ms. FLETCHER. When he was first born; yes. I was working then.

Senator KENNEDY. And so you had some insurance.

As I understand, you had Blue Cross and Blue Shield, and you had Aetna major medical; is that correct?

Ms. FLETCHER. Then; yes.

Senator KENNEDY. Then.

But that didn't pay for all of it; is that correct?

Ms. FLETCHER. No; it didn't.

Senator KENNEDY. How much did you have to pay?

Ms. FLETCHER. Well, all together, for the past 3 years, we've paid between $6,000 and $7,000 from our own pockets.

Senator KENNEDY. $6,000 or $7,000?

Ms. FLETCHER. Yes.

Senator KENNEDY. And has that pretty well wiped out your savings?

Ms. FLETCHER. Completely.

Senator KENNEDY. And is this part of the reason that you haven't got the resources for the next hip operation?

Ms. FLETCHER. Yes.

Senator KENNEDY. And what has this meant to you as a parent, to know that your child needs this medical attention and to have the financial kind of a burden that you're facing here that makes it necessary to defer it, and the anxiety?

Ms. FLETCHER. It's very frustrating to know that your child is born without fault and that you cannot give him the best—even though we have tried to give him the best possible health care that we can afford.

It also means that there are always financial problems in the house, and with that you have bickering within the family, not to mention outsiders that influence us also.

It also means that our son does not get the treatment when he's supposed to get it. As he gets older, it's more difficult, rather than as he is younger.

Senator KENNEDY. You're concerned about the future, as well?

Ms. FLETCHER. Definitely.

Senator KENNEDY. Well, it seems that here the science or technology process has really moved far and away ahead of the policy of medicine; with science and technology we can treat that child, but we've got a nonsystem which puts extraordinary financial and emotional burdens and health burdens upon the child and upon the family.

That, I think, gets again to this issue about our society, whether we're going to really free our people from this kind of emotional strain and emotional tension which exists. It doesn't exist in any industrial society that has health insurance, with the exception of South Africa, perhaps. OK.

Senator JAVITS. Mr. Chairman I have only one remark. I think those who are listening should constantly be reminded that we're dealing here with middle-class families—the bulk of our country.

Senator KENNEDY. Our next witness, Ms. Connie Jackson.

Ms. Jackson, could you tell us how old you are and where do you work?

## STATEMENT OF CONNIE JACKSON

Ms. JACKSON. I'm 41. I am presently doing some consulting for science and public information, but it is not a full-time position.

Senator KENNEDY. I understand you have two children and that you are divorced; is that correct?

Ms. JACKSON. Right.

Senator KENNEDY. Now, I understand your oldest daughter is an asthmatic.

Ms. JACKSON. Both children are asthmatic. The older is a chronic and severe one; and the younger it's less, it's mild.

Senator KENNEDY. Could you describe for us a little bit about the medical attention that's been necessary for your older daughter?

Ms. JACKSON. Yes. I'll certainly try.

My oldest one was a colicky child from the time she was born. For a full 9-month period afterwards, I spent every single night up, and this was not until she was 9 months recognized not simply as colic but as asthmatic bronchitis, and from that point—called bronchial asthma—there were many, many mornings over the years—and my child is now 17. She is much better at this point.

But we spent about 15 years of spending 6 and 7 and 8 mornings in a row in emergency hospitals for care. Adrenalin was given that relieved her.

She has also spent time in the hospital itself. Medication is outrageous. The type of care that I was able to get varied.

When it was initially started, I in fact myself was on welfare, and had just gotten a job and, you know, was working, and it had been established that I did not—that I made too much money—I in fact made $60 more per month—to make me eligible for medicaid, so I was thrown off medicaid.

The particular year—the years most difficult for me were 1969, 1970 and 1971—those particular years were the years in which my children were more frequently hospitalized for longer periods of time, and I had excessive bills which Blue Cross/Blue Shield took a year and a half to make a decision that they were not going to cover it, and medicaid had said it was not going to cover it, and so I was in a fit.

Senator KENNEDY. Now, if I understand—and I think you've stated it very well—you had these two children who were asthmatics, and then you were getting the coverage under medicaid; but you went out and got a job, and were being covered by Blue Cross because you were employed. But under that particular policy, they would not cover what they called preexisting illness.

That takes place in instance after instance in the insurance policy. Am I correct?

Ms. JACKSON. That's correct.

Senator KENNEDY. They don't cover that. So here you go out and get a job, you're working, you're making just a little bit more than the medicaid level. Under the new coverage that you're getting from Blue Cross, you're unable to get the coverage or the inclusion of the medication which is necessary to provide for those children, and unable to pay the bills.

So what happened in November 1977?

Ms. JACKSON. In October 1977.

Senator KENNEDY. October.

Ms. JACKSON. Eventually, I had to file bankruptcy. I think there's some steps before that, just if I can say it quickly?

Senator KENNEDY. OK.

Ms. JACKSON. And that is, after this initial job that I finally got—and I'd gotten a series of positions, which paid increasingly well—so that I'd started out with an income of something like $6,500, and wound up eventually—this is over a 12-year period—with a $20,500 salary.

The expenses—I was sued constantly by hospitals. I must say that private institutions, voluntary institutions in particular, were very, very difficult to deal with. I dealt with them because of the doctor that I had.

And I soon learned—and about the only support I could ever get was from public hospitals, who did not drive me into the wall. [Applause.]

The point I want to make is that the more and more money that I made, I therefore was able to establish more of a credit—you know, credit line, or whatever, however you refer to it—and therefore the suits, the lawsuits from the hospitals—I then got loans to pay them off. This repeatedly occurred.

I got to a point where interest—it was impossible to deal with the loans. There was one of the hospitals that I absolutely could not deal with. All of this—I wound up with about a $22,000 medical—everything was related directly to medical expense.

And, in addition to that, I had put out $100 a month out of my pocket. At that point, I had Blue Cross/Blue Shield, a major medical, and it still did not cover it. It did not begin to cover it. And it did not allow me to go about the preventive kind of care one needs.

I hadn't been to a dentist, my children hadn't been to a dentist. It was like a luxury. I didn't even know what that was about. I mean I in fact knew what it was about, but it was not something that I could handle.

And there's one other thing I want to say, if I may.

Senator KENNEDY. Sure.

Ms. JACKSON. And that is it's very difficult to understand this kind of thing when you're—I mean, supposedly, you're an intelligent—I'm supposed to be a quasi-sophisticated woman, who's supposed to be able to deal with the system. I am insulted by living in a situation in which I can't even begin to contribute whatever it is that I was born to do, to work very hard at, because I'm just totally wiped out by a burden that—it's unfair. It's absolutely unfair to me in that.

And I have met many, many parents with the same identical problems, problems far worse than mine, children who were in the hospital for months at a time with asthma, and had not been home for ages.

[Applause.]

Senator KENNEDY. The only mistake or crime in terms of our society is having a child who is asthmatic. Here is a mother who has talent and ability, and the will and desire to work, and who just cares about trying to provide for her children, and this is what our nonsystem has done, is to force her into bankruptcy. There is enormous anxiety that she has, continues to have, in providing for her children, and our society has put this absolutely, I think, intolerable emotional burden on her and upon the children. Again, it's an indication of the failure of our system to deal with it.

We're losing a young Leavitt, I think. I know you have to leave.

Mr. LEAVITT. Yes; we have to.

Senator KENNEDY. Thank you very much.

Mr. LEAVITT. Could I just say this? I was a very early supporter of President Carter in Queens, and while I still believe strongly in split attentions, I think this is an area where he needs to see the light a little brighter.

[Applause.]

Senator KENNEDY. OK. Mrs. Merlow.

Could you tell us how old you are?

## STATEMENT OF CECELIA MERLOW

Ms. MERLOW. Yes, Senator. I'm 63 years old.

Senator KENNEDY. And you have grown children; is that correct?

Ms. MERLOW. I have a girl and a boy.

Senator KENNEDY. You're retired now?

Ms. MERLOW. Yes, I am.

Senator KENNEDY. Are you married?

Ms. MERLOW. No; I'm divorced.

Senator KENNEDY. How long did you work before you retired? How long did you work?

Ms. MERLOW. I worked at my job 16½ years.

Senator KENNEDY. Sixteen-and-a-half years?

Ms. MERLOW. Yes.

Senator KENNEDY. And what kind of health insurance coverage did you have?

Ms. MERLOW. I had Blue Cross and Blue Shield.

Senator KENNEDY. And do you still have insurance, health insurance?

Ms. MERLOW. Yes; I'm still paying for it.

Senator KENNEDY. And, as I understand, you have an individual policy?

Ms. MERLOW. Yes; it's my own.

Senator KENNEDY. Is that correct?

Ms. MERLOW. Yes.

Senator KENNEDY. Now, what happened this past March? Did you have surgery?

Ms. MERLOW. I went to the doctor, and I was examined, and he said I had to go into the hospital for surgery, which I did. When the pathologist found the finding, he said that they weren't what they thought they were going to be. The doctor got in touch with a doctor

in Flower Fifth Avenue Hospital, and he did a preliminary surgery, and than I was told that I had to have major surgery done, which I had done, and it was found to be a malignant cancer.

Senator KENNEDY. Now, after the Blue Cross finished paying for everything, the hospital and doctor's bills, how much did you have to pay out-of-pocket?

Ms. MERLOW. I figure what I had to pay on my own, the little that I did have, was over $3,300.

Senator KENNEDY. $3,000.

Do you have medicaid?

Ms. MERLOW. I applied for medicaid, and I was there yesterday. I was turned down because I had a slight increase in my social security for July—and the little that I get for the SS disability.

Senator KENNEDY. And so you were turned down?

Ms. MERLOW. Yes.

Senator KENNEDY. And are you going to require additional treatment?

Ms. MERLOW. Oh, yes. Yes; I have to have chemotherapy until this coming October.

Senator KENNEDY. And how are you going to pay for that?

Ms. MERLOW. Well, I have no resources. I have no nothing.

I spoke to the supervisor, and she told me that I had to refile a new application on account of the increase that I had received. Now, in the months that it takes for a new application to be taken care of—there's time, but where am I going to get the money for my cancer blood tests and my cancer therapy?

Senator KENNEDY. Does that worry you?

Ms. MERLOW. Yes; very much so.

Senator KENNEDY. Well, this is a situation of a woman who had worked in her last job for 16 years, retired, has an individual health insurance policy, now has a malignent cancer, has effectively been denied the medicaid coverage, has virtually no funds as I understand it——

Ms. MERLOW. No.

Senator KENNEDY. And needs the treatment, and is going to be hard-pressed to obviously receive it, and is not only faced with the financial but certainly the emotional problems and worry and concen about how to deal with that over the period of the future.

And whatever it's going to be, whatever little savings are going to be there, are going to be swallowed up by this treatment, I would imagine, whatever savings you do have.

Senator JAVITS. If she can get the treatment at all. As she points out, she may simply be unable to obtain it. She's caught both in the bureaucracy and in the inadequacy of the financial resources she has available.

Senator KENNEDY. Does this make any sense to you, Ms. Merlow?

Ms. MERLOW. No; it doesn't make any sense whatsoever. I think Medicaid should take the responsibility from now on in; whatever Blue Cross will pay, and perhaps medicaid can pay the other share of it, and I will be able to get my treatment as a matter of life and death.

Senator KENNEDY. Mr. Carlson. Could you tell us how old you are and how old is Mrs. Carlson?

## STATEMENT OF EDWARD CARLSON

Mr. CARLSON. I'm 64 years old. My wife is 63. She's a registered nurse——

Senator KENNEDY. A registered nurse.

Mr. CARLSON [continuing]. And she is sitting behind me. That's right.

Senator KENNEDY. And you're on the executive board of the National Council of Senior Citizens?

Mr. CARLSON. That's right. I'm also on the community service and head of the retired members department of the IUE. We have 26,000 retired union people in New York State, 55,000 nationally, and I hear all their problems.

And I'm here to talk about mine personally.

I have figures in here, Senator Kennedy, that I'd like to talk about.

Senator KENNEDY. All right. Well, you'll give Bill Cutten Senator Javits' and my warm good wishes.

Mr. CARLSON. I'll do that.

Senator KENNEDY. Tell us what happened to Mrs. Carlson in February 1977?

Mr. CARLSON. I think, Senator Kennedy, in answer to the question you were asking previously—I have my W–2 forms here. My salary last year was $16,500, and my wife was able to earn $701 before she wound up in the hospital in January. But I also want to tell you that that's a total of $1,700 and $201.00 and add up that with health. From my salary and taxes—complete, I paid $5,275 before I even got into my hospital costs.

So, when we talk about middle income—you don't take home what you're asking about.

I'd like to tell you that the total hospital costs during this time for 67 days was $30,689.60. The extras that were paid out, other than that, was $1,871.42. And the doctors that were paid by me, with no coverage—and I have all the canceled checks here—was $6,173. And the drugs that we had to get by prescription out of the drugstore myself, not the drugs in the hospital, was $478.73. And I have all those bills here too, if anyone wants to see them.

I also might want to tell you that in view of all these bills and everything I got here, it is nice to tell you that I got two refunds from the hospital. One was for $8 and the other was for $43.

I'd like to also tell you that that made a total, as I said, of $8,523.15.

I think that what I really want to tell you about here is the exorbitant cost of a pacemaker, and the ironic things that happened to my wife during those 67 days.

She went in the hospital to the emergency, in an amublance. At one time they tried to put the pacemaker up in the left side of her shoulder here with a wire going down into her heart. She was in the operating room 4 hours, and you've got to be conscious while this is going on. They were unsuccessful.

The next day she went up and they tried to put the pacemaker in the other side, they got the wire down into her heart, and she was home only a litle while when it started to malfunction. And, one of the things contributing to it, and all this time my house burnt down. I lived in a trailer for 3 months while this was going on.

Senator KENNEDY. Let me ask you, if I could. You had some insurance as I understand. Mrs. Carlson had the heart attack. You, yourself, had a heart attack.

Mr. CARLSON. That's right.

Senator KENNEDY. These heart attacks were for retired people——

Mr. CARLSON. We're not retired.

Senator KENNEDY. You're not retired, good.

Mr. CARLSON. I'd like to tell you about my insurance coverage. That might answer your question.

Senator KENNEDY. Well, that's the point. You did have Continental Insurance.

Mr. CARLSON. That's right.

Senator KENNEDY. As I understood it. So, now could you tell us a litle about the coverage?

Mr. CARLSON. Yes, Senator. I have a, what most so-called middle income people, realize as adequate coverage. Well, I'm very fortunate because I've got adequate coverage. But, going in, the thing that we're not facing today is that if you're brought into a hospital, in New York, or anywhere else, that they put you in something new called cardiac care unit. And this is about the cost; it goes from $350 to $500 per day. I found out that my coverage cost, in 1975 it was a $167, subtract from that. And then, again, I was very fortunate, Senator, I had major medical.

So, it was 80 percent of that was picked up, but the remainder—but you wind up paying as high as $36 a day out of your pocket that you can't recover. And, over a short period of a few months, if you have 100 days in the hospital, that's $3,600 just for the hospital room alone that you cannot recover with all your hospital costs.

So, and it goes the same way with the doctor. All your hospital funds are now—Senator, your insurance coverage is before stated a certain amount for a certain operation. So, it does not cover pacemakers, and cardiac operations, and certain amounts now.

Now all your insurance policy says is what is customary and usual. Now' that's according to the area and you'll find out that your insurance company which says that does not agree with the doctors, and then over that you get the kind of bills that I have here and the kind of checks that I had to pay that you have—as an individual have to pay.

So, I'm concerned about not only the middle income, but the middle income who's working, who's thinking he has adequate coverage until something like this happens to us, and the bills that you get.

We raised four children, had about $16,000 saved, what we thought was going to be for our retirement, and in 1 year you wind up with $6,000 to $8,000 of that lost. I'd like to stay in New York, but I don't think I can afford to live here anymore if that's my cost.

I can't sell my home, my children are here.

Senator KENNEDY. Well, no matter where you move you may very well have those same things, because we get the same story, I want to tell you, whether we're down in West Virginia, or Detroit, or in Chicago, or Denver. We're going to hear the same story in Los Angeles tomorrow. So it won't make any difference where you move.

The problem is what we're going to do with it in terms of trying to deal with it from a uniform and rational point of view.

Mr. CARLSON. Senator?

Senator KENNEDY. Let me just ask, as I understand now, you know we have hundreds of thousands of heart attack victims a year, hundreds of thousands of them. So we're not talking about something that's extraordinarily unique. Working family, a person who has saved over a period of their lifetime, $16,000 to $18,000 and sees these—your wife and yourself have had these heart attacks, had health insurance, had two programs.

We're talking about the small print. And that is what has been an extraordinary burden upon you.

Mr. CARLSON. Senator, could I answer one thing, please?

Senator KENNEDY. Yes.

Mr. CARLSON. When we talk about the cost of national health insurance throughout the Nation, I think one of the things, that question that I raised that I haven't heard anywhere else, and I'd like for your judgment: It's the fact that if we take into consideration all the money that the individual pays for health insurance, and all their coverage, then take into consideration all the money that the companies, the corporations pay for all their coverage for the executives, and their programs for the employees, and then take into consideration all the money that the Government pays under medicare, medicaid programs, and for their employees for the Government employees and everything.

And you add all those three figures up, I'd like to know what they are. Subtract them with the threatened figure that they say, we can't afford it; and then let's see what's left and I bet you we could afford it. [Applause.]

Senator KENNEDY. You're absolutely right. And I want you—we're going to have Mr. Carlson down to Washington to tell the rest of our colleagues that.

Mr. CARLSON. I'll even give you figures if I can.

Senator KENNEDY. All right. Thanks.

Mr. Kipp, could you tell us a little bit about how old you are?

## STATEMENT OF WILLIAM KIPP

Mr. KIPP. I'm 34 years old.

Senator KENNEDY. And your wife?

Mr. KIPP. And my wife is 30 years old.

Senator KENNEDY. And where do you work?

Mr. KIPP. At the present time, because of my condition, I'm unemployed.

Senator KENNEDY. Where does your wife work?

Mr. KIPP. My wife is a New York City teacher.

Senator KENNEDY. A New York City teacher?

Mr. KIPP. Yes.

Senator KENNEDY. What disease do you have?

Mr. KIPP. I have Hodgins disease, which is cancer of the liver glands.

Senator KENNEDY. And when did you discover that you had it?

Mr. KIPP. I found out 8 years ago. And Hodgins disease is one of the most favorable forms of cancer and certainly treatable, but I have one of the most advanced stages, 4B. And, so in a sense I'm a testimony to the tremendous progress that's been made.

Senator KENNEDY. Wonderful. Now you've had surgery and you had chemotheraphy. Is that correct?

Mr. KIPP. That's correct. I've had the lifetime doses of radiation and I've been on chemotherapy for the last 5 years now.

Senator KENNEDY. And what kind of health insurance policies do you have?

Mr. KIPP. Well, fortunately, I've never had my own coverage. I got out of the service and I was a student, at the time my wife was a teacher, so we have Blue Cross and we have GHI major medical.

Senator KENNEDY. And do they cover the expense of your treatment?

Mr. KIPP. Well, up to a point, We've laid out about $4,000 a year on our own, and they've laid out a great deal of money. We've gotten around the tremendous costs by expedience. Most of my drugs were experimental so the NCI paid for it. Unfortunately, now that the Hodgins drug works so well, they're available to the public and now we have to pay.

Senator KENNEDY. So you had $4,000. And what was your income, and your wife's?

Mr. KIPP. Well, I worked part-time whenever I could. The treatment is very extensive. I was a professional patient or professional outpatient. So her income slowly rose from $12,000 to, I guess, about $18,000 now.

Senator KENNEDY. And, so your wife's employment rules out medicaid. Is that correct?

Mr. KIPP. With no children it's $4,200. If we spend-down $18,000 to $4,200 we qualified for medicaid.

Senator KENNEDY. And what about social security disability?

Mr. KIPP. At this point, although I've tried to work; I'm applying for it because in 2 years I'll get medicare. The reason why this is so important to us is we have a $20,000 life, unlimited on our GHI/major medical policy, which will be rapidly approaching, and then we have——

Senator KENNEDY. And what is that? I think we know, but tell us.

Mr. KIPP. Well, major medical/GHI is something that most——

Senator KENNEDY. What is the limitation?

Mr. KIPP. OK, well it's a life-time limit. My wife has $20,000, I have $20,000. So, once I have used up $20,000 in benefits from the policy, I am no longer covered. So, in effect I don't have major medical coverage.

Senator KENNEDY. Well, is that a source of concern as you look down the road now?

Mr. KIPP. Absolutely. Because we don't qualify for medicaid. We have to spend $40,000 a year on medical bills to qualify for medicaid, so our entire income would go for the treatment for my cancer, which would go forth.

It's treatable and I could be a productive citizen, so what's the use of the limit. I don't know what we're going to do.

Senator KENNEDY. This is a disease which you're probably told 7 or 8 years ago was virtually nontreatable—10 years ago. Is that correct?

Mr. KIPP. That's correct.

Senator KENNEDY. And now in the early stages it is treatable and there's a good opportunity for remission on it and you've gone through, I think, as anyone would understand, an extraordinary almost miracle, in surviving during this period of time. And, now, effectively, have excellent prospects from a medical point of view and are faced with the financial burden it's going to place upon you and your wife, in terms of what the continued kinds of medical treatment that you're going to face without any kind of relief.

Now you're faced with, I imagine, a good deal of anxiety about your own future.

Mr. KIPP. Yes. Even if I would get disability, I would be 2 years before medicare would take over. I think there's a point I'd like to bring up.

During the New York City fiscal crisis of 1975 and 1976 my wife came very close to being laid off. She just barely had enough seniority. If she had been laid off, you know, in her particular area of teaching she would have been rehired within 4 or 5 weeks. However, the distinction clause of 24 months would have been put on there and we would have been wiped out financially at that point. Make that the 24-month clause.

You can imagine the heartache we went through waiting day after day for the mail. She wasn't laid off, but if she was then I would have lost my coverage if she had been out of work one day.

Senator KENNEDY. You see the pre-existing condition goes on, the triggering of the pulse, the cracks in the system when we hear about how health insurance covers all these problems.

Here, if his wife had been unemployed for as much as a day, the kind of additional financial burden it would have placed on this family.

On the questions of employment, the questions of employment having an absolutely dramatic impact on this family, and the kind of help that they're going to receive. What possible sense does that make? I mean, what possible, possible sense? It makes none.

And, as I say, we're about the only society that has that kind of situation.

Ann Mallon as I understand, you are 36 years old and a registered nurse?

## STATEMENT OF ANN MALLON

Ms. MALLON. Right.

Senator KENNEDY. Could you tell us what happened in 1975?

Ms. MALLON. Well, up until March of 1975 I was working as a registered nurse. At that time some past problems with my back forced me to quit my job, which terminated my major medical insurance.

In September I was admitted to the hospital. I had developed hydrocephalus, and after several months of diagnostic tests I had some brain surgery. I was in the hospital 5½ months and over the next 7 months in a municipal hospital. It had completely eaten up all the savings that I had.

Senator KENNEDY. Do you remember how much your savings was at that time?

Ms. MALLON. At the time I had about $4,000 I was saving for a car. I walked with a cane and it is essential that I have a car. I cannot get around without one.

So, it eliminated everything I had. In addition to which I was sued by the first hospital for $18,700 and by the municipal hospital for $4,000.

Senator KENNEDY. You had had a Blue Cross with limited benefits; is that right?

Ms. MALLON. I had the basic 21 full-day, 180 half-day policy. But, I was hospitalized for a solid year.

Senator KENNEDY. After that you were covered, even though you had some coverage and after those days you ran out, you had to assume the burden yourself.

Ms. MALLON. There was still another $18,000.

Senator KENNEDY. $18,000?

Ms. MALLON. Yes.

Senator KENNEDY. And that's what you were sued for?

Ms. MALLON. Yes.

Senator KENNEDY. And that wiped out all of your savings. Is that correct?

Ms. MALLON. Completely.

Senator KENNEDY. And do you have any insurance now?

Ms. MALLON. I have medicaid disability. I looked into the Blue Cross, but I can't afford the premiums.

Senator KENNEDY. Do you work at the present time?

Ms. MALLON. Under social security I'm allowed to earn up to $50. So I work for pay 8 hours a week at Fordham University Hospital.

Senator KENNEDY. And you like to work more?

Ms. MALLON. I would love to work more.

Senator KENNEDY. You'd like to work more.

Ms. MALLON. I've worked since I was 16, because I enjoy work, but the Government now says you can't work for 20 hours. We'll pay taxes for you to sit home. I want to work, take the money out of my social security checks.

But it's essential, I think probably more so for handicapped people than anybody else. We need to work.

Senator KENNEDY. And you're a health professional as well.

Mr. MALLON. Yes.

Senator KENNEDY. Somebody who's been trained as a nurse—wanting to work, a professional person, but virtually denied employment. We seen how the employment potential of unemployment was Damocles sword over Mr. Kipp and his future, and now we find out in your own life, where because of this nonsystem, effectively you're precluded from the opportunity to work.

Ms. MALLON. Yes.

Senator KENNEDY. In order to maintain the coverage. Now we're back to Mr. Lee.

## STATEMENT OF MORRIS LEE

Mr. LEE. That's correct.

Senator KENNEDY. Would you tell us a little bit about how old you are, where you work, and what your income is?

Mr. LEE. Thank you. I'm 48 years old, and I work for American Airlines.

My problem actually started back in 1967 in New York. Basically, I was in the military like 10 years, and I was aware that the insurance policy I had, I had plenty of coverage with a young family, wife and two kids. So, I never worried about major medical or anything like that. We had full coverage all the time.

When I accepted a job at American Airlines, they have to serve them for 10 years. They had a company policy, it cost about $5 a week. They gave you some similar or same type coverages.

I had an accident in the Bronx in May 1967 and it caused a break of the femur, upper bone in my leg. I was laid up around 3 months in Jacobi Hospital.

While I was there the bill came to around $16,000 or somewhere in that vicinity—the company paid 80 percent of that bill—leaving me approximately $3,000 I had to pay.

In the meantime, my wife, with the kids; my daughter at the time had just started college, I had just bought a house 7 years prior to that which took most of my savings. We were barely just living as a normal family, wife and two kids.

But, my wife had to go back to her original profession as a beautician just to keep the mortgage loan on the house for a while, because we had nothing coming in.

Because I did not have an industrial injury I had to settle for that disability allowance, which was $55 a week they paid for 6 months. That was nothing to keep the mortgage on the house going, and my family going, my son in high school and my daughter going to college. And I got completely wiped out at that time.

Her work, in terms of a beautician working a full 8 hours a day, every day she can, just about maintained some of the bills. But we got drastically back in the hole.

When I got out of the hospital I had to walk on crutches for another 2 or 3 months until my bone built back up again. My wife got sick.

I didn't have a chance to mention this. She had to go to Long Island Jewish and she was there for a major operation and I was able to get enough to put her in the hospital but that bill came to be a tremendous amount again for me.

So, we had approximately 4,000 dollars' worth of medical bills that I just couldn't afford to pay. So, the only thing that was left for me to do was, hopefully, when I get back to the company, go to the credit union, try to borrow the money.

I got back to American Airlines and I borrowed about $6,000 from the credit union to pay some of my bills off. I don't mean just medical bills, but to catch up on the bills in the house. And we were actually wiped out.

Fortunately, I was in Jacobi Hospital, and I could imagine if I was today in a private or voluntary hospital what it would cost. And that was a public hospital that cost that much money. So, it was just something I couldn't see.

I do feel that you need—since I was a product of the military for a number of years and had that full coverage—you need coverage for people. My family got knocked out. It took me at least 8 years.

Senator KENNEDY. Eight years?

Mr. LEE. Eight years to bounce half way back to where I should be.

Senator KENNEDY. And you earn how much now?

Mr. LEE. Presently I earn approximately $25,000.

Senator KENNEDY. $25,000 a year? And it's taken you 8 years to pay off. It's taken you to pay off what is not a very unusual—it seems like it was an unusual break, but you're talking about a broken leg as I understand it. It was a very serious one, a very complicated one. But that was the principal source of your own hospitalization. Is that correct?

Mr. LEE. That is correct.

Senator KENNEDY. Carol Horne.

Would you tell us how old you are?

## STATEMENT OF CAROL HORNE

Ms. HORNE. I am 31.

Senator KENNEDY. And as I understand it, you became unemployed in 1976?

Ms. HORNE. That's correct.

Senator KENNEDY. Before you knew you were ill?

Ms. HORNE. Right. I was between jobs at the time of my diagnosis.

Senator KENNEDY. And what kind of disease do you have?

Ms. HORNE. I have mycosis fungoides, which is an incurable lymphoma.

Senator KENNEDY. And what kind of treatment have you needed?

Ms. HORNE. I needed chemotherapy and radiation therapy. Originally I was treated by a private physician, paying for these out of my personal savings and money borrowed. When my savings were depleted I was referred to a local cancer hospital for more extensive treatment. There I was told that I would not be accepted as a clinic patient as I had no insurance coverage.

Senator KENNEDY. You don't have any coverage?

Ms. HORNE. I have none whatsoever. I am beyond the medicaid limits and there is a waiting period of 2 years for medicare. I have not yet reached that limit and they would not pay for all my treatments.

In any case, it would not be retroactive and I have exorbitant outstanding medical bills.

Senator KENNEDY. Did you use up your savings to pay these doctors' bills?

Ms. HORNE. Yes; I did.

Senator KENNEDY. How many bills? What are we talking about in terms of rough figures?

Ms. HORNE. My overall bills for just under 2 years have come to approximately $11,000. Out of this I have paid about $4,000, leaving unpaid $7,000.

Senator KENNEDY. And you have continued medical needs?

Ms. HORNE. Absolutely.

Senator KENNEDY. And, how do you feel about your situation? Do you have to worry about the payment of the medical bills?

Ms. HORNE. It's totally devastating.

Senator KENNEDY. Does it add to your worries about the illness?

Ms. HORNE. Of course. The psychological impact is overwhelming.

Senator KENNEDY. Have you tried to get any insurance coverage?

Ms. HORNE. I can't get insurance.

Senator KENNEDY. What do you mean you can't?

Ms. HORNE. If I apply for it, if I could afford a private coverage, which I can't, there is still the preexisting condition clauses which would not benefit me at all.

Senator KENNEDY. So, at a time when you really need it the most, is the time when they deny it?

Ms. HORNE. Absolutely. Yes.

Senator KENNEDY. And this is something that we've heard about for. OK. Mrs. Hart. As I understand, you are 50 years old.

## STATEMENT OF JANET HART

Ms. HART. That's right.

Senator KENNEDY. Are you married?

Ms. HART. Single.

Senator KENNEDY. Would you tell us, I understand it you had a Blue Cross/Blue Shield for 10 years and used it once?

Ms. HART. Yes.

Senator KENNEDY. Is that correct?

Ms. HART. Yes.

Senator KENNEDY. Did you have to pay out any out-of-pocket costs at all when you were operated on?

Ms. HART. No, no. The Blue Cross covered all of it.

Senator KENNEDY. Do you have coverage now?

Ms. HART. No; I don't. A couple of years ago I had to drop my Blue Cross coverage because I was unemployed and I could not pay the premiums.

Recently, I reapplied for Blue Cross and was turned down by them because in the interval I found out that I had hypertension and I was refused Blue Cross because of my hypertension. So, I have nothing; no kind of insurance coverage.

Senator KENNEDY. So, you were effectively denied the opportunity to get back into Blue Cross?

Ms. HART. Yes.

Senator KENNEDY. Because you have a mild case of hypertension.

Ms. HART. Yes.

Senator KENNEDY. Even though you had it for a period of some 10 years?

Ms. HART. That's right.

Senator KENNEDY. And had only used it once?

Ms. HART. Yes.

Senator KENNEDY. Are you woried about not having any health insurance?

Ms. HART. Oh, I am, yes. I don't know what I would do if something should happen to me.

Senator JAVITS. Mr. Chairman, I'd like to ask this witness a question because it's very pertinent to me.

Ms. Hart, you seem like a very fair woman. You can understand, I gather, why an insurance company would reject your application. They have actuarial problems.

But isn't it a fact that you feel, as an American, you're entitled to some kind of coverage somewhere, and that a national health insurance scheme is the ony scheme that will give millions of Americans, who fall between the cracks, like your self-coverage.

Ms. HART. That's right. [Applause.]

Senator JAVITS. The thrust of your testimony is not that someone is being cutthroat in not giving you insurance. It's just that we do not have a system that deals with millions of Americans who fall in your situation.

Ms. HART. Yes; but, on the other hand, Senator, I was thinking that if I had taken a job someplace I would just automatically be covered. They never ask any question if you go into a—if you take a job and you're under a group plan. I would have been automatically covered. But as an individual I can't get it.

That doesn't make any sense to me.

Senator JAVITS. We need a net which is broad enough to deal with these cases which fall, and become deeply unjust, between the cracks in the present system. That is why we are here to discuss national health insurance.

Ms. HART. Yes.

Senator JAVITS. This simply won't do.

Ms. HART. That's right.

Senator JAVITS. Thank you.

Senator KENNEDY. Well, we want to thank you, Mrs. Hart. We also had intended to hear from Mrs. Glynn of Queens Village, N.Y. And the point that Mrs. Glynn was going to make is that living on $325 a month from social security and pensions, she needs drugs and she needs to see a doctor because of some chronic problems, and she needs the additional few dollars a month to see the doctor, and also the drugs.

And she does get help and assistance from her children to help her out. If she didn't get it, she doesn't know what she would do.

And I think the point being that we've heard about dramatic and significant bills that have wiped out a lifetime of savings, or sizable bills that have wiped out savings of younger people, middle income.

We find out that they can be catastrophic expenses when we're talking just about $30 and $40 a month, particularly among senior citizens that need those prescription drugs and who are unable to afford it.

And I think that's a fact that we have heard from her, which is somewhat a different aspect of this particular situation.

Just before excusing the other witnesses, I think all of us are very grateful for their willingness to tell us about their experiences. I think there's been some unifying factors in their testimony.

First of all, none of these witnesses are asking something for nothing. Every one of these witnesses that we've heard this morning have worked during the course of their lives; and desirous of working; are married to people who have worked; have been paying their taxes living in this community; and have been, in every sense of the word, participating members of our society, whose illnesses that affect themselves and impact their children are virtually without any respect not due to their own activities or inactivities—I mean they couldn't have controlled them.

And, nonetheless, each and every one of them, either themselves or their families, are faced with the enormous fear of the continuing ongoing bleeding of their savings; or their anxiety for meeting the future health care medical bills. Each and every one of them.

And the additional interesting fact is that just about every one of them, with one or two exceptions, have been covered with insurance policies. And these are not the 26 million people that don't have any; the additional 18 million who are inadequate.

Or part of 52 million Americans who live in areas which are inadequately served. These are people who are covered.

The average family in many instances, from an income point of view, making more than the average, and that are being absolutely decimated by an irrational system that in many instances is keeping people from working who want to work. In other instances, the dangers and fear of their wife losing employment and what that would mean in terms of pension.

Other instances seen, that children are denied needed health care, with our young family that was afflicted with spinbifida because they're not able to get the resources to pay for additional treatment.

I mean, you can imagine the anxiety of those parents, looking at that child every day, saying "I know that that child needs the medical attention, and even though we're making $16,000 or $18,000 a year, we're still not caught up to provide for that."

Now what possible sense does that make? In a system where the costs are widely out of control. And that are bankrupting every middle-income family in this society, and are putting the middle class of this society as well as the neediest people, elderly people who are finding that they're not even getting their expenses paid and their medical bills paid, even the way that they had been prior to medicare. Let alone the neediest people in our society who are suffering.

What possible sense does that make? It just doesn't. And as we heard, very eloquently said by Mr. Carlson, we're spending more than any other industrial society in the world. We're spending it, my friends. We're spending it. We're emptying your pockets. Every one of your pockets, and we're going to continue to do it until you demand of the Congress and the Senate, and the President of the United States, that we're going to bring some rationality and some humaneness into our health care systems. And that's what this series is all about. And that's why we're here.

[Applause.]

Senator JAVITS. By way of concluding the testimony of the witness, I ask unanimous consent that there be inserted in the record an opinion poll of the New York Daily News of November 13, 1978. Which shows the following:

That 78 percent of the people surveyed in New York City, a representative sample, favor a health insurance program that will cover doctor and hospital bills. Only 15 percent opposed; and more importantly that 50 percent of those surveyed favored such a program even if it meant higher taxes, only 37 percent opposed.

Now, I think that that is very conclusive evidence, Mr. Chairman.

[Applause.]

Senator KENNEDY. We want to thank all of you. You've been enormously helpful. And, I just tell you my friends, we hear, not today, because I think we have a very constructive comment from Dr. Way of the medical society in New York State, but we'll hear, Senator Javits and I will hear, you know, that we searched around and finally found the one or two people out there in Queens with tragic problems. Or we found the one person out there in Chicago, or Detroit.

Yet we had some 88 witnesses that were prepared to comment this morning on similar kinds of stories, that wanted to testify on this. We could have filled this hall with similar kinds of stories. Make no mistake about it, what you've heard today you'll hear in every city, you'll hear in every rural county.

We've heard it in the hollows of West Virginia. The names were different, but the types of illnesses and sicknesses were the same. And the human tragedy is identically the same.

And, so, we're enormously grateful to you for coming and we're going to do our best to try to deal with it in a way that brings some humane and responsible sense to our health care system.

I want to thank you all. We'll move on to our final witnesses.

Thank you very much.

[Applause.]

Mr. CARLSON. Senator, we would like to thank you and Senator Javits for the opportunity to come here.

Senator KENNEDY. Thank you very much, Mr. Carlson.

Mr. Kipp, we'll recognize you one moment here.

Mr. KIPP. Senator Kennedy, I know personally hundreds of cancer patients that could have testified here today to these problems. Just in my own experience, you're absolutely right.

Senator KENNEDY. Thank you very much.

There is transportation leaving for Rockaway Beach, and if you're planning to return to Rockaway, that transportation is leaving very quickly. So we'll urge those that are going to Rockaway Beach and want that transportation, if they want to excuse themselves while we have our final panel.

Which is: Dr. George Way, the president of the Medical Society of New York; Dr. Schoolman, the president of the committee of interns and residents, physicians national house staff; Nurse Lillian Roberts, the associate director, district council 37, American Federation of State, County, and Municipal Employees; Ms. Arlene Ezratty, who's the vice president of district 1199, National Union of Hospital & Health Care Employees.

All of those witnesses will come up, please. We'll excuse those that are on their way to Rockaway. And if we have your attention for probably one-half hour, that's what we're going to ask, one more half hour of your time and attention.

We want to thank all of our Rockaway friends for being with us.

[Applause.]

Let's be in order now. We'll start with Dr. Schoolman.

## STATEMENT OF MICHAEL SCHOOLMAN, M.D.

Dr. SCHOOLMAN. Thank you very much.

My statement takes on added importance in view of the——

Senator KENNEDY. We have about half an hour. What we're going to do is we'll have the full statements put in their entirety in the record, and then what we're going to do is ask them just to summarize it, take 5 or 6 minutes. And then what we're going to do is ask any of you who want to, write to Senator Javits and myself here at the Senate committee. Please write to us; we're going to keep the record of this hearing open for 10 days and if you have a story that you want to tell us, if you have an opinion you want to express, you write to us and we're going to make sure it's included in the record. Now, what about that. [Applause.]

Here we go. Dr. Schoolman.

Dr. SCHOOLMAN. I have a 5-minute statement which I'd like to be able to read. It takes on added significance in view of the——

Senator KENNEDY. Read that into that mike.

Dr. SCHOOLMAN. In view of the newspaper reports of the massive closings of city hospitals here in New York—the Committee of Interns and Residents is a union of about 6,000 house staff doctors in New York. Our organization has for a number of years struggled to deal with the shortcomings and failings of our current health care system. Today with renewed talk of huge cutbacks in vital health care programs in New York City, there is special urgency to our call for enactment of comprehensive national health insurance. We are at a crossroads in our health care policy: While some say we cannot afford any large-scale changes, it seems clearer every day that we cannot avoid a large-scale overhaul—inaction or stopgap measures will only produce more confusion and more waste.

Health care in New York City dramatically illustrates the urgent need for national health insurance.

New York City demonstrates the best and the worst of medical care in this country. In the borough of Manhattan we have four world-famous academic medical centers and many other prestigious teaching hospitals where patients come from all over the world for the highest of high technology medical care.

Park Avenue in Manhattan has become as synonomous with doctors as Madision Avenue is with advertising, and the concentration of hospitals on the East Eide of Manhattan has led to the designation "bedpan alley."

Despite this tremendous concentration of expensive medical resources, large areas of Manhattan and other boroughs have no doctors, no health care centers, and an estimated 1 million people in this city have no health insurance whatsoever, even if they could get to a health care provider.

Medical care in New York City is a multibillion-dollar industry, but there is a growing question about who is getting what for all that money.

Voluntary hospitals have expanded and continue to build in areas already crowded with such facilities, while municipal hospitals that serve only the poor are cut back.

The growth of voluntary hospitals that occur—the agency claims that there are 5,000 excess beds. Our members, many of whom work in municipal hospitals, report they frequently could find no beds for acutely sick patients in poor areas.

Billions of dollars of public money now pour into private, medicaid mills and private nursing homes, often with questionable benefits or accountability. Yet when the word comes down to retrench on health care expenditures, the first target is, as usual, the public health care system which provides a vast amount of outpatient and emergency care, and most of the inpatient care, for those millions of people least able to get it otherwise for economic or geographic reasons.

The plight of the city hospital system in New York shows the potential of our current health care system not only to expend vast amounts of money, but also to devour and destroy our most valuable resources. The system of clinics, outpatient departments, emergency facilities, and hospitals run by the city once represented a highly developed public health system. It provided the right kind of care when it was needed to all people, regardless of ability to pay.

It functioned not only to diagnose and treat disease, but more importantly, to prevent it and promote health.

Our "progress" in health care now is destroying this valuable and cost-effective system. The economic incentives in the payment system lead to "skimming" of profitable cases and "dumping" of unprofitable ones by the voluntary sector on the public.

Because health care dollars are big dollars, the private sector in New York is now wasted a lot more on the more efficient, less costly municipal system. The most inviting cutback target is, and always will be, not the fat voluntaries, but the muscle of our system, the public health hospitals.

Only with a comprehensive national health insurance program can we escape this destructive spiral.

The experience with a costly, fragmented, and inefficient system of health care in New York is an important example for the rest of the country. It shows that simply adding a few more patches to the current system will not solve our problems and may make them worse. Efforts to control use of resources through planning regulations, certificates of need, and other mechanisms demonstrate that the providers are more imaginative than the regulators. Programs like Hill-Burton, medicare, and medicaid, which provided financing with little emphasis on quality, efficiency, or accessibility of care, make the flaws of our system stand out even more clearly.

A program of national health insurance must incorporate several essential features.

It must provide universtal coverage and comprehensive benefits. Simply adding a wider group to medicaid coverage or putting another chronic disease under medicare is not an acceptable solution. The wasteful administrative red tape of patchwork coverage is a compelling reason alone for simple across-the-board universtal coverage. And the ability of providers to deliver the appropriate care in the proper setting without twisting it to fit the patient's insurance is another important reason.

National health insurance must also provide for an equitable financing basis on both ends of the system.

Employer and employee taxation would distribute the taxation more fairly. Prospective budgeting and comprehensive planning would insure that important services are provided where needed and prevent the swallowing up of resources by an insatiable health care industry.

Finally, national health insurance must reemphasize preventive and ambulatory care, something that is not presently done by the voluntary sector who operates to make money.

One of the greatest ironies found in our current expensive system is the disincentives it provides for the most effective and efficient form of medical care, that's preventative care.

The campaign against a real national health insurance program will be waged by those groups with a great interest in the status quo. Many others including consumers and health care professionals may be uncertain about the risks and results of national health insurance. A heavy propaganda battle is already underway.

One response asserts that our health care system is fine, the best in the world. Certainly, we have a great deal to be proud of in American medicine; but we also have tremendous problems, and these can't be ignored.

Another objection cites increased costs, unacceptable Government budgetary increases, Yet it is clear that simply rechaneling the waste and inefficiency of our disorganized system through comprehensive national health insurance would be highly beneficial.

And the charge is raised that national health insurance will lead to the development of "rationing" of health care. Clearly we have already rationed out in the worst and least logical way in a system that provides care, not based on need or effectiveness, but on the basis of payment status.

And it should be the top priority, it's an urgently needed program. It should be fully and quickly implemented.

Thank you.

[Applause.]

Senator KENNEDY. It's important to point out that, not only you, but your Committee on Interns and Residents in the national organization have been strongly in support of what we've been attempting to do.

And, I think your testimony has been enormously constructive and positive.

Ms. Roberts.

## STATEMENT OF LILLIAN ROBERTS

Ms. ROBERTS. Senator Kennedy and Senator Javits and other distinguished members of the committee.

I am Lillian Roberts, associate director of district council 37.

I am here today representing Victor Gotbaum, executive director of district council 37 and the more than 100,000 public employees who are members of our union.

We strongly applaud your vigorous efforts to provide national leadership in developing a high quality, comprehensive health program for all people in this Nation.

[Applause.]

Ms. ROBERTS. Thank you.

District council 37 strongly supports a national health security plan because it attempts to systematically deal with the nation's health care problems. We need to develop a framework to develop high quality care at a reasonable cost.

I welcome the opportunity to testify before your committee on the problems New Yorkers face in obtaining quality medical care.

I would like to focus upon an area I have first hand knowledge of—that is the New York City municipal hospital system.

Our union members have first hand experience, working in the city's 17 municipal hospitals. Indeed, we represent more than 25,000 public employees in these institutions. They deal on a daily basis with the problems faced by all New Yorkers, particularly the working poor. These are not just patients to our members, they are friends and neighbors.

And not only do they work in these hospitals, they also live in the community and take special pride in providing valuable and much needed services.

The city municipal hospital system, one of the only examples of a unified health care system, embodies many of the most important principles of a responsible health care plan. First, this system assures access to all people regardless of their ability to pay.

It is essential, there are about 1.4 million people, 1.4 million people in New York City alone who do not qualify for medicaid coverage, or other third party insurance plans, and simply cannot afford the high cost of medical care.

The municipal hospitals are their only source of health care and, second, the municipal hospitals are publicly accountable and open to full review and investigation by all government agencies.

And, third, the public hospitals of New York City are less expensive to operate than their voluntary counterparts.

And, finally, the municipal hospital system is primarily structured to deliver ambulatory and emergency care. And while representing about 20 percent of the city's hospitals, they deliver 50 percent of its ambulatory care.

Given the shortage of private physicians in certain parts of the city, these hospitals provide the only available source of medical care to many local areas.

My purpose in highlighting certain features of municipal hospital system is to call attention to their financial plight. Despite their critical value they are under threat of closure.

Tragically, the dilemma that New York City's municipal hospitals find themselves in is a symptom of a much larger crisis. The fiscal crisis that has gripped New York City over the last several years, and increasingly threatens the viability of our Nation's other cities, jeopardizes the basic fabric of our society.

Municipal hospitals obtain a sizable portion of their funding from local tax levy support. The difficulties of this city's fiscal crisis has made it more difficult for the local government to carry out this burden by itself, providing health care, and for that matter, other human services. It's a national problem demanding national solutions.

The case of the municipal hospital system illustrates the contradictions of how public policy is made in America today.

Why do our public officials want to close those institutions which by any measurable criteria justify their existence?

Who will serve those less fortunate members of our society who so desperately depend on these hospitals for medical services?

Why would our society rather see thousands of hard working men and women who now serve their community go onto the public welfare rolls rather than working to support themselves and make a contribution to society?

And these questions can go on and on.

Our public officials tell us that we cannot afford to pay for these services from public funds. Here then is the essence of their contradiction: All hospitals are basically public in nature when it comes to their funding.

Clearly, though, they all do not serve the public, as do the municipal hospitals.

The irony is that we, the public, are paying more for hospital services in the private sector and are often getting less for our hard-earned money.

It is clear that this is a political decision, a decision which costs our society dearly in both financial and human needs.

We will not achieve our goal of the national health securities plan unless we come to grips with the high costs associated with medical care. Indeed, we in New York City are under a mandate from Congress to do just that. And under the terms of the Federal loan agreement to New York City, Congress wants to make certain that we do all we can do in the managing of all public funds.

We must look at the entire health care system in New York City and evaluate it in terms of its effectiveness and cost efficiency. To simply make decisions based upon political criteria is bad public policy, and wholesale meat axe approach—[applause] and wholesale meat axe approach to cutting the municipal hospital system does not make sense from either a human or financial point of view.

I would recommend that you and your colleagues give serious consideration in coming to New York City and study the feasibility of using the city's municipal hospital system as a model for a national health plan. [Applause.] A full and complete investigation of the issues I have identified here today is required so that the public will know the real truth.

In conclusion let me again emphasize the pressing need to address the problems facing our Nation's poor.

These well paid workers who are struggling to better themselves cannot be forgotten. Our ability to deal with these individual problems is a test of our Nation's real strength.

Again, I thank you for giving me the opportunity to present this district council 37's fears, and we applaud your kindest efforts to realize the fullest potential of our health resources so that they can serve the needs of all Americans.

You can be assured that we will give you our fullest support.

[Applause.]

Senator KENNEDY. Mrs. Ezratty.

## STATEMENT OF ARLENE EZRATTY

Ms. EZRATTY. My name is Arlene Ezratty, vice president, district 1199 of the National Union of Hospital and Health Care Employees.

I wish to thank Senator Kennedy and Senator Javits, and the Senate Health Subcommittee, for the opportunity to contribute to today's discussion of national health insurance.

I am here on behalf of over 70,000 district 199 members, who work in voluntary hospitals, nursing homes, pharmacies, and health related facilities in New York State.

Members of district 1199 are registered nurses, licensed practical nurses, medical and radiological technicians and technologists, dietitians, social service workers, pharmacists, secretarial and clerical workers and service and maintenance employees.

As providers, and also as consumers of health care, 1199 members are intimately aware of the need for a comprehensive national health plan, designed to contain our burgeoning health costs and to insure the availability of high quality health services to all persons residing in the United States.

Although the medicaid program was a step, it has failed to meet the needs of the medically indigent, the working poor, those ineligible for medicaid yet too poor to afford any decent health care are inadequately provided for.

Medicaid recipients often receive substandard care. A double standard system of health care delivery has been created that dispense care to the poor that is inferior to that received by higher income groups.

Inability to pay for preventive care or any treatment, leads to more severe illnesses which eventually must be treated at a higher cost. Reduction of medicaid eligibility standards for low wage earners has driven them to the welfare lines when illness strikes their families.

Far too many medicaid dollars have been scooped up by ruthless profiteers. We must learn from our mistakes and carefully formulate a national health insurance plan that will effectively control costs, curb abuse, and make health services available to all.

We believe that every American is entitled, as a matter of right, to the best health care that our Nation's skill and technology can command. [Applause.]

Ours is the only industrial country in the world, apart from South Africa, that does not have comprehensive, universal health insurance.

President Carter has announced on his statement on principles of national health insurance that no additional money, Federal money, will be spent now to establish a comprehensive program until fiscal year 1983, due to tight fiscal constraints.

He explains that the program should be phased in gradually and the rate of its progression will be determined, in part, by the status of the economy.

We find this plan totally unacceptable and a betrayal of President Carter's election commitment to national health insurance. [Applause.]

If Money can be found to augment the defense budget, then progress in comprehensive health care is not beyond the means of this country. [Applause.]

Health care costs are rising dramatically. Proliferation of the sophisticated and expensive medical technology, duplication of medical equipment, and third-party reimbursement systems devoid of cost cutting and sometimes are the major contributors to this phenomenon.

Contrary to the claims of everybody, increasing wage rates of hospital employees are not responsible for driving up hospital costs. Hospital spending for labor has declined.

Payroll accounted in 1955 for 62 percent of hospital costs; it is now down to 53 percent in 1975. The wages of nonsupervisory hospital employees continue to lag behind those of the general work force.

The average wage for nonsupervisory hospital employees was $4.68 an hour in 1977 as compared to $5.25 for the same type of employee in the entire private sector, including manufacturing and services.

Because the cost of health care, good housing and life's other necessities are increasing, we must have national health insurance now. We must shift away from our present nonsystem of patchwork health care that is run to a profit, to a national system that will make health care accessible and affordable to every American who needs it.

Such a system must include universal and comprehensive coverage, health care must be a matter of life, not privilege. There must be one system for all. Everyone must be entitled to care regardless of race, income, sex, age, religion, or any of the barriers that now create inequality.

Comprehensive care should include doctors, hospitals, convalescent care, and home help services. These services and facilities should be used to maintain health and prevent illness as well as to treat sickness.

Equitable financing, health care should be removed from the profit-making arena and financed by the Federal Government from general revenues. [Applause.]

A sound organization to develop a national system for the delivery of health care, it is necessary to:

(A) create an organized service in which the providers of medical care work together with government and the community for common objectives;

(B) we should establish neighborhood medical facilities and community medical centers, easily accessible to the people they serve and control by duly elected community boards;

(C) we ought to encourage the development of comprehensive group medical and dentist practice, with effective consumer participation;

(D) finance a recruitment and training to meet health manpower needs and support medical and health research requirements;

(E) we must evaluate health care costs and expenditures to insure that the best care is delivered at the lowest cost.

There has yet to be an honest evaluation of our health care delivery system. Hospitals must be required to disclose detailed financial information, both to the Government agencies and to the public in general.

We realize that the problems of the Nation's health goes beyond what can be done to improve the delivery of medical care. To insure good health also means to provide decent food and housing, clean air, and pure water.

We believe that our Nation has the material and human resources required to fill these essential objectives.

We believe that a national health budget must be adopted that makes the delivery of health care a matter of top priority. Our national emphasis must change from war and destruction to the preservation of life. [Applause.]

Our union pledges to actively promote and work for Federal, State, and local legislation that is most consistent with the goals set forth in this statement.

Our union pledges to work together with the AFL–CIO, Senator Kennedy and the Senate Health Subcommittee. The committees for national health insurance and other organizations and groups actively engaged in the campaign for comprehensive national health care protection for all Americans.

We also pledge to continue to be mindful of our responsibilities as human beings, and as union members in taking care of the sick, and aged, and infirm.

Finally, we call upon the U.S. Government to make use of the knowledge acquired by health practitioners concerning delivery of health care.

We, as the representatives of over 70,000 health care employees in New York State, are able to make a valuable contribution to any disclussion on health programs and should be consulted before any action is taken.

Thank you. [Applause.]

Senator KENNEDY. We welcome these statements from the committee of interns and residents and also Ms. Roberts excellent statement and comment in analyzing the problems that are being faced in our municipalities.

And this is the same story we could hear whether it was Boston, or St. Louis, or Chicago, or any of our areas. And we welcome Ms. Ezratty's comments as well, in terms of the employment situation, the pressures, the imbalance in terms of employment and reimbursement and the pain. It's very helpful.

We thank all of you for your testimony.

We had intended to have Dr. George Way, who is president of the Medical Society of New York. He was here earlier. We don't know whether he was called away, he's a practicing physician, but he has an excellent statement and comment, and we will take this and we'll talk to him later in the day and see if he wants to include it in the record. We'll certainly include it.

It is a very forthcoming and constructive statement and commentary, and it's a very clear indication to those of us who are supporting national health insurance, that we are going to be able to find those within the medical practice who we can work with in fashioning and changing the program.

And I think it's extremely encouraging, and we take note of that at this time and will make that part of the record with his approval.

Senator Javits, would you care to make any further comments?

Senator JAVITS. I would like to thank the witnesses, Mr. Schoolman, Ms. Roberts and Ms. Ezratty, for their testimony. It's been very helpful and very useful.

Second, I would like to thank you for bringing this hearing to New York, a site I think is amply suitable to make a case for national health insurance.

Senator KENNEDY. We'd like to thank all of you. We hope our friends from Rockaway made it on their bus.

How about it? Are you going to support our bill on national health care? [Applause.]

At this point I order printed all statements of those who could not attend and other pertinent material submitted for the record.

[The material refered to follows:]

RE-Hearing conducted in New York City, Dec. 14,1978

INTRODUCTORY

I heard of this meeting and was informed by phone that the witnesses were chosen far in advance. I attended the meeting and heard Senator Kennedy state that one could write and ask their testimony to be included. Hence this letter which I will try to present as if I had been a witness. You have my permission to condense it where needed.

Testimony

My name is Mrs. Marion Stoughtob, age 61. and my husbane is Ralph Stoughton, age 62. Due to physical and mental illness, my husband became elgible for Medicare in 1973 as a S.S. disability pensioner.

It is my understanding that the proposed national health insurance progran would be tied into Mediacare to provide comparable benefits. Physicians, however, would be paid directly by the insurance plan instead of billing Medicare patients. (1) I hope that the propsed plan would also include that out-patient hospital treatment would be paid directly by Medicare. It is this latter factor that has been the cause of much mental turmoil tome sice I write the checks and keep the books.

Specifally, my husband suffers fro mental depression and requires electro-shock treatments. I am required to be a computer and book-keeper. The first I do fairly well;; the second comes harder. For those of you who are not aware of these treatments, they are standard treatment for mental depression given to patients either as in-hospital or out-hospital patients. One of their side effects is a slight loss of memory; my husband is one of the people who experience this. Although he may know the address of the hospital, he may not remember exactly where it is or how many times he has been there.

If I should be unable to continue my "books", I think he would have to secure the services of an accountant.

This preamble is necessary to understand my testimony. From 1973 to May 1977 we lived in New Jersey from May 1977 to the present date we have been living in New York and my "mental turmoil" has increased many-fold.

Please understand that no hospital nor doctor has done anything that is contrary to existing laws.(2)

(1) AARP NEWS BULLETIN, Dec.'78, page 3
(2) MEDICARE--PART B, page 24--Assignment
page 24, Outpatient Service
page 55--State providers

In New Jersey the out-patient electro-shock treatments were administered at Fair Oaks Hospital, N. J. They followed the procedure(bless their hearts) of billing Medicare and our private carrier-Blue Cross/Blue Shield and Major Medical.

In New York these treatments have been given at Gracie Square Hospital, New York City, N. Y. We pay them in advance $50. each treatment which does not include the doctor's fee, usually $50, billed to us separately. The hospital bills Medicare and private carrier who then re-imburse us. We send the doctor's bill to Medicare and private carrier for re-imbursement. Sounds simple? No, mistakes happen. The hospital sent a 3 month bill to Medicare who promptly sent the hospital an extra check. Oh, we received a refund from the hospital. As for the private doctors, I do not feel as kindly toward them. Actually, in New Jersey, a different doctor might have given the treatment each time because the patent is under anaesthesia. Not so in New York, in fact the doctor who has given most of the treatments to my husband is not his psychiatrist(who is not licensed to give shock-treatments.)

It is difficult maintaining a normal home life with your spouse sufferine from mental depression and I am only human. I know I am blaming him(unfairly, of course) for the added burdens of book-keeping. When I write check A to Hospital B and check C to Doctor D and then wait for Hospital B to send their bill to Medicare and I send bill from Doctor D, I end up glaring at my husband with mixed emotions. How much longer do I have to do this, but who would do it for him if I didn't?

(You can delete the previous paragraph if you desire-or condense it to a simple statement.)

It is not the financial burden; our income,Socisl Security, private pension and my salary is approximately $18,000. We are well covered by Medicare and private plans. But could some one please put it into one simple package?

One other brief comment. Preventive medicine can include out-patient treatment. The figure Medicare pays for doctor's visits for mental illness is $250. per year(3). Three days in Mt. Sinai Hospital room and board only is $750. (Penny-wise and pound foolish.)

Marion D. Stoughton

Mrs. Marion D. Stoughton
60 West 13th St.
New York, N. Y. 10011

December 18, 1978

(3) MEDICARE B--page 25

IF A MEETING WILL BE HELD IN NEW JERSEY, I WOULD LIKE TO ATTEND IT.

D.2

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Mrs. Theodora G. Jackson, *Executive Director*
William E. Gould, *Associate Director*

Public Hearing on
National Health Insurance
Italian Charities
83-20 Queens Blvd.
Elmhurst, N.Y.

Thursday, December 14, 1978

My name is Oliver Patterson. I am the newly elected President of the Advisory Council of the Rockaway Blvd. Senior Citizen Center, and a member of the Senior Citizen Advisory Council of the Jamaica Service Program for Older Adults.

There are approximately 70,000 senior citizens of South East Queens. 65% of our population is non-white; more than 1/3 is below the poverty level. Like many other Americans, we are alarmed and threatened by the spiraling costs of baisc health care today. In a position paper on health care policy Mayor Koch said, "the cost of health care for New Yorkers has at least doubled in the last decade, to the point in 1975 where some $6.7 billion was spent to pay for health services to the people of New York City."

Seniors on fixed incomes cannot provide for all their medical needs. With chronic illnesses, it is impossible for families to maintain the elderly. Even with Medicare, the elderly find it difficult to pay the 20% required for doctors' fees. Furthermore, the 80% that Medicare pays is based upon their determination of what the cost of care should be, not on what the cost actually is. Therefore, appointments are missed due to the lack of finances. In addition, the lack of transportation poses a serious problem. Unless transportation is built into the plan for those in need, there is no access to health care. At a time when we need them for our well being and dignity, Medicare does not pay for dental care, eyeglasses, out-patient medications, blood transfusions, and podiatry (except in cases of accidental injury.) Costs far exceed our ability to pay. We are on fixed incomes and important medical services must be neglected in order for us to survive. The exorbitant costs of out-patient medications, alone, are rapidly emptying the pockets of many. A woman I know recently filled a prescription for $11.65 on one day, only to return less than a week later to discover that the same drug now cost $15.00. People, especially the elderly, should not be subjected to the whims of pharmacists/doctors/others in the medical profession to pay exorbitant fees. Therefore, we urge uniform coverage under a National Health Insurance Plan.

Medicaid is another story. Currently, to be eligible for Medicaid, one must be practically destitute. An individual's income plus expenses cannot exceed $2500. This is incredible! Many people in need "fall between the cracks" of the system, and do not receive decent medical care. We either have too much money to be eligible for Medicaid or too little money to afford the exorbitant costs of private health insurance

policies. As a result minor problems become major because of neglect due to the lack of sufficient incomes.

Even with the Blue Cross, Blue Shield Supplementary Program which is supposed to contribute the 20% not covered by Medicare, the cost per person, per month is $14.

It has become profitable today to hospitalize people for relatively long periods of time. It appears that the more insurance one has, the more welcome he is. We must find alternatives to in-patient care - alternatives which in the long run are far less expensive than hospitalization.

Home health care is one such alternative. Currently, the regulations governing Medicare coverage for home care are very stringent. Medicare pays only for limited care within a specific time following hospitalization. We urge an expansion of coverage for this program so that the marginal income elderly will receive the home health care to which they are entitled.

In closing, I would like to express our concern with the growing discord among so many segments of our population. Young and old, middle class and poor are fighting for the drastically diminishing dollar. The poor, the elderly, the young and middle class must join together. Each group has special needs and each must understand the needs of the others. Government must recognize that people already barely surviving day-to-day cannot be asked to give up any more.

We are disheartened that the Democratic Party at last week's mini-conference in Memphis accepted a proposal that social programs be decreased and the defense budget increased. How can services to benefit people be cut any further than they already have been?

We strongly urge the passage of the National Health Insurance Bill because of the security it will provide for all Americans, especially to the elderly and the chronically ill and those in need of frequent specialized treatments such as dialysis/cancer care services.

We appreciate the interest and efforts of Senator Kennedy in promoting a National Health policy which would benefit all Americans.

I would like to thank the Committee for this opportunity to share with you today the concerns of older Americans.

Statement by Queens Borough President Donald R. Manes, submitted to Senate Committee on Health and Scientific Research hearing at Italian Charities, 83-20 Queens Blvd., Elmhurst, Dec. 14th, 1978:

ON BEHALF OF THE NEARLY TWO MILLION RESIDENTS OF QUEENS, I WANT TO WELCOME YOU TO THIS BOROUGH AND THANK YOU FOR GIVING MANY OF US AN OPPORTUNITY TO PRESENT OUR VIEWS ON THE QUESTION OF NATIONAL HEALTH INSURANCE. THIS IS AN ISSUE WHICH SURELY IS ONE OF THE MOST IMPORTANT AND MOST PROMINENT PROBLEMS FACING OUR COUNTRY.

I THINK IT IS QUITE CLEAR THAT THE HEALTH OF THE CITIZENS OF THIS NATION IS A MATTER OF NATIONAL CONCERN. BUT I REGRET TO HAVE TO SAY THAT THE FACT THAT THE HEALTH OF THE CITIZENS OF THIS NATION IS A NATIONAL RESPONSIBILITY IS NOT SO READILY ACCEPTED.

QUESTIONS AND ISSUES OF HEALTH AND HEALTH CARE SHOULD BE VIEWED ON A NATIONAL BASIS. IT IS UNFAIR FOR CITIZENS IN ONE PART OF THIS COUNTRY TO RECEIVE LESS ADEQUATE CARE THAN CITIZENS OF ANOTHER SECTION.

I AM CERTAIN I DO NOT HAVE TO EXPLAIN TO THIS PANEL THE NEED FOR A NATIONAL HEALTH PROGRAM WHICH WOULD PROVIDE ADEQUATE HEALTH CARE FOR ALL OUR CITIZENS. I BELIEVE WE HAVE REACHED THE POINT WHERE WE MUST DECIDE THE BEST WAY TO IMPLEMENT A PROGRAM WHICH WILL GUARANTEE A BASIC RIGHT TO EVERY CHILD, ADULT AND SENIOR CITIZEN IN THIS LAND.

FOR FAR TOO LONG, THE BURDEN FOR PROVIDING BASIC HEALTH CARE HAS FALLEN UNFAIRLY ON OUR LOCALITIES. THE ADOPTION OF MEDICAID HAS HELPED, BUT IT STILL DOES NOT FULLY RECOGNIZE THAT ANSWERING THE HEALTH NEEDS OF OUR CITIZENS IS A NATIONAL RESPONSIBILITY.

(MORE)

QUEENS BOROUGH PRESIDENT DONALD R. MANES 2-2-2

A NATIONAL HEALTH INSURANCE PLAN SHOULD BE SUBSTITUTED FOR MEDICAID--A PROGRAM WHICH NOW COSTS THIS CITY SOME $430 MILLION A YEAR. THIS IS AN IMPOSSIBLE BURDEN FOR ANY MUNICIPALITY TO CONTINUE TO CARRY.

THE SAVINGS TO NEW YORK CITY WOULD GO WELL BEYOND THIS $430 MILLION ANNUAL MEDICAID ALLOCATION.

THERE IS A SIZABLE POPULATION WHICH IS NOT ON WELFARE BUT ABOVE THE MAXIMUM INCOME TO QUALIFY FOR SSI, AND WHICH EITHER DOES NOT CARRY PRIVATE HEALTH INSURANCE, OR HAS WOEFULLY INADEQUATE COVERAGE.

THE FAILURE OF OUR PRESENT HEALTH CARE MECHANISMS, WHICH LEAVES THESE PEOPLE OUT, IS MOST OFTEN CITED AS A PRINCIPAL REASON FOR THE NEED FOR OUR VAST MUNICIPAL HOSPITAL SYSTEM.

A PROGRAM OF NATIONAL HEALTH INSURANCE WHICH WOULD PROTECT EVERY-ONE WITH REALISTIC COVERAGE COULD GO A LONG WAY TOWARD SUBSTANTIALLY REDUCING OR EVEN ELIMINATING THE NEED FOR THIS CITY TO DIRECTLY SUB-SIDIZE AND OPERATE A MUNICIPAL HOSPITAL SYSTEM.

THE PRESENT MUNICIPAL HOSPITAL SYSTEM COSTS THIS CITY MORE THAN $450 MILLION A YEAR. MEDICAID SUPPORT EQUALS $430 MILLION ANNUALLY.

THAT MEANS THAT IT COSTS THIS CITY OVER $880 MILLION A YEAR TO PROVIDE HEALTH CARE TO ITS RESIDENTS.

(MORE)

QUEENS BOROUGH PRESIDENT DONALD R. MANES 3-3-3

WE IN THIS CITY HAVE LEARNED THAT WE SHOULD PAY ATTENTION TO OUR BASIC RESPONSIBILITIES. WE HAVE LEARNED THAT POLICE, FIRE, SANITATION, EDUCATION, WATER SUPPLY AND OTHER BASIC, LOCAL SERVICES SHOULD BE THE PRIMARY FOCUS OF LOCAL GOVERNMENT.

I FIRMLY BELIEVE THAT NEW YORK CITY WILL BE ABLE TO MEET ITS RESPONSIBILITIES TO ITS RESIDENTS. INDEED, WE WILL BE ABLE TO AFFORD A PROPER LEVEL OF TRULY MUNICIPAL SERVICES IF THE FEDERAL GOVERNMENT WILL ATTEND TO THOSE AREAS OF SERVICE WHICH ARE PROPERLY ITS RESPONSIBILITY.

THE VALUE OF A NATIONAL HEALTH INSURANCE PROGRAM SHOULD BE CONSIDERED, FIRST AND FOREMOST, AS A QUESTION OF PROVIDING ALL OUR CITIZENS THROUGHOUT THE NATION WITH PROPER HEALTH CARE.

BUT WE SHOULD NOT LOSE SIGHT OF THE ADDITIONAL AND EQUALLY JUST BENEFIT OF LIFTING THE CRUSHING BURDENS IMPOSED BY THE PRESENT SYSTEM FROM THE SHOULDERS OF LOCAL COMMUNITIES THROUGHOUT THE COUNTRY.

OUR CITIZENS AND OUR LOCAL GOVERNMENTS WILL BE HEALTHIER IF WE ADOPT A JUST AND FAIR NATIONAL HEALTH INSURANCE PLAN.

THANK YOU VERY MUCH.

-30-

Senator KENNEDY. The committee is in recess.
[Whereupon at 12:30 p.m., the committee recessed.]

# NATIONAL HEALTH INSURANCE, 1978

FRIDAY, DECEMBER 15, 1978

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
OF THE COMMITTEE ON HUMAN RESOURCES,
*Garden Grove, Calif.*

The committee met, pursuant to notice, at 10 a.m., Garden Grove, Calif., Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

President: Senator Kennedy.

## OPENING STATEMENT BY SENATOR KENNEDY

Senator KENNEDY. We will come to order if you could, please.

First, I would like to welcome our friends from Canada who have traveled many miles to be with us here this morning. We are enormously grateful that they would take time out of their lives to share the health experience in our neighbor to the north.

I think all of us in this country recognize that we have very important friends, very warm friends, in the country that neighbors so many of our States, Canada. There are probably more people who have relatives in my own State of Massachuetts who can trace their ancestry to Canada than any of the other countries of the world. I know it has been a relationship which has been extremely warm and strong with many shared values just as our relationship with Mexico. We are enormously grateful that they would be here this morning. [Applause.]

Have we got a little more sunshine here than up in Canada? You have got snow up there. Well, it is 20 below. OK.

Seven years ago, as its new chairman, I brought the State health subcommittee to southern California to explore the need for a national health insurance program.

American society has changed in many ways since that visit. But the human and economic need for a universal and comprehensive national health insurance program is more compelling now than ever.

The economics of the situation are truly frightening. Everyone today agrees that health care costs are out of control. This rampant inflation takes its toll everywhere—on Federal budgets where the percentage of the Federal dollar spent on health has risen from 4.3 percent in 1963 to 12.7 percent this year; on State budgets where medicaid is the single most rapidly escalating cost; on corporations, which must pay more and more each year for health benefits; on the American family, whose health bill care is $2,115 today, and will be $3,590

in 1983—for benefits which cost $533 in 1963; on the elderly, who pay more for their care today out of their own pockets than the year medicare was implemented.

The Nation as a whole will spend $252 billion in 1981 on health care, and that money will pour into a system without cost controls, without quality controls, with uneven access to care and without any prospects for improvement. Make no mistake about it; left unchecked, health care costs will bankrupt this Nation.

National health insurance is the last, best chance to halt this staggering economic waste. That is because cost containment is at the very heart of the health insurance debate.

Every American family knows what it means to live within a budget. It is time the American health care system learned to live within a budget. The Health Care for All Americans Act imposes one. Under this approach, all health care costs will be prospectively budgeted. The American people will no longer have to hand a national blank check over to the health care industry. No other program to guarantee comprehensive benefits to all Americans will cost less than this proposal. In fact once it takes effect, the Nation will pay less for health care under national health insurance than if the current nonsystem is left unchecked. That is a fundamental point. The choice is not, as opponents would have us believe, between an expensive new program or no program at all. The choice is between comprehensive benefits for all Americans in a system with cost controls at every level or a continuation of the current patchwork system, with millions and millions of Americans denied care and costs continuing out of control.

The economics of the situation alone makes a compelling case for national health insurance. But the testimony we will receive today from California residents makes an even more compelling case. These families live just a short distance from our other witnesses—families from Canada. Illness is a time of great emotional stress for all families. But under the Canadian system of national health insurance, that stress is not complicated by the fear of bankruptcy, by the fear of bill collectors, by the fear of collection agencies. In the United States, no family should have to sell their home in order to pay a hospital bill—no family should have to worry whether or not they can afford to treat a sick child or a sick parent.

National health insurance is about people's lives. It is about the quality of life at times of greatest emotional stress. It is about fear—of financial ruin compounding the fear of serious illness.

What we really do in this country is penalize people for getting sick. We penalize them financially for something over which they have no control. They have trouble getting insurance. They have to pay more when they do get it. It is a peculiar kind of American Darwinism—survival of the wealthiest.

No other industrialized nation in the free world except South Africa penalizes its people for getting sick. All of them have universal, comprehensive national health insurance. None of these systems is perfect—they have real and serious problems. But not a single political leader, not a single political party, not a single respected commentator, would turn the clock back and substitute our system for theirs.

This morning we will hear from California residents. In recent weeks in this subcommittee has heard similar stories in Detroit, Mich.; Osage, W. Va.; Chicago, Ill.; Denver, Colo.; New York City and Washington, D.C. We could hear them repeated by citizens in every city in this Nation. Let the people of California listen to these stories. Let them listen to the testimony of our friends from Canada. Let the people of California make up their own minds. I am confident that when they do, there will be important new support in this State for national health insurance.

Just before hearing our first witnesses I would like to just mention one or two points which illustrate the points made in the opening comment.

I don't know whether those in the back can see this chart, but perhaps maybe during the morning they will have a chance to examine it.

This chart was prepared by the Congressional Budget Office. It is a bipartisan group of Democrats and Republicans. It has a highly qualified staff, and what they did some 2½ years ago is to make an estimate about what the costs were going to be under different health proposals before the Congress and Senate of the United States, and I think that the most interesting part of these comparisons is this line right here which shows that if we do nothing at all, that is, if we do not pass any form of health insurance, if we do not pass a vigorous cost of containment policy, we are going to be spending some $252 billion in or by 1981. We are spending $171 billion this past year—$252 billion. It ought to be of interest and importance that the people that are going to spend those inflated dollars are going to be middle-income families. They are going to be paying with increased premiums or with reduced benefits, and that is the story that we are going to be hearing about later today as we heard yesterday in New York, the absolute explosion of health care costs.

And on the next chart we have the targeted approach, which is catastrophic. It shows that even with the catastrophic without the kinds of cost controls it is expensive, the premium, finance. Next we see what would have been S–3, which would have put a heavy burden on the budget, but still in terms of total costs would have been more modest.

I want to also mention this chart here. It compares the amount of gross national product that is spent in Canada and the United States and shows the difference and the growth of it from 1968 to 1978. In 1968 Canada was spending 6.8 percent of their gross national product on health. In 1978 it is 7 percent, .2 of 1 percent difference and they had implemented national health insurance in 1968. They finalized it. So they have been able to effectively stabilize the amount of resources percentagewise. They have been impacted by inflation, and they have got other aspects and concerns about their policy, but we will hear today from some of our friends from Canada about whether they are satisfied with this program. I just want to make reference to the last poll that was taken in Canada this last spring, showed that 84 percent of the people in Canada were well satisfied with their health insurance proposal. Effectively they have cost controls and cost containment. The United States in 1968 was 6.5 percent, now 8.8 percent

and climbing, and we are going to find out today whether even with those additional expenditures we have a humane system in our Nation.

These other charts are self-explanatory, the comparison explosions of health care costs and what the families of four would be spending.

We will now hear from our witnesses and get started with them.

What we have tried to do before this hearing is to match various families here in this community, the general community, with Canadian families that have similar kinds of illnesses or sicknesses, similar general areas and similar incomes, so we are matching sicknesses, incomes, ages to try to match them as closely together to try and see how the two systems function and work. I think you will see as the hearing develops during the course of the morning that the Canadian and U.S. are very closely matched with the types of illnesses and sicknesses, and we are going to see how the two systems actually deal with them, and see if we can reach any general kinds of conclusions as a result of hearing those witnesses. Later in the morning then we will be hearing from the representatives of the medical society, from the nurses and from young doctors, that is from Christine P. Burr, UCLA School of Nursing, Greg Anderson, Physicians National Housestaff Association, and William M. Thompson from the Orange County Medical Association.

We will first of all hear from Mr. and Mrs. Dan Neal from Bakersfield, Calif., and then we will hear from Mrs. Boychuk from Williams Lake, B.C.

I am wondering if we can start with Mrs. Neal. If you would be kind enough to tell us how old you are and what happened, Mrs. Neal.

## STATEMENT OF MR. AND MRS. DAN NEAL, BAKERSFIELD, CALIF., AND RUBY BOYCHUK, WILLIAMS LAKE, B.C.

Mrs. NEAL. I am 43 years old, and 12 years ago I was coming home from a class at school and was hit head on by a drunk driver who was driving without a license and who was in a car with $2,000 worth of insurance on it.

My insurance at the time was the maximum medical coverage allowed, which was $5,000 medical.

Because of this I had 3 years approximately in the hospitals, 20 major surgeries, reconstructive surgeries, and astronomical medical bills, which we are still paying and which I feel in a way will never ever be paid off.

I am a mother of four. My children suffered. They couldn't have what I wanted them to have. I was about to start a teaching career, which ended before it began, and our income, of course, was minimal because of the accident.

What stands out most in my mind aside from any of the pain and the problems involved was the fact that even though some surgeries were lifesaving I couldn't get into hospitals because I didn't have enough money, and also my medical insurance was canceled right after this happened because the bills would have been too much to pay.

There were times when my husband had to leave a job he was on because they would take me into a hospital if I had an unemployed spouse, but they wouldn't take me into a hospital if my husband was working.

This, of course, you can imagine the hardship involved then.

In the same year as my accident the Medi-Cal program was begun in California, and I was really a guinea pig. When my husband was earning a little over $800 a month, they wanted us to pay $778 before Medi-Cal would pay. So I had to pay $778 in medical expenses before Medi-Cal would help us pick up any of the rest. That didn't leave anything left over for house payment, food, just the little things that we wanted to have, like food and clothing and shelter.

Senator KENNEDY. Little things.

Mrs. NEAL. Little things. Right. Yes.

So if you care to ask me any questions about this.

Senator KENNEDY. What was the total amount that your bills were?

Mrs. NEAL. We tried to figure that out.

Senator KENNEDY. As I understand, you had shattered cheekbones, you had nose and ribs, arms, legs, collapsed lung, very serious injuries, and then you had both the pain then and the suffering, but you also had the extraordinary medical bills.

Now, could you remember just approximately how much the total bills amounted to?

Mrs. NEAL. I would just say $50,000 at that time, because this was a day when a hospital daily cost $35 a day, if anybody remembers that far back.

Senator KENNEDY. But during this time you were a teacher, as I understand?

Mrs. NEAL. Yes; I was to start teaching in September, and this happened in April.

Senator KENNEDY. And your husband had some form of insurance?

Mrs. NEAL. Yes.

But it was canceled. He was on a job that was a fairly new position, and the dependents weren't all covered as yet, and they refused payment. They just canceled on the spot because they said it was a chaotic, catastrophic accident, and felt that our automobile insurance would have to cover it.

Senator KENNEDY. So you not only have—do you still have some debt now?

Mrs. NEAL. Yes.

Senator KENNEDY. And what are you trying to do?

Mrs. NEAL. We are trying to pay it off, because we are sued quite regularly.

We had a lien on our house before we were able to sell it, which we had to do, and that paid off.

I was thinking of one thing. My husband designed a prosthesis, which was utilized by a doctor, and my husband received nothing for it. This was to help me, of course. My husband didn't receive anything for this design, and then the doctor turned around and sued us on top of that for payment.

Senator KENNEDY. This was an accident through no fault of your own, extraordinary pain and anguish and suffering, overwhelming debts, some partial insurance that was canceled, not only the financial burden, but I think as you pointed out the impact that this has had on your professional career as well as personally, the impact it has had on your children, you feel that has been a source of considerable anxiety.

Mrs. NEAL. Well, I really can't help my children as much as I want to, and I see them ready for college, and I know that one son joined the service for the benefits to go through college, which is not bad, I am certain, but I would have wanted as a parent to be able to help my children at that time of life and never was able to because medical bills had to be paid first.

Senator KENNEDY. Through no fault, through absolutely no fault of your own, and you are trained as a teacher, professional, been working?

Mrs. NEAL. Yes.

Senator KENNEDY. Mrs. Boychuk? I think I will ask approximately how old you are, too.

Mrs. BOYCHUK. Can I ask you how old you are?

[Laughter.]

Senator KENNEDY. I am getting older. I will tell you.

Either fortunately or unfortunately, I have my birthday on Washington's Birthday. There is no excuse for the members of my family to forget about it.

Would you tell us?

Mrs. BOYCHUK. Yes.

My name is Ruby Boychuk. I come from Williams Lake. I am a public health nurse there, and I am 37 years old.

Senator KENNEDY. OK.

Mrs. BOYCHUK. In 1973, I was on my way to Vancouver to take a course at UBC, which is the university, and approximately 200 miles from Vancouver, I hit a semi-truck on the highway, and that was my fault. My car went out of control, slid into the semi-truck; it was a U.S. truck transporting, taking mail to Alaska.

I sustained 11 broken bones. I had lung and heart damage, facial fractures, nose fractures. I had extensive dental work done, and I was hospitalized for 3 weeks. I had five surgeries, two on my arm; I had a cast on this arm, and I had another cast on my leg and had a pin put into my leg.

Senator KENNEDY. You have two children?

Mrs. BOYCHUK. I have two children. At that time, my husband's income was approximately $800 per month, and we had extensive bills because of me attending the university, and we also had to change locations, so we had to carry a mortgage on our house as well as pay rent in our new location.

Senator KENNEDY. Well, it seems to me that in terms of the types of injuries as Mrs. Neal had, ribs and arms, legs, collapsed lung, facial, and other medical difficulties, very similar to yours, and then you were in the hospital for a number of different times, had series of operations, can you tell us what kind of expenses you had or how you——

Mrs. BOYCHUK. The expenses to myself?

Senator KENNEDY. The medical expenses.

Mrs. BOYCHUK. My expenses were nil.

My husband was paying medical insurance along that was split with his employer, and that was approximately $4 per month, and that is for the family. The cost of the hospital stay was $1 a day, and the rest was covered by our insurance.

Senator KENNEDY. Did you ever——

Mrs. BOYCHUK. I had physiotherapy and the ambulance which took me 200 miles, and I had a doctor accompanying me because there was not a nurse available—it was a very small hospital—and he had accompanied me the 200 miles. It did not cost me a cent.

I had multiple X-rays with no problems there. This was all covered. I had two specialists. One was an orthopedic doctor, and the other was a plastic surgeon, and this was absolutely at no cost to me.

Senator KENNEDY. No cost. And you have, obviously, no deficit or debt from that.

Mrs. BOYCHUK. I have no debt at all. None.

Senator KENNEDY. Well, Mrs. Neal, tell us how you feel about this. Mrs. Boychuk has mentioned that she also had physical therapy. Were you able to have physical therapy?

Mrs. NEAL. They recommended it, and I never could afford it, so they brought a physical therapist in to show me what should be done, and I asked how much and how often, and they said minimum of 3 days a week, and I never could afford it. It was just beyond us, so I never could have it, and I still walk with a cane.

Also you mentioned dental work, and they did what was necessary for me to be able to repair both my jaws, but I never could afford the rest of the dental work needed because it took work that had to come up through the lower jaw, so I had just a partial job done, and the rest I had to neglect because we can't afford it.

Senator KENNEDY. This, of course, Mrs. Boychuk, is done within a total expenditure which is less of their gross national product than what we are expending here in the United States again.

How do you feel, Mrs. Neal, when you hear this type of——

Mrs. NEAL. I just can't believe it. Even though I heard of this type of insurance in Canada, I didn't know how terrific it really was.

Senator KENNEDY. Are you satisfied, Mrs. Boychuk?

Mrs. BOYCHUK. Extremely. I feel very privileged to be here to testify. But I consider myself extremely fortunate that I don't have to incur the type of costs that you people do, and I sympathize.

Senator KENNEDY. Are people satisfied with paying taxes?

Mrs. BOYCHUK. Definitely.

Senator KENNEDY. I don't hear that answer very often around here. [Laughter.]

Mrs. BOYCHUK. Well, we grumble—believe me.

Senator KENNEDY. That's right.

Mrs. BOYCHUK. Our hospital costs went up $3. We pay $4 per day now. You know, you can't really complain.

Senator KENNEDY. OK.

Mr. Williams from Banning, Calif. Could you tell us how old you are?

## STATEMENT OF JAMES T. WILLIAMS, BANNING, CALIF., AND MR. AND MRS. CLIFFORD STATA, PRINCE ALBERT, SASKATCHEWAN

Mr. WILLIAMS. Yes, sir. Sixty-one years old this year.

Senator KENNEDY. And are you retired?

Mr. WILLIAMS. Yes, sir. I have been retired the first of February past 6 years.

Senator KENNEDY. And how long did you work before that? Were you employed before that?

Mr. WILLIAMS. Yes, sir. For one organization 31½ years.

Senator KENNEDY. One organization for 31 years. OK.

Now, as I understand it, your wife had some surgery this past August. Could you tell us what it was and what the outcome of it was?

Mr. WILLIAMS. Yes, sir.

It was bypass surgery, heart bypass, August 27 this year, and she did not survive.

Senator KENNEDY. I am sorry to hear that.

Could you tell us what the bills were that you experienced?

Mr. WILLIAMS. Yes, sir.

To begin with total time involved at the time preceding the surgery was approximately a week, five days actually in the hospital, the counseling prior to the operation, the office visit, there was one day devoted to EKG and treadmill testing. The length of the stay in the hospital was $17,389.73. This is for less than a week.

Senator KENNEDY. Less than a week.

Mr. WILLIAMS. Yes, sir.

Senator KENNEDY. Well, now, you had a group policy.

Mr. WILLIAMS. The surgeon's fee the date of the operation, $6,000. The surgeon's assistant, $1,125, the day of this surgery. The anesthesiologist alone $3,000. I am talking about 1 day. The total for the week run more than $30,000.

Senator KENNEDY. You had a group policy with Riverside County, is that correct?

Mr. WILLIAMS. Yes, sir.

Senator KENNEDY. And in spite of the coverage did you owe any money?

Mr. WILLIAMS. I will have to pay approximately $6,000.

Senator KENNEDY. Did you have to use up your savings?

Mr. WILLIAMS. I sure did.

Senator KENNEDY. Did you use all your savings?

Mr. WILLIAMS. Yes, sir.

Senator KENNEDY. From a lifetime of work, 30 years on the job. And how are you going to pay the rest of it?

Mr. WILLIAMS. My monthly pension from retirement. I will have to allot so much of each of that to finish the payments.

Senator KENNEDY. You are on pension now, and you are going to try and handle your debt from your medical expenses through a few dollars a month from your pension, is that correct?

Mr. WILLIAMS. The best I can.

Senator KENNEDY. Is that easy given the increasing costs of everything that you possibly have to purchase?

Mr. WILLIAMS. There is going to have to be a lot of things you don't purchase. I will do the best I can with what I have.

Senator KENNEDY. That is the way you have been doing all your life. You worked all your life?

Mr. WILLIAMS. Yes, sir, and what I managed to put aside went in 1 day.

Senator KENNEDY. One day for 30 years of work.

Mr. Stata from Prince Albert, Saskatchewan.

Will you tell us a little bit about yourself, how old are you, and where did you work?

Mr. STATA. Mr. Chairman, I am 74 years of age, and I worked for 46 years as a grain dispatcher on the Canadian National Railways.

Now, I think I have two particular items in connection with my medical services.

Senator KENNEDY. I want to hear about them, but as I understand, you had a serious operation for an aneurysm, is that correct?

Mr. STATA. That's right.

Senator KENNEDY. And when was that done?

Mr. STATA. That was in July 1970.

Senator KENNEDY. I see.

And you have had other medical expenses beside your aneurysm, is that correct?

Mr. STATA. That's correct.

Senator KENNEDY. How long were you in the hospital for the aneurysm?

Mr. STATA. For the aneurysm?

Senator KENNEDY. Yes.

Mr. STATA. I was there 17 days.

Senator KENNEDY. Seventeen days?

Mr. STATA. Yes.

Senator KENNEDY. You were in there three times as long as Mr. Williams' wife. She was in just about a week is that right?

Mr. WILLIAMS. Yes, sir.

Senator KENNEDY. And, now, did you require surgery when you were in there for 3 weeks?

Mr. STATA. Yes. The aneurysm was removed.

Senator KENNEDY. Right.

Mr. STATA. And the aorta where the aneurysm was, was bypassed with plastic.

Senator KENNEDY. And what were your medical bills for the bypass for the aneurysm?

Mr. STATA. My medical bills for that treatment?

Senator KENNEDY. Yes.

Mr. STATA. Were nothing. I paid nothing at all.

Senator KENNEDY. And you were in there for 3 weeks, and you had the surgery, as well?

Mr. STATA. Yes; and this was very delicate surgery, too. So, I paid nothing at all, Senator, for that treatment.

Senator KENNEDY. You also were in an accident; you were struck by a car, is that right?

Mr. STATA. That's right.

I was struck by a car when I was crossing one of the avenues in the city of Prince Albert in March 1977, and that necessitated moving me into the University Hospital in Saskatchewan because it was obvious that due to the impact of the car against my body that I had sustained a partial stroke or at least paralysis in my left arm and hand, and I was in the hospital at that time undergoing several tests for the same amount of time, namely, the 17 days—and I was—after I was released and discharged and sent home after the 17 days. I took approximately 3 weeks, no, 3 months physiotherapy to try to restore the function of this left arm, and that is about all I have got on it.

Senator KENNEDY. What did that cost you?

Mr. STATA. That cost me nothing.

Senator KENNEDY. So, you have been able to get physical therapy as well as a result of the accident. Let me ask you, were you satisfied with your doctor and the hospital, the kind of treatment that you received?

Mr. STATA. Senator, we endure the very harsh climate and the very harsh weather we have in Saskatchewan in the wintertime, and we do not choose to move from Saskatchewan because of this peace of mind that this plan gives us. We wouldn't think of moving.

Senator KENNEDY. Well, tell me about the peace of mind. We have got charts here now that show figures, that show dollars, that show cents, and you are talking about something else. You are talking about relieving the population from the anxiety of financial burden, for illness and sickness and therapy. Can you tell us in your own words about what peace of mind means to you and what it means to your neighbors?

Mr. STATA. Well, what the peace of mind means to me and means to my wife is that we can never tell what kind of medical bills or what kind of medical problems we may face from day to day. None of us can tell that, and we know that if these things happen to us that we will not be assessed with astronomical medical bills. They will be taken care of, and that gives us great relief that mental——

Senator KENNEDY. You worked for a number of years. Were you able to put a few savings, a little savings aside?

Mr. STATA. Oh, very modest, but some.

Senator KENNEDY. Yes; but you haven't had to turn them over to either the collection agencies or use them for paying bills like Mr. Williams has, have you?

Mr. STATA. Not 1 cent.

Senator KENNEDY. And you worked for a little over 40 years?

Mr. STATA. Forty-six years.

Senator KENNEDY. Mr. Williams worked some 31 years and saw all of his savings, a few thousand dollars, over that period of time wiped out in 1 day's hospital costs. You are still able to use those savings for yourself and for your——

Mr. STATA. Whatever I had at the time that I was pensioned off back in 1967 I still have all that money. None was ever taken from me for this particular purpose to pay medical expenses.

Senator KENNEDY. Well, I think this you heard earlier from two women who basically were similar in age, had similiar tragedies, one completely without fault, and extraordinary medical expenses in both situations. That is really the bottom line, and how the two systems dealt with that situation.

Now you have two people who are retirees, one who worked over 40 years, one worked over 30 years, one in Canada, one in the United States, one who saw savings completely wiped out, the other was able to retain their savings, and I think very importantly also have the peace of mind that any additional kinds of health problems that they might face in the future are not going to be the kind of financial burden that has been such a devastating burden to Mr. Williams, I think it is important how our different systems are treating retirees.

Mr. and Mrs. Gary Thompson, I hope our friends from Canada will understand if we start out with the United States.

Mr. Thompson?

Mr. THOMPSON. Yes, sir.

Senator KENNEDY. Could you tell us how old you are and where you work?

## STATEMENT OF MR. AND MRS. GARY THOMPSON, LOS ANGELES, CALIF., AND MR. AND MRS. DONALD PATTERSON, VANCOUVER, B.C.

Mr. THOMPSON. Senator, I am 41 years old. I was 41 October 25, which was the day I filed bankruptcy because of my medical bills.

I work at a radio station as an engineer, and what brought about the bankruptcy was my wife and I had a little girl who was born near the end of March 1976 and died near the end of June, and in those 3 months she spent more than half of that time in intensive care in the hospital, and the medical insurance that I have with the company where I work is very good and was paying 80 percent in the major medical field. However, even after this was paid the doctor bills and the hospital bills was left over, came to over $10,000. I never did get a handle on exactly how much it was.

She was in and out of the hospital two or three times during that period, and each time we started a new series of bills, and I was never sure exactly how much I owed. I knew it was a large amount, and then earlier this year they were getting to the point they were going to sue me and garnish my salary, and that was the time I decided to go bankrupt.

Senator KENNEDY. Are these the collection agencies?

Mr. THOMPSON. Yes; they did.

Senator KENNEDY. You have a major medical?

Mr. THOMPSON. That is correct.

Senator KENNEDY. You have a program that covers very significant amount of medical expenses. And yet we will hear as we have heard in Washington from some groups talk about these that have health insurance and about how that really resolves the problem, really resolves the problem. It is difficult listening to Mr. Thompson to be very persuaded about that, and I think it illustrates the point that it does not resolve the problem. It resolves in many, many instances a far too insignificant part of it.

Now, this is a situation where parents, Mr. and Mrs. Thompson, were really penalized for trying to care for an ill and sick child, newborn child, for a period of 3 months, trying to deal with the extraordinary emotional and other problems. They were trying to help and assist a newborn child and seeing what it has done to their own situation, being bankrupted for that reason, that reason only.

Mr. THOMPSON. Certainly with our first child, and it was very, very destructive to our life, and the reason why my wife is not here she is pregnant again, and after talking with Mrs. Boychuk earlier in the room I was thinking about maybe moving to British Columbia. [Applause.]

Senator KENNEDY. Well, now, well, you know, you say that facetiously.

Mr. THOMPSON. Yes, sir.

Senator KENNEDY. We will hear from some witnesses a little later that can tell us about a situation about moving.

The thing that also, Mr. Thompson, as I understand, with the type of sickness that your child had, several years ago, that child probably would not have survived. We have made important progress in the areas of scientific research and in the areas of technology, and that has been very, very important. I can think of even personal experience the disease which President Kennedy's son died of. Now progress has been made on that to keep that child alive. So we made enormous kinds of progress in technology and science both in terms of infants and in terms of children, also in terms of older people, but the public policy aspects of this have not caught up with it. The public leaders have not been willing to address them. What we find is the kind of enormous tragedy which you have felt, which is the most important obviously, loss of the child. We are all heartened by the good news of a new pregnancy, but there is still, I am sure, the whole emotional trauma of bankruptcy and all the other factors.

OK. Could I hear from Mr. Patterson.

Mr. PATTERSON. My name is Donald Patterson. I am associate professor of economic history at the University of British Columbia.

Senator KENNEDY. Now I would like if you could—you are going to have to give us your age, too, and then I want you to talk about your first child.

Mr. PATTERSON. Yes; my age is 36.

My wife in May 1974, gave birth to our first child 2 months prematurely. It was a case of placenta ruptured. Casarean section, of course, was necessary.

The child was than in intensive care for 4½ weeks. My wife was released from the hospital within 7 days. The cost at that time was $7, $1 a day charge for my wife, no charge levied for the child on the argument that this incident he was born in the hospital, he had no option, and the fees, therefore, didn't apply.

Senator KENNEDY. Could you run that one by me again? Even as a professor you will have to.

Mr. PATTERSON. The term fees apparently can only be charged to those who voluntarily go into a hospital, and, therefore, being born there exempts you from the charges.

Senator KENNEDY. And the charge if it had been applied would have been the figure of?

Mr. PATTERSON. $1 a day.

Senator KENNEDY. I see. OK.

Mr. PATTERSON. I should note that at the same time my father-in-law was dying of cancer, my father had cancer, and my mother was suffering from the effects of a stroke. Subsequently my wife then miscarried. That necessitated a number of genetic tests, and subsequent pregnancies, of course, have been monitored very closely with the use of tests.

The total costs of my premium is $9.37 a month. My employer matches the equivalent amount.

Senator KENNEDY. That is your premium for health——

Mr. PATTERSON. Yes; entirely.

Senator KENNEDY. It isn't obviously free in this sense. You have a fee deduction from that amount that covers your medical expenses.

Mr. PATTERSON. Yes.

Senator KENNEDY. $9.37 a month.

Mr. PATTERSON. Yes.

In addition this is with family, of course, and in addition we carry——

Senator KENNEDY. That covers your whole family, $9.37 a month?

Mr. PATTERSON. Yes.

In addition we carry——

Senator KENNEDY. Is that right, Mrs. Boychuk?

Mrs. BOYCHUK. Yes; that is family.

Senator KENNEDY. That is family.

Mr. PATTERSON. That is family. Right.

In addition we carry what is called extended health benefits, which gives us the right to a private room, say, or would cover us while on the visit to the United States and——

Senator KENNEDY. How much is that?

Mr. PATTERSON. That is a $1.35 per month.

Senator KENNEDY. A month. $1.35 per month. What does that entitle you to if you get sick in the United States.

Mr. PATTERSON. The standard medical insurance will cover treatment in the United States up to the cost of the Canadian equivalent.

I might note that my parents did winter in Florida. My mother had to spend 3 weeks in the hospital there, largely for observation. The total cost was $2,500. The equivalent cost which was met by the Canadian plan was $1,800. So that we have an exact comparison of the charges.

Senator KENNEDY. OK. Now, with a child we have on the one hand Mr. Thompson, who had the significant child costs, had the sick child 3 months, child dies, and some $12,000 of debt, covered by major medical insurance, has gone into bankruptcy, as I understand pretty much hounded by collection agencies, is that correct?

Mr. THOMPSON. That is right.

Senator KENNEDY. And, on the other hand, we have in Canada the Dr. Patterson who had premature birth of a child, took the child out, was in the hospital for 6 weeks, as I understand.

Mr. PATTERSON. Yes: right.

Senator KENNEDY. Receiving the total coverage, and then you mention the additional kinds of medical complications that impacted your family.

Mr. PATTERSON. Yes.

Senator KENNEDY. And those were covered in their entirety, as well.

Mr. PATTERSON. I think if I might add something?

Senator KENNEDY. Yes; please do.

Mr. PATTERSON. What was important to us with so many people in our family being sick and in fact all separated by thousands of miles, this allowed us to be with family. when two of our family members were dying and essentially added dignity I think to the process of dying, which we felt was very important.

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Senator KENNEDY. Could you just elaborate a little bit on this because I do think it is important. I wish you could elaborate on this, the dignity, and that you receive under this other program.

Mr. PATTERSON. Well, for instance, since we obviously pay no charges apart from trivia, monthly premiums——

Senator KENNEDY. You are paying it with your $9.38 for your family.

Mr. PATTERSON. That's right.

Senator KENNEDY. But continue.

Mr. PATTERSON. But it does mean that we therefore have incomes which we can then devote to travel to spending time in our case with dying parents, and in the case of my father-in-law, who died of cancer, my wife was able to spend a month with him, and from our incomes we could help to look after the children, and this certainly pleased him and her. It was essentially help.

Senator KENNEDY. You are talking about a humane system.

Mr. PATTERSON. Yes.

But I think I should add that we have a tendency not to think of it as anything special. It is an assumption that this is ours. We claim it almost as a right.

Senator KENNEDY. Yes; as a right.

What would you do to Canadian politicians who tried to take it away from you?

Mr. PATTERSON. It is inconsistent. No one could be a politician and do that.

[Applause.]

Senator KENNEDY. I can see you are a professor.

That is very fine.

Maybe if we could—could we start—Mr. Paul, from Burnaby, British Columbia, and if you would be kind enough, Mr. Paul, to tell us your age and then tell us what happened to you last August.

## STATEMENT OF MR. AND MRS. WILLIAM PAUL, BURNABY, B.C., AND MRS. ELIZABETH WEHN, FULLERTON, CALIF.

Mr. PAUL. Well, my age is 77. I was 77 on the 28th of October this year, and my profession down through the years, I have been somewhat varied, but I am a steam engineer or was before I retired, but I worked in the mines and in the logging camps and the mills and what have you, you know.

Senator KENNEDY. For how many years have you worked?

Mr. PAUL. Well, I worked until I was 66, and I started working somewhere around 15. You can figure that one. I don't know how many years exactly.

Senator KENNEDY. It is a long time.

Mr. PAUL. It is a long time.

Senator KENNEDY. The record will show that it is a long, long time.

Mr. PAUL. Actually I started working when I was 12, but not very steady.

Well, I would like to say this to begin with, that I realize the difference between the American and the Canadian medical systems, but after listening to these horror stories that we have heard this evening, I am more than ever pleased to be living up in Canada, although I admire the United States and all Americans.

Now, again I have been fortunate, very fortunate, throughout my life and largely because I worked around the mines and around the mills for one reason. You may be surprised at this, but I never paid but one doctor's bill in all my life, and that started way back, and it was a mistake. The doctor went out of business, and some debt collector took over his uncollected bills, and he found one that he supposed that I owed.

Senator KENNEDY. I see.

Mr. PAUL. It was a mistake in the first place, but it was 20 years afterward, and I didn't pay attention to it. It was only $25.

Senator KENNEDY. Tell us about——

Mr. PAUL. But, anyway——

Senator KENNEDY. Tell us a little bit about last August.

Mr. PAUL. I am here now because I had got up to, see, I was busy complimenting myself on having reached or almost reached the age of 77 without any serious medical bothers when this thing hit me.

Senator KENNEDY. What thing hit you?

Mr. PAUL. It was a stroke. I had a stroke on August 9.

Senator KENNEDY. All right.

Mr. PAUL. From there I was taken from my home to the Burnaby General Hospital, and I received care, all kinds of medical care, for the next 3 weeks or so until I could be removed to what is known as the GF Strong Rehabilitation Center, because they didn't have any physiotherapy facilities at the Burnaby General Hospital.

You will have to excuse me because my speech went about the time I had that stroke, and they tell me that I have been making wonderful progress although to me it seems very slow.

Senator KENNEDY. Well, you are doing awfully well here today.

Mr. PAUL. That is fine. Then I hope you can understand me, understand what I have to say, because in addition to having had a stroke I have no teeth here, that doesn't help, and I am Scottish, and sometimes you don't know what I am saying, anyway, but in any case I had medical attention ever since the 9th of August, and I believe even before I heard those horror stories that I heard this morning that one of the main reasons for what they call my rapid progress has been like having no financial worries.

Now, I have heard others mention just exactly what this cost them, but I have been 4 months now approximately in hospitals, and the rehabilitation centers, and that is covered entirely by the Government medical insurance, which unfortunately costs $4 per day now, costs me $4 a day, but I discovered that I was covered by the medical insurance which costs my wife and I $7.50 per month since there is only two of us now, you see. We have no children living at home.

Now, I should explain, though, that this cost varies according to your income tax. Now, the $7.50 is a standard charge, but, for instance, if I did not pay any income tax, I would only be paying 75 cents per month each. That is if I just stood under the wire, even if I had a fairly good income, because, you know, you are allowed certain sums that you could deduct from your income tax, and that is what it would cost.

Now, the next stage is if you are taxed on up to $1,000. Then you pay a little more. It, I believe, is $1.50 or something like that, but I am not too sure what it is.

Senator KENNEDY. OK. As I understand, you were in for several weeks. You also spent time at the rehabilitation center; is that correct?

Mr. PAUL. Yes. That's correct.

Senator KENNEDY. And are you still getting some rehabilitation at the present time?

Mr. PAUL. Yes, I am.

Senator KENNEDY. And tell us what it has cost you now for the hospitalization and the therapy?

Mr. PAUL. For the hospitalization up to now it has cost me $4 per day.

Senator KENNEDY. $4 a day. And the therapy?

Mr. PAUL. Approximately that is about $140 per month. You couldn't get board and room for that.

So then now that I am living at home, and they allowed me to go home, because they felt I was making progress.

Senator KENNEDY. You get therapy at home?

Mr. PAUL. No. I go to the Strong Rehabilitation Center twice a week, and that will cost me I understand $1 per day.

Senator KENNEDY. For the therapy.

Mr. PAUL. For the therapy.

Senator KENNEDY. OK.

Mr. PAUL. But I haven't got that bill in yet because I have only been home about 3 weeks, you see.

Senator KENNEDY. OK. All right.

Mr. PAUL. So the big thing is that I have had absolutely no financial worries at all because I knew that my old age pension would cover any bills that were coming in, and roughly it has cost me less than $150 a month to be sick.

So you see my story is really a happy story after listening to some of the tales that I have heard here this morning.

Senator KENNEDY. I think now we will hear from Mrs. Wehn.

We have heard where it was $9.38 per month for a family, and I think Mrs. Boychuk and Mr. Stata mentioned that. Others it is $7.50 a month, and in the eastern provinces it is somewhat different. It is all within those ranges, though, of figures, and what we see is the different provinces, but the underlying theme is that there is the universality, and there is the comprehensiveness. It is in patient care, it is therapy, and it is covering all of those effectively no matter what provinces you live in. You have these minor kinds of adjustments, which basically as we have heard from the witnesses amount to either a dollar a day or the minor amount which have been mentioned, but those are basically why there is some distinction is each one of the provinces has some minor kinds of adjustment in terms of how they are going to do it and permits the provinces to do it.

But it is all as we have seen from every witness considered to be extremely manageable by every one of the witnesses, at least so far. I think we will see it through the remaining witnesses.

Mrs. Wehn from Fullerton, Calif.

Mrs. WEHN. My name is Elizabeth Wehn, and I have a husband in convalescent hospital. He is sick for the last 5 years, and through these 5 years he was five times in the hospital, which now for the 17 months he has been in the convalescent hospital.

Then I spend all my money what I have. I have no insurance because the medicare is not paying the insurance for the convalescent. So I spend all my money.

My husband got a stroke. He was 61, and now he is 65. So medicare is not paying any medicine, and they tell me I have to spend everything what I have before they start paying.

Senator KENNEDY. Before they start helping you and assisting you, is that right?

Mrs. WEHN. I spent my money. This was September 1. I go to the Medi-Cal, and I told them, I said, I spent all my money, and I didn't hear anything yes or no from the medi-Cal yet.

Senator KENNEDY. Basically what it says, and this is true in every State, is that you have got to spend all your savings, lifetime of savings.

Mrs. WEHN. Yes.

Senator KENNEDY. Before you begin to get——

Mrs. WEHN. I spent my life savings. I spent my life insurance and everything what I have, and I now know of any yes or no. I don't know. I owe the——

Senator KENNEDY. You were a working person?

Mrs. WEHN. No.

Senator KENNEDY. I mean your husband worked?

Mrs. WEHN. My husband worked.

Senator KENNEDY. How many years has he worked?

Mrs. WEHN. He was working for 21 years by one company.

Senator KENNEDY. One company. And he had a group health insurance with the company?

Mrs. WEHN. Yes.

The day he was disabled the day the insurance were canceled. I have no——

Senator KENNEDY. Wait a minute now. We don't want to go over that point. This is an important one. Tell us again what happened. When was the insurance canceled?

Mrs. WEHN. He was disabled. He could not work any more. The group insurance canceled. He and I have no insurance.

Senator KENNEDY. So when he is unable to work——

Mrs. WEHN. Yes.

Senator KENNEDY [continuing]. The insurance was canceled, and at the time when he needs the insurance the most——

Mrs. WEHN. I have no insurance.

Senator KENNEDY. At the time when it is virtually impossible either to get or to find insurance is when it is canceled, and this is true all over the country. You can take parents in here that have a retarded child or have an illness or sickness, and when they go down there they will find out that there these marvelous words, pre-existing condition. You hear those back there, our friends; you know what pre-existing condition is. They just exclude those factors from any kind of coverage.

Mrs. WEHN. Yes.

Senator KENNEDY. Now tell me in your own words what happened. You used all your savings.

Mrs. WEHN. Yes. I went by the Medi-Cal for help, and they tell me I have to spend all my savings first. I spent my savings. I spent my life savings and life insurance.

So everything I have is gone, and I am 57 years old. I don't know on what I live now. I can't work because I am a diabetic, and I am

arthritic. I am sick, too. I got hospital risk insurance, too, but only pay $34 a day hospital.

So I don't know how it goes for. I signed up in September. I been with the medi-Cal and told the medi-Cal. I spent all my life savings. What now? And I didn't hear anything yes or no yet.

Senator KENNEDY. You know, you talk about your bureaucracy and rules and regulations and redtape. How the average citizen weaves their way through all of these forms is virtually unconscionable, and it happens in every State and in every situation.

Well, now, what do you think? You here over here from earlier Mr. Paul, who was 77, had a stroke. Your husband is how old?

Mrs. WEHN. 65.

Senator KENNEDY. 65. He had a stroke.

Mrs. WEHN. He was 61.

Senator KENNEDY. 61. He had insurance. Insurance was not sufficient to cover the medical expenses, wiped out your savings. Mr. Paul is able to keep his savings. You have got health problems at the present time, as I understand it, arthritis and from diabetes.

How do you react when you hear what the circumstances have been for Mr. Paul?

Mrs. WEHN. Well, I been afraid to listen to him, know my problems, you know, and he is that, doesn't compare. I think I move over there, too.

Senator KENNEDY. Now, we don't want everybody doing that now. [Laughter.]

We don't want that to happen.

OK. Now we have two more pairs of witnesses, and we will ask, is it Mr. and Mrs. Vandergrift from Smithers, B.C.?

## STATEMENT OF MR. AND MRS. WILLIAM VANDERGRIFT, SMITHERS, B.C., AND MR. AND MRS. PAT AMBROSE, NAPA, CALIF.

Mr. VANDERGRIFT. Yes.

My name is Bill Vandergrift.

Senator KENNEDY. Let's see. I think I need it a little louder on the mike.

Mr. VANDERGRIFT. My name is Bill Vandergrift, and I live in Smithers, B.C.

I am a kidney patient. I am a hemodialysis patient.

Senator KENNEDY. I am not sure we can hear. I don't know. Let's just see if we have got it now.

Mr. VANDERGRIFT. OK.

Senator KENNEDY. There we go. Good.

Mr. VANDERGRIFT. OK.

My name is Bill Vandergrift, and I live in Smithers, British Columbia, and I am a kidney patient. I am a hemodialysis kidney patient.

I became sick 3 years ago. My age is 61. I thought I would mention that, too; 3 years ago I became dependent on kidney machine.

At that time I was an independent businessman, and I spent approximately 2 months in the hospital, was all paid for except $1 a day, except for the hospital insurance, and since that time I live on the kidney machine, as I said, and we had to use it three times a week. We do

it at home. The kidney machine is supplied by the Department of Health of British Columbia. All supplies are paid for, prepaid, because we live quite a ways out from Vancouver, and that is where the supply center is. They ship these supplies every 3 months at no cost, and I do it myself, my wife assists me, because you need some help on the hemodialysis machine.

Also, of course, I was an independent businessman, and I am not any more because through the illness I couldn't continue in the business. I had partners, and they couldn't continue dealing with me, so I sold my share to the partners for $30,000. I couldn't get my hands on the $30,000 because they were not able to pay me out. They will pay me out in the future.

In the meantime the Department of Human Resources took over and supplied me with sufficient money to live on. I own my own home, and I have an old car. I have also seven children. Three are married. Two are in college in Iowa State, and that is just about the story. I am now fairly happy with the situation. I am not happy with my situation in all ways, but at least I don't have to worry about material things.

Senator KENNEDY. Mrs. Vandergrift, has she been in good health?

Mr. VANDERGRIFT. Three years in excellent health, yes.

Senator KENNEDY. OK. Mr. Ambrose of Napa, Calif. Could you tell us how old you are?

Mr. AMBROSE. I am 60 years old, and my wife is——

Senator KENNEDY. You are 60. Mr. Vandergrift is 61. OK.

Mr. AMBROSE. Yes.

Senator KENNEDY. Could you tell us approximately your family income? I think the point that we are establishing here, these are basically middle income, what would be considered middle income, families both in Canada and in the United States.

Mr. AMBROSE. Well, I am a real estate salesman, so I am not on a salary basis. I am on a commission basis, though. From 1 year it is good, and the next it isn't, you might say. However, for the past 7 years I have been pretty fortunate, and I have been averaging between $25,000 and $30,000 a year.

Anything else, sir?

Senator KENNEDY. That is fine.

Now can you tell us a little bit about what happened to your wife 5 years go?

Mr. AMBROSE. Well——

Senator KENNEDY. We are talking about $30,000, and 87 percent of the American taxpayers who are below $25,000. We are talking about people who are what would be considered generally upper middle income. This is true. Some may make comments later on, but the fact is these are middle income problems.

Let's hear about what happened to your wife 5 years ago.

Mr. AMBROSE. Well, in, let's see, in November 1976, when she came down with kidney failure and gradual at age 50, but in 1976 she needed a kidney transplant, and she had a cadaver of a transplant, and it was rejected in 1977, and from then on—it was in March 1977—so she has been on a renal dialysis machine like Mr. Vandergrift, and so far for this year, for example, our bills——

Senator KENNEDY. Just before that now you have Blue Cross coverage. You have got Travelers Insurance coverage and medicare coverage, is that correct?

Mr. AMBROSE. That's right.

Senator KENNEDY. So you have got three different insurance coverages. Now tell us a little bit about what the medical, what your expenses have been.

Mr. AMBROSE. All right. Our 20 percent, which is 80 percent is covered by medicare, our 20 percent for this year amounts to $8,300, $8,378, and that does not include the doctor and medication. So I don't have added up that yet, so I could imagine it would be at least another $1,000 or so.

It is that the only problem I have as I see right now, and unfortunately I better not get sick, because I am a commissioned salesman, you might say.

Senator KENNEDY. Well, you know, why do you feel that way, about that you better not? Why are you concerned about getting sick?

Mr. AMBROSE. Because I wouldn't have any income, and these bills will continue.

Senator KENNEDY. Do you fear that? Is that a factor just that you are concerned about?

Mr. AMBROSE. Well, let's say this is $9,000 a year. Your house payments would run up to about $6,000, food bills $4,000, clothing. Pretty soon and you are at $20,000 in a hurry with no income. It would only be a short time and I would be wiped out like everybody else. Then what would I do.

Senator KENNEDY. You mentioned $8,300 without the doctor's bills, and that is a year. This is what you are paying a year now. Now you have again the middle income, upper middle income, families, one from Canada, one from the United States, virtually the same disease. The American has got probably as extensive a coverage, three different insurance policies, and still is being faced with these extraordinary kind of financial burdens. He also feels himself the fear of sickness and illness himself and what it would mean in terms of being able to meet his responsibilities to his wife and to his family. We contrast that with what Mr. Vandergrift, who at least in his own words commented that he felt relieved from the fear of financial pressures, from the medical expenses, which are associated with kidney illness and disease. I would like to ask that we will go on from here and hear from Mr. Pelgrim from Santa Barbara.

Mrs. Pelgrim wrote a very moving letter. Is Mrs. Pelgrim here? You could tell your story, and then if you don't mind, Mrs. Pelgrim wrote the President of the United States about this issue and was kind enough to send me a copy, a very moving one, and let's hear first from Mr. Pelgrim, and then Mrs. Pelgrim, I might just read it to the group here.

Mr. Pelgrim, could you tell us how old you are?

## STATEMENT OF MR. AND MRS. KENNETH PELGRIM, SANTA BARBARA, CALIF., AND MR. JEFF SALLOT, TORONTO

Mr. PELGRIM. We are both 61, Senator. I have been retired for 4 years.

Senator KENNEDY. You had a job in Hartford, Conn. for 12 years.

Mr. PELGRIM. Yes.

We are another case of not being able to buy insurance without a waiver on the physical malady

Senator KENNEDY. Could you just tell us in your own words what that means?

Mr. PELGRIM. Well, any preexisting problem cannot be covered by a newly purchased insurance policy. In fact those claims against an insurance policy will have to await a period of time. It varies with insurance companies. Various policies are handled differently.

But it just means that if you go out and buy a policy any preexisting condition is covered by a side letter or waiver to any claims that are related, and this is quite complete by definition, in medical definition.

Senator KENNEDY. You used to have insurance, as I understand it, when you worked in East Hartford, Conn.; am I correct?

Mr. PELGRIM. Oh, that is quite correct, and we have been paying insurance premiums for 35 years.

Senator KENNEDY. Sure.

And you retired, and then Mrs. Pelgrim developed the medical problem which is high blood pressure, hypertension, is that correct?

Mr. PELGRIM. That's correct.

Senator KENNEDY. Mrs. Pelgrim, could you tell us about this?

Mr. PELGRIM. Perhaps I can answer your questions.

Mrs. PELGRIM. I don't mind. I will give it a try.

Senator KENNEDY. All right.

Mrs. PELGRIM. My husband worked for 12 years when we lived in East Hartford, and during that time I developed high blood pressure, and since during the last 4 years I have had a treadmill test, and it was positive, and they recommended an arteriograph. I think that is the right term.

But I have not had one because I don't know what it is going to lead to, so I have opted to jog and walk and diet, and I feel fine at this point, but I live with the idea that I could be hospitalized, and these bills will accrue, and they will come out of our savings, which is what we are using to live on now.

Senator KENNEDY. Do you have some coverage now?

Mrs. PELGRIM. None at all.

Senator KENNEDY. No health insurance?

Mrs. PELGRIM. No.

Mr. PELGRIM. Just the AARP augmented policy.

Mrs. PELGRIM. The hospitalization policy. I am sorry. I forgot about that.

Senator KENNEDY. The fact is for any of the medical problems or any medical expenses that would be associated now you have to pay out of your own pocket.

Mrs. PELGRIM. Right.

Senator KENNEDY. Technically.

Here is a working family that for a number of years have retired. She developed a high blood pressure problem, and is living I imagine with the fear of the development further of the high blood pressure.

Mr. PELGRIM. Yes.

Senator KENNEDY. Is that correct?

Mrs. PELGRIM. I am not sure how I would handle this if we had insurance. I am not sure that I would have an arteriograph. I think I am a little afraid to have it because it will give me news that I should have an operation or something similar, and I just don't want to face that.

Senator KENNEDY. Do you mind if I just read your letter; do you mind?

Mrs. PELRGIM. No. That's all right.

Senator KENNEDY. OK. This is dated October 9, 1978.

Mr. President: After being insured for 39 years either in an individual policy or jointly on my husband's I now find myself in the position where it is impossible to buy health insurance without falsifying the application.

When my husband was 57 years old, the company which employed him merged, and the new management terminated most of the executives. Now after 12 years of service he was not eligible for retirement pay now and our health insurance was canceled.

During that period I developed high blood pressure and other changes associated with this disease, and now Blue Cross will not insure me without a waiver on the only health problems I have. Every subsequent application is questioned whether the applicant has ever been turned down for health insurance.

By changing our style of living we are managing despite rising costs and inflation on the money we have saved for retirement, but I live with the fear that in these times of ever increasing medical costs a prolonged illness would wipe us out financially.

After all the money paid for insurance and all the taxes and social security payments deducted from my husband's paycheck why should we find ourselves in this position. Can you be of any help in solving this dilemna? We are still capable of paying reasonable fees for health insurance, but don't know where to turn.

I think that is a very eloquent, precise comment on and indictment really of our system.

OK. Mr. Sallot?

Mr. SALLOT. Yes, sir.

I am 31, and I am from Toronto. About——

Senator KENNEDY. You are an American?

Mr. SALLOT. Yes.

I am in a unique position because I have seen both sides of the coin. I grew up in Ohio, and about 14 years ago when I was in college my sister became very seriously ill with a disease, and she was in and out of the hospital, and she was referred to various specialists. She required expensive treatment at the Cleveland Clinic. We were fortunate that we lived in the area so that this fine medical facility was nearby, and my father had a private health insurance coverage, but it was inadequate for this kind of serious illness, and as a result for the first time in her life my mother had to go out to work. I was trying to go through the university and working at the same time, and when, you know, unfortunately after some surgery and continued treatment, drug treatment, my sister had regained her health she had relapsed every now and then, but she is now married and has celebrated the birthday of her son, first birthday, on Thanksgiving.

So, in that sense the story had a happy ending. But there was the double tragedy at that time of the financial burden.

As I say, after all of the coverage had been expended from the private insurance my dad still had to take up bankruptcy, was in

$7,000 into the hole at one time, and as a result the mortgage on the house was never paid off at a time when he should have been able to sock some money away for retirement. That was lost.

So, anyway, my experience in Canada was quite a difference. In 1971 I got a good job over in Toronto, and I moved, and since, you know, I met a girl and you know that is home now. We are married and I know that I have tremendous peace of mind if a serious illness should befall either my wife or myself that I won't be in the position that my dad was. My health has generally been good. The only time I have been in the hospital was a year ago for tonsilitis. You know, it seems, you know, kind of funny to be even discussing it considering the very serious illnesses of the people around the table, but on my way in preparation for coming here I asked the Ontario Ministry of Health to provide some figures. My tonsilectomy had some complications, and there was post-operative bleeding, and I had to go back into emergency, and I was readmitted to the hospital the second time, had to have transfusions. I had gone there in shock. At any rate, the total if I had to pay for that kind of medical and hospital service the total would have been $1,343.10 for tonsilectomy, but because of the Ontario Health Insurance Plan I didn't have to pay a cent.

Senator KENNEDY. Now, you wrote to me a very moving letter. I will put it in the record.

I would like it if you would develop one of the points which I think is worthwhile mentioning here, and that is you point out that the physician-patient relationship is as close and as sacred as any with U.S. doctors. And it might actually even be better because my doctor and I both know that he won't have to worry about payment for his services, and I know he will not have to send bill collectors out after me.

What do you mean by that? It says it pretty well, but I would like to maybe develop that point.

Mr. SALLOT. Well, it is a relationship, you know, the doctor-patient relationship, is professional relationship on the part of the doctor. It is not as if I am going to a salesman in a store or, you know, trying to bargain down the price for something that I need. He can attend to any medical problems that I have, and he is not seeing me as a customer. He is seeing me as a patient, and I think that is a worthwhile point to consider.

Senator KENNEDY. OK. I am wondering if either our Canadian friends or American neighbors if there is anything finally they would just like to comment on either on the quality or any message you would like to just leave with us here.

Mrs. BOYCHUK. I would like to say something if I could.

Senator KENNEDY. OK.

Mrs. BOYCHUK. The Government of British Columbia has now implemented a new program called long-term care, and any party considered disabled falls under this and is allowed up to a minimum of 32 hours per month depending upon what services are required, physiotherapy, home care, homemakers. This does not cost the client anything.

Also we have a home nursing program that is a branch of the public health service where a nurse comes into the homes once a day or whenever, whatever care is necessary, whether it is in a short-term or long-term basis, and this is at no cost to the client, either. This is paid by the medical plan.

Senator KENNEDY. I don't know whether there is any comment you would like to be made by our American friends.

Mrs. NEAL. May I?

Senator KENNEDY. Please.

Mrs. NEAL. It is something I thought I would add. I needed a lot of home care, too, but my mother, who was caring for a stepfather with Parkinson's disease, had to fly out from New York and care for me because there was no free care or even minimal financial amount of care, and this nearly wrecked her health, too, but she felt she had to be there.

Senator KENNEDY. Well. again, the difference, I think with our friends here this morning, our neighbors in southern California, we are talking about is middle-income people. We are talking about people who have worked all of their lives or their husbands or wives have worked all of their lives, people that have tried to cope with the system. Most of them have had some kind of insurance coverage over time, and you would have to gather from listening to these people that not one of them is asking for something for nothing. All they want to do is be able to provide sufficient kind of coverage, health care coverage, for themselves and for their children, and to make sure the parents are going to be covered, as well. They are willing to pay the premiums or the things which are necessary. Nonetheless, when we see and begin to match them with our Canadian counterparts in terms of age, of their backgrounds, of their experiences, we find out what has happened to the seniors in our society, the retired people. We find out that a lifetime of savings after a lifetime of work is being wiped out in 1 day of health care costs or the lifetime savings of a spouse is being wiped out by illness and all of the other types of indignities which must go along with it. But you have to wipe out your whole lifetime of savings before you are able to even participate in the medi-Cal patient program. We find out the penalties that exist in the United States to parents whose only crime was to have a sick child. They devote their love and affection and their resources trying to provide for that child. They are forced to deal with bill collectors and to go into bankruptcy in fear of losing their home.

We hear of young parents, young parents in southern California, young parents in northern California, young parents in my own State of Massachusetts, young parents all over this country, the same type of situation.

We find mothers, who through an accident no fault of their own, going through the anguish and the pain and the agony of fighting back to good health and feeling anxiety of not being able to provide for their children because whatever savings they have are being wiped out. My friends, what really we are seeing is in these circumstances and the contrast with a system that does have a universal comprehensive system that includes all people, all parts of Canada. Sure, the provinces have different tuning mechanisms, but you hear very well

expressed in witness after witness from Canada the sense of being free from the fear of the extraordinary financial burden when they have been sick in the past or if they have some illness currently or some therapy that they are involved in or some potential difficulty sometime down the road in the future. They are free from that type of devastating fear which every American unless you are one of those that live at the top of the mountain like we do in the Congress and Senate of the United States and as the wealthiest individuals in our society are fortunate to have. There has been no family in America that has benefited more than my own family in terms of looking out after their children or myself in the hospital or my father. There is no family that has benefited more, but every middle income family ought to listen to what has happened here.

On the one hand you have a humane system. Sure, it has problems. It has difficulties, and we could hear about those. But on the basic and fundamental issue of human dignity and human compassion they have a responsible program which we have not, which we have failed in assuring the American people. I mean you could talk about the dollars and cents, my friends, but we ought to be talking about human beings. That is what is important. [Applause.]

The final point, the final point on that particular issue, is that a universal and comprehensive program not only deals with the human element but correspondingly it deals with the cost, dollars and cents, point of view. This chart reflects the last figures that have been made available to HEW by the Ministry of Health in Canada, it shows they effectivey are providing this kind of humane service at a cost which is less burdensome to the taxpayers than that which we have in the United States.

So let's not lose the significance of important cost containment and perspective budgeting which the Canadian system has. Cost containment and perspective budgeting. They have been able effectively to limit the expenditures and still proved these range of services. We have not been able to limit the costs, and we are not providing the services, and if that makes any sense to any American or any reasonably rational citizen in this nation, then I would like to hear about it. [Applause.]

I want to say again that we have some witnesses to hear from, but I do think all of us are enormously grateful to our friends from Canada. They have come here and shared with us their experiences. [Applause.]

It is never easy; it is never easy to talk about one's illnesses and sicknesses. It always seems to me that is one of the reasons that this country has been slow in really coming to grips with the problems. Most people will bear under this and feel personal kinds of responsibilities rather than sharing these experiences. All of our witnesses, both from California and from Canada, have done us a great service in being able to share and being able to develop this kind of a record. I think it really illustrates what this problem is all about in human terms. We want to thank again our friends from Canada today, thank our witnesses, and we will recess for just about 2 or 3 minutes just so our witnesses can be able to be excused, and then we will hear from Dr. William Thompson, who is president of the Orange County Medi-

cal Society, which has a membership of approximately 2,000 physicians; Gregg Anderson, president of the Joint Counsel of Interns and Residents and an organization that represents many physicians who are in postgraduate medical education-training throughout the United States, and Ms. Christine Burr, who is a member of the faculty of the School of Nursing, University of California at Los Angeles.

So in about 2 or 3 minutes.

Mr. STATA. Senator Kennedy.

Senator KENNEDY. Yes.

Mr. STATA. Could I have one slight or small observation to make?

Senator KENNEDY. Sure. Yes. We would welcome it.

Mr. STATA. In addition we in Saskatchewan take great pride in being the progenitor of the plan throughout the Dominion of Canada because of the spinoffs that the rest of the Dominion enjoys originated from us in Saskatchewan.

However, there are some extra benefits that we have recently introduced into Saskatchewan, and that is we have free prescription drugs for all citizens, and all we pay——

Senator KENNEDY. Don't make this too good now.

Mr. STATA. All we pay is for the dispensing charge, and I will go on from there.

Senator KENNEDY. Give him a couple of minutes here.

Mr. STATA. And we also provide hearing aids, crutches, and other supportive devices for those who need them at cost, which means a considerable reduction and savings over the market value. Children up to the age of 12 receive free dental service. It is now being proposed by the government to extend this treatment to boys and girls up to the age of 18 provided they are students.

Thank you.

Senator KENNEDY. Well, I gather basically from our Canadian friends that sure, there is probably some problems, problems with the system, but there is a basic and fundamental judgment that you are well satisfied with it.

Mr. STATA. Oh, well satisfied.

Senator KENNEDY. The record will show they all shook and nodded their heads, and our first three rows of guests here can acknowledge that, and we want again to thank all of you.

We will have a minute or two recess, and then we will go on with our other hearing.

[Recess.]

Senator KENNEDY. We will come to order, please. All right. We will be in order now if you would, please.

Do we have Dr. Thompson? Is Dr. Thompson here?

Now, what I would like to do is if we hear from the scheduled witnesses and we have some time I am going to ask whatever time we have I will ask people to sign up. I will put a yellow pad over there, and we will see if we have any time for people who want to make any comments.

We will also give you the assurance of—is anyone in this hall who wants to write to me in the period of the next 10 days and tell their story, we will make their comments a part of the Senate hearing record. We can't hear from everybody, but we can insure that your comments, and your statements, and your story, and your views will be made a

part of the record and I will ask Dr. Thompson if he would make a comment.

OK. Dr. Thompson.

## STATEMENT OF WILLIAM M. THOMPSON, M.D., PRESIDENT, ORANGE COUNTY MEDICAL ASSOCIATION

Dr. THOMPSON. Thank you.

Senator Kennedy is an outstanding extemporaneous speaker. I have heard him on a number of occasions. I prefer that mode, but I have prepared and I will read a statement.

I really appreciate the opportunity to appear before you.

Senator KENNEDY. All right. Now we will ask everyone. You have been enormously cooperative and patient and attentive this morning, and the doctor is entitled to be heard and given all the attention and the courtesy we have given our other witnesses. We have a very interested group here this morning, and we are enormously grateful for the attention you have given us.

Doctor.

Dr. THOMPSON. Thank you.

I appreciate the opportunity to appear before you to submit my remarks regarding national health insurance, especially since Senator Kennedy is recognized as the national spokesman for health matters in the United States.

I appear before you as president of the Orange County Medical Association. Thus, I am a spokesman for organized medicine.

However, I submit to you that I am also speaking for physicians, and for patients, and for the patient-physician relationship.

First, I am a general surgeon, practicing and living in Huntington Beach. I am married and have five children.

Second, I have participated in many forums concerned with health matters involving laypersons representing special interest groups rather than patients. I submit to you that patients are a selected group of consumers and physicians are a selected group of providers as they relate to the marketplace.

Of even greater importance, the patient-physician relationship is critical to American medicine, which I believe to be the greatest health care delivery system in the world.

I submit to you that this relationship must be preserved through any modifications of the system.

I am in full agreement that a single physician who abuses his professional status is intolerable. I also believe that the denial to any patient of access to comprehensive quality medical care is unacceptable.

However, it must be remembered and emphasized that abusers of the health care system, both patients and physicians, and those denied full access to the system are relatively few in numbers.

It always seems that Government is capable of considering a problem only in terms of its solution by regulation.

It would be refreshing to learn that programs were being proposed by Government to ferret out and punish the relatively few abusers of the health care system, both physicians and patients, and to bring into the mainstream, the relatively few patients who are denied complete access to the system.

Not only do Government programs seem to be inherently restrictive but the typical Government response to the failure of its regulatory programs is that "more is better." Thus such widely heralded panaceas of the health care delivery system as medicaid, PSRO, HSA, and HSO have not lived up to expectations and the answer seems to be to compound the error by pouring more funds into such programs.

However, before anyone else makes the assumption that I intend to be "agin" everything as has sometimes been the case with spokesmen for organized medicine, let me state unequivocally that I am by nature a positive activist and I intend to present to you proposals for realistic, positive approaches to helping to solve any "defects" in the health care delivery system.

Let us start with the premise that the health care delivery system in this country is the best that has been developed in any country in all of history. It is only because the overall level of access and quality is so high that certain defects are magnified. It seems axiomatic in such a highly developed system that the defect should be cured by selection, and evaluation, and solution rather than by redesigning the entire package.

It is the premise of a relatively small group in this country that too much of the gross national product is expended in health care. How does one determine what is too much? Perhaps too much of the GNP is expended for transportation or recreation or education. Every study I have seen indicates that people want more and better medical care. The No. 1 growth industry in this country in the last 30 years has been medical care, not auotmobiles, not electronics, but medical care.

It seems clear to me that in this growth industry, the major source of inflationary pressure is the increased demand for quality health care by patients. Moreover, Government subsidization of such access must be considered as a major factor in producing inflation in the system.

It also seems to me that the way to control such inflation is to reduce demand for health care services by improving the environment and by educating the public to choose a more healthful lifestyle.

I submit that this educational role is proper for the Government.

On the other hand, I do not believe that such inflation can be controlled by regulating health care expenditures at the top in the manner of a spigot which can be gradually turned off. This technique has been perfected in other countries such as Great Britain, and in our own medicaid program, and the result is reduced access to a reduced level of medical care. In particular, this type of regulation produces rationing of medical services and elimination of newer, innovative capital equipment.

With the forgeoing in mind, let us proceed to positive programs.

First, I want to congratulate Senator Kennedy for his development of the preventive health program which essentially is designed to provide education for the public to improve their lifestyle. I was pleased to have been present when he announced this program last January at a medical meeting in Chicago. This motivational and educational role is most suited to Government as I have discussed above. I hope this role will be expanded in the future.

Second, governmental programs have been developed to improve access into the health care delivery system by the elderly [medicare], poor [medicaid], women and children [pedicare]. In view of the foregoing, it would seem obvious that the most significant remaining aspect of medical care which is relatively uncovered and which is of extraordinary concern to many individuals is catastrophic health coverage. This type of medical coverage is long overdue. There is nothing more disheartening in my practice than to encounter patients who have been driven to bankruptcy because of an unfortunate member of their family having been the subject of a catastrophic illness. I recall vividly a middle aged gentleman appearing in my office several months ago with a hernia in need of repair. He recounted to me a horror story in which, although he had not missed a single day of work in many years, he found it necessary to undergo bankruptcy, because of extraordinary expenses encountered in the treatment of breast cancer suffered by his deceased wife.

How can we allow this type of catastrophy to happen in 1978?

I believe that catastrophic health insurance coverage is actuarially sound and relatively inexpensive. I know that my own catastrophic health coverage is an important part of my insurance portfolio and costs very little.

It would be appropriate for Senator Kennedy to alter his long-standing opposition to catastrophic health insurance coverage, especially in view of the current precarious economic situation and President Carter's announced "step by step" health care program.

Third, one great strength of American medicine, its "cottage industry" image, is also apparently its greatest weakness.

Generations of physicians have been trained in this country to treat patients on a personalized one-on-one basis. This personalized approach admittedly neglects business efficiency.

In relatively recent years in this area, physicians have become grouped in buildings adjacent to hospitals forming a complex of great benefit to patients and physicians. These complexes are seemingly adaptable, employing computer technology, to significantly improve cost efficiency of business aspects of medical practice without deleteriously affecting the patient-physician relationship. It would be an appropriate role for Government to develop eduational and pilot programs to aid in this application of modern business practices to modern medicine.

Last, there is a relatively unique medical problem in southern California having to do with indigent patient care, which might be appropriate to the deliberations of Senator Kennedy's group.

There are in our community many individuals who do not have citizenship papers such that they are not eligible for medicaid treatment. These people often avoid contact with the health care delivery system for fear that they will be turned in to the immigration service. Such individuals present a significant reservoir of health problems, not only to themselves but to others in the community unnecessarily exposed to them. The citizenship problem does not seem to be capable of solution and in some way needs to be developed programs in which such individuals can be given access to the health care delivery system without fear of deportation.

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In this regard, it must be mentioned that the medicaid program which started with such great expectations has become a national disaster. The poor patients have been shunted from the mainstream and physicians have become alienated because of administrative red-tape and the turning off of the spigot.

In Orange County, because of further inroads on health care caused by reduced funding under proposition 13, there has been convened a task force of health care providers, which hopefully will eventually include patients, and which has the opportunity for developing innovative methods of improving medical care for indigents.

Also in this regard, there is a recent socioeconomic survey by the California Medical Association which demonstrates what we physicians already knew, that medical care in Government hospitals, for example, Veterans' Administration and military and county hospitals, is substantially more costly than in the private sector.

Almost every practicing physician has spent a portion of his training in Government hospitals and we are well aware of the cost inefficiency and poor quality of such medical care.

It seems axiomatic that if Government hospitals were turned over to the private sector for management the quality and cost-efficiency of medical care in such hospitals would be significantly improved overnight, especially in relation to indigents.

Finally, I am frequently involved with programs developed by social planners employed by Government agencies which are sterile and unrealistic and unrelated to the needs of patients, physicians, and especially the patient-physician relationship. There must be input into such planning at the onset by not only practicing physicians but by other members of the health care delivery team. It is the nature of the physicians to devote their energies to treating sick patients and not to take part in activities related to the planning of health care delivery systems. Obviously we are going to have to take greater part in these planning activities or else the system will seemingly be overturned. In regard to Government planning in a vacuum, I am mindful of a recent conversation concerning prepaid medical care which is a current Government panacea. It seems that under the present regulations which require that an employer must offer each employee the choice of an HMO or insurance coverage, employees who select the insurance program usually have a family physician whom they want to retain, while employees who select the HMO usually have no affiliation with a physician.

Consequently, those employees seeking insurance coverage usually have existing medical problems whereas those choosing HMO most likely have little or no need for medical services.

Thus, an artificial situation is created in which insurance companies have difficulty breaking even on health insurance with ever-increasing premiums and the cost experience in the prepaid sector appear to be better than for fee-for-service but only because of an artificial preselection imposed on the system.

In conclusion, I submit that it is a proper role for Government to provide motivation and education to all participants in the health care equation especially in helping to improve the business aspects of medical practice, and in improving the lifestyles of the public.

An example of the educational approach should be the recently heralded "second opinions" program of HEW. Second opinions have long been traditional in medicine and it is certainly appropriate to educate patients to seek alternative opinions as to medical treatment.

To make such opinions mandatory would not serve any beneficial purpose, especially since studies concerned with second opinions have not demonstrated any cost savings of significance.

Again, Senator, thank you for the opportunity to appear before this group and make this presentation.

Senator KENNEDY. Thank you. [Applause.]

I will have some questions when we come back to you, but I will ask Dr. Anderson to make a statement. Perhaps he can make a comment whether he agrees, make whatever other comment.

## STATEMENT OF GREG ANDERSON, M.D., VICE PRESIDENT, PHYSICIANS NATIONAL HOUSESTAFF ASSOCIATION

Dr. ANDERSON. Short comment about whether I agree or my entire statement?

Senator KENNEDY. Well, let's hear your statement.

Dr. ANDERSON. I will make a short statement first, and that is the proposal for the insurance that would cover devastating illness only is to me a——

Senator KENNEDY. Catastrophic you are talking about?

Dr. ANDERSON. Catastrophic, devastating. It is a form of playing medical Russian roulette. If you catch the right disease, you will be covered. If you are unfortunate and catch the wrong disease, you are unfortunately not covered and may well face the same type of horror story that we heard recited earlier today.

I also assert that the cases that were discussed earlier today were not staged, that they are representative, they are standard fare in American medicine today.

I would like to commend Senator Kennedy on his both eloquent and courageous demand for national health insurance program. Though the debate on this issue has gone on for some 40 years, I firmly believe that with the Senator's dynamic leadership and the help of all of us that program will not be far of.

[Applause.]

Senator KENNEDY. Let's have a little order now.

Dr. ANDERSON. In the preamble of the U.S. Constitution, it specifically states that one of the tasks of Government is to "promote the general welfare." The fifth amendment, part of the Bill of Rights, states that no citizen should be deprived of "life, liberty, or property, without due process of law." This same statement appears again in the 14th amendment. It is clear today that citizens are being deprived of life without due process of law because of lack of access to quality health care. There is nothing more fundamental in promoting the general welfare than preserving the right to life and health of all Americans equally.

The present system for providing health care in this country is inadequate and fails to meet the needs of large segments of our population. The patchwork quilt of health care coverage which is made up

of private payment, private health insurance, and State and Federal programs such as medicare, medicaid and medi-Cal, leaves many people uncovered and unprotected. In a country as well endowed with resources as ours, it is a national tragedy that so many of our people receive inadequate health care.

My testimony today is not designed as an indictment of individual, conscientious, hardworking physicians, but instead will define the vast shortcomings in our present health system, health care system, and demonstrate the desperate need for a workable national health insurance program.

Senator Kennedy has called for legislation providing comprehensive and universal national health insurance. As vice president of the Physicians National Housestaff Association, an organization which represents more than 12,000 physicians in medical training programs across this country, I want to register our strong support of these principles. At our national convention last spring, we adopted a resolution calling for the establishment of a national program that would in part,:

1. Include access to health care for all people residing in the United States.

2. Provide funding and planning to secure health care for sections of the population which have traditionally been underserved.

3. Provide benefits to cover all medically indicated services with adequate cost control mechanisms.

4. Restructure the current system to emphasize preventive and ambulatory care.

Organized, private medicine, as represented by groups like the American Medical Association and the Orange County Medical Society, will no doubt argue that we do not need national health insurance. They will try to preserve the status quo but, if we look closely at our present system, we can clearly see that it is not meeting the needs of vast segments of our society.

I am a physician who works at Harbor-UCLA Medical Center, a county hospital in Los Angeles. Everyday I see the consequences of the failures of our present system. Today I want to share some of my experiences with you.

The patients that I care for are often those who have fallen through the cracks of our present system. They are composed in part of the poor, the elderly, and racial and ethnic minorities. But, there are surprisingly large numbers of middle-class people who thought they had adequate health insurance that would protect them in the event of illness, that end up in county hospitals.

The last time I was on call at the hospital, was a typical day and the patients I saw were typical of the patients we see everyday at Harbor-UCLA Medical Center. The problems faced by these patients demonstrate many of the problems in our present system of health care delivery. I saw an elderly Chicano gentleman with diabetes who had had amputations of both his legs. He had suffered a stroke early in the morning. He could find no private physician to care for him, because he had no health insurance and could not himself pay for his care. He was reluctant to come to the county hospital because he knew he would have to wait for many hours and he was scared. He there-

fore chose to stay at home. His two sons finally persuaded him to go to the hospital, and he was admitted at Harbor. Fortunately, he will do well; yet, he is typical of large numbers of the elderly and ethnic minorities who cannot obtain private medical care under the present system. They must rely on a public system which is underfunded, overcrowded, and inferior in many ways when compared to private health care. I would be very upset if my father were unable to receive first class health care if and when he needed it, yet that inability as demonstrated by my patient, is the reality shared by millions of elderly Americans. We have created and allow to continue a two-class health care system that discriminates against many groups of Americans.

I saw another gentleman while I was on call who demonstrates another type of problem. He had private health insurance and in fact was under the care of a private physician. Unfortunately, this patient deteriorated over the weekend and developed a blood clot in his lung. His private doctor could not be reached, and the patient therefore ended up at the county hospital. This points out other cracks in our present system. Average Americans with average health insurance plans may not receive the quality of care they expect. For example, if they are hospitalized in a private hospital and their insurance runs out, they are transferred to a county hospital. I have seen this happen frequently. Every weekend we get patients who are transferred from private hospitals and nursing home to the county hospitals for no apparent reason except convenience to the private physicians who seem to want their weekends free. Private medicine always has and always will continue to utilize the public hospitals as dumping grounds for patients that they consider undesirable.

Other Americans face similar jeopardy. Nationwide over 22 million people under the age of 65 have no form of health insurance. That's nearly 12 percent of our population. They constitute but one portion of the medically indigent and for them the door to private medicine is sealed shut.

A large percentage of the work force received health insurance coverage from their place of employment. Termination of employment for one reason or another usually results in loss of health coverage. A recent study found that an estimated 35–39 percent of persons who lost their jobs during the recession of 1975–76 also lost their health coverage.

I saw another patient while on call, a young black woman who had her fourth baby four weeks before. She had developed severe hypertension complicated by seizures in conjunction with that pregnancy. Because she was poor and black and on welfare, she could not find a private obstetrician to care for her during her pregnancy, and therefore she received inadequate prenatal care. Had she received appropriate care her present problems might have been avoided. Again our present system failed this patient.

The statistics are ominous and most distressing. In spite of our vast resources we rank well down the list among developed nations in parameters such as maternal and infant mortality rates.

In 1965 the average life expectancy of a newborn white was 70.2 years while that of a nonwhite was only 63.6 years.

The infant mortality rates in the white population in 1966 was 20.2 deaths per 100,000 live births. In the nonwhite population the death rate was 72.4 deaths per 100,000 live births, more than three times as high. This higher death rate is directly related to less prenatal care. lower rate of in-hospital deliveries, less contact with medical specialists, and the poorer general health of the average nonwhite mother. all the consequences of a two class, discriminatory health care system.

My patient with hypertension and seizures has had and will continue to require extensive medical care. She was neglected by our present health delivery system at a time when appropriate care might have prevented her problem from developing. She symbolizes yet another segment of our population which receives inadequate care under the present system.

In the period from 1949–51 the United States had the 6th lowest infant mortality rate in the world. By 1964 we had fallen to 11th, and by 1976 according to a Bicentennial Commission Report on American children there were 16 countries with lower infant mortality rates than ours. How I ask can we defend our present system of health care delivery as adequate?

By other parameters as well we do poorly. We rank 10th in maternal mortality rate, 20th best in relative risk of death from heart disease, our No. 1 killer between 19th or 20th in male life expectancy, and depending on the study between 7th and 17th in female life expectancy.

In one study done recently in Watts there were only 50 physicians located who had offices which were easily accessible to local residents. This resulted in a ratio of 35 physicians per 100,00 population compared to the overall county rate of 187 physicians per 100,000 population. A recent article in the Los Angeles Times noted that the physician-to-patient ratio in some parts of East Los Angeles was lower than in the underdeveloped country of Bangladesh.

The horror of these types of statistics continues. There are presently nearly 3 million medi-Cal recipients in California. Many cannot find a private physician to treat them and therefore have nonexistent access to private health care.

In 1977 the California Department of Health found that the extent of ob-gyn underservice for medi-Cal patients was alarming. In Shasta County there were approximately 250 annual medi-Cal financed births, yet there is not one medi-Cal participating ob-gyn provider. In Kings County there is one medi-Cal participating ob-gyn practitioner for nearly 300 medi-Cal births yearly.

Of the nearly 1,600 private physicians practicing ob-gyn in California less than one-third of them will even see medi-Cal recipients, and of those who will see them many limit the numbers seen to a very small percentage of their practice.

Who will dare to say that we do not have a discrminatory two-class health care delivery system? If such statistics don't make the argument for a change to national health insurance, then let us return again to some specific personal examples.

I recently saw another patient who suffered as a result of our present system. He was a skid-row transient who had been robbed and beaten up. He was taken to a private hospital for emergency care.

Because he was poor and had no health insurance he received only the required emergency treatment. His cuts and bruises were administered to and he was sent on his way without provisions for followup care. A few days later he became severly ill and went back to the hospital at which time he was first treated. At this point he was transferred to Harbor-UCLA Medical Center. In the interim since his first emergency visit the cuts on his face and scalp had become infected. He developed gangrene of his entire face and scalp and ultimately died at Harbor. Those who cared for him at Harbor are convinced that his death could have been prevented if he had received appropriate followup care for his initial injuries. Since he lacked medical insurance, he did not receive again the necessary care. This represents a failure not of individual doctors, but of our system as a whole.

I want to discuss one last tragic patient before moving on. This patient was seen first in one hospital, then sent to another hospital because of "lack of available facilities" she was transferred in a routine fashion. Unfortunately as our medical system was playing ping-pong with this patient something went wrong. Something happened and in midroute an emergency developed. She was taken to yet a third hospital where she was dead on arrival. Our medical skills, our technology, our compassion, and all our best intentions failed this patient as they have failed so many others.

We have developed public assistance programs such as medicare, known in California as medi-Cal. These programs are designed to provide quality health care for those who are too poor to obtain it for themselves. In many cases these programs fall far short of their goals. These programs do not require private physicians to participate in them. Because of disincentives inherent in these programs such as slow physician reimbursement, low reimbursement rates, and the stigmata attached to patients on such programs, painfully few private physicians in California will see medi-Cal patients. These patients must, therefore, receive their care in public hospitals and clinics as the court of last resort. Unfortunately, the resources available to the public sector have been evaporating over the last several years. The passage of proposition 13 in California and similar measures in other parts of the country will further reduce the ability of our public hospitals and clinics to meet these needs.

Perhaps another example from my personal experience will help to show how threadbare the public portion of our health quilt has become.

There are presently more than 20 intensive care unit beds closed at Harbor-UCLA Medical Center. Because these beds are closed many of our patients do not receive the level of nursing care and monitoring that their illnesses require. I can say without doubt that patients have suffered and died needlessly because the resources that they required were not available. I want to point out quickly that this fact does not reflect on the hospital or its staff, but rather on the priorities that have been established by our public officials. Those beds at Harbor have been closed for almost 2 years because we cannot compete with the private sector to hire the nurses needed to staff and open them. The resources needed to provide quality care in the public sectors are not available under the present system.

Although the problems faced by public hospitals are vast and varied, they are not themselves the subject of these hearings. Yet public hospitals are an integral part of our present system, and as I said they are the court of last resort for all those patients not served by private medicine. To the extent that we have problems, and I can assure you that we have serious, life-threatening problems, we are unable to meet the needs of those who depend upon us. For an excellent, detailed analysis of the problems of the public sector, I refer those who are interested to the recent Report of the Task Force on Public General Hospitals of the American Public Health Association.

As I have progressed through my medical studies, it has become increasingly clear to me that the present system of health care in America is not meeting the needs of the people. Private health insurance is often too expensive, too limited in its coverage, and available to too small a part of the population to be the solution to our present problems. Government programs as they exist are piecemeal and inadequate. Our present system of health care delivery has done precious little to address the problems of maldistribution of health resources and meeting the needs of those portions of our population living in underserved areas. The entire health care industry as now constructed is geared towards treating existing illness which is far more expensive than preventing illness in the first place. It is clear to me as it is to Senator Kennedy, to PNHA, and to many, many others that we need a bold new approach to financing health care delivery.

We can learn from experience in other countries that national health insurance works, it is well accepted and supported by the people, and that it solves many of the problems that we presently face. England recently celebrated the 30th anniversary of its national health service and while its national health service has its advocates and its critics, polls consistently show that greater than 80 percent of the population like their system. They live longer than Americans, they spend less time in hospitals, and they have lower infant and maternal death rates. Data proves that health care in Britain is much cheaper than it is here in the United States. The per capita for fiscal year 1976 of health care in England was $189 compared with $638 here in the United States.

In Canada, health care is available to all residents on uniform terms and conditions. Eligibility for benefits is based on medical necessity. Their plan is publicly administered and open to public audit. Administrative costs for health care in Canada average 2.1 percent for the 10 provinces. In the United States, administrative costs for private insurance carriers consistently run at about 14 percent—nearly seven times the cost in Canada.

Many myths about national health insurance have been advanced by various groups like private insurance companies, drug and supply companies, the AMA, the AHA. These groups are all interested in preserving the status quo in health care. A careful look at our present system, a sensitive examination of our national health presently shivering under a threadbare, tattered-and-torn patchwork-quilt arrangement for providing health care, should convince well-intentioned Americans that we need a change. I hope that some of my personal experiences have helped to demonstrate the need for change to national health insurance.

In conclusion, there are many reasons for developing national health insurance. But, the most important reason for national health insurance in this Nation, or indeed anywhere, is that health care should be considered a right of all people, not a privilege enjoyed only by some.

[Applause.]

Senator KENNEDY. Ms. Burr, a member of the faculty of nursing at UCLA representing the American Nurses Association.

## STATEMENT OF CHRISTINE P. BURR, R.N., UCLA SCHOOL OF NURSING

Ms. BURR. Thank you.

My name is Christine Burr. I am representing not only the American Nurses Association but the UCLA School of Nursing. I am here today to speak in support of comprehensive health insurance.

We are a nation of people who expect to be healthy and we expect to do so with a minimum of personal effort. Our expectations for what the health care system does and can do for us sometimes approach the magical. It is true that advances in medical technology have created a system that enables us to provide early diagnosis and therefore treatment of illness and injuries which were once inevitably fatal. We fail to consider, however, that because of these advances, we are daily increasing the numbers of disabled and recovered people who will live to old age but with a different lifestyle and generally increased health care needs. This group adds significantly to rising health care costs. Regrettably, many of these people, as well as those who have not experienced catastrophic events, lack either adequate income or health insurance to cover the health care expenditures necessary to maintain themselves in the most effective manner.

In the State of Oklahoma, for example, heavy industry is not required by law to provide employee health and disability insurance. Workers injured on the job or who develop chronic illness from job-related experiences are left without adequate resources to secure care and to maintain their families. A parallel situation exists in California, in spite of protective laws. Disabled workers may find that they do not qualify for either disability or long-term health care coverage because of the nature and duration of their employment. These people, many in the age range of 40 to 50 years when their family responsibilities are high, become the unfunded unemployable victims of a system which ties health care benefits to employment or ability to pay.

A second cause of rising health care costs is the lack of knowledge as to when medical care is required. In many instances, what is needed is assistance in problem solving, advice on basic health care practices, and ready access to validation of plans for self-care. That such services can be cost effective has been documented by the Metropolitan Life Insurance Co. Beginning in 1901, this company maintained a visiting nurse service for its industrial policyholders. Under the slogan "Send for the nurse when you need to be nursed," Metropolitan provided direct access to nursing care, health education, and evaluation of health status by a professional nurse as a routine policy benefit.

This program was sufficiently effective in terms of its impact on the morbidity and mortality of the policyholders that it was maintained

for over 40 years. Similar success stories regarding the benefits of direct access to professional nurses working in collaboration with physicians have been repeated in a variety of settings. The Frontier Nursing Service in Kentucky is a classic example. The Madera County, Calif., experiment with nurse-midwives is another. In that case, nurse-midwives significantly reduced maternal-infant health problems during a 3-year period. When the experiment was over, the nurses had to leave and the maternal-infant health statistics returned to their former sorry state.

In 1978, it is often not possible to send for the nurse when you need to be nursed. While current access to such services through public health and school nurses varies with the state of the local budget, both these nurses and the visiting nurses may not provide care without physician supervision. Physician involvement is required because the current system for delivering health services is based on the presumption of illness. With the exception of the maternal and infant care programs, there is practically no reimbursement for preventive care for significant portions of the population.

In 1977, the Federal Government in recognition of the need for preventive health care expanded medicare coverage to include limited health education for the elderly and permanently disabled. This, too, requires physician supervision. The reimbursement structure prevents the recognition of either health education or direct preventive health care by professional nurses. People who are essentially healthy or medically stable are forced to inappropriately utilize physician and nursing services. Were the system structured so that these people had direct access to professional nursing care, both efficiency and effectiveness would be greatly enhanced.

Let me tell you about one of my patients at UCLA. This 85-year-old, recently widowed, essentially healthy woman came to the clinic seeking information, advice, and reassurance about her health practices. Because of the current structure of the system and the existing reimbursement policy, it became necessary to involve the physician in her care. In fact, I as a family nurse practitioner could have provided all the care she needed at that visit, including an evaluation of her physical status as well as the education and counseling which were her immediate need and request. I practice in collaboration with a family physican who is available should the patient later need medical care.

At the other end of the age span I recently provided care for a young woman and her 5-week-old infant. I became involved when she called the clinic seeking advice about cradle cap and diaper rash. It was apparent from our phone conversation that this was an uninformed, inexperienced mother who required professional nursing care. She simply did not know how to care for her baby. What she needed was education, emotional support and access to ongoing advice. She came into the clinic and I spent 2 hours with her. During this time she learned to bathe and feed the baby and to prepare the baby's formula. This was her second visit to the clinic. At the time of the baby's 2-week checkup the mother had seen the physician but had been unable to express her need for the information.

In these two cases early involvement of the professional nurse forestalled later more serious problems. In both instances, which involve preventive nursing care, I used my knowledge as a nurse practitioner.

As a family nurse practitioner, I provide the traditional health assessment and the management of minor acute and stable chronic illnesses in conjunction with my nursing knowledge and skills. While many physicians endorse patient education and preventive care, the focus of their professional education is oriented to the cure of the sick and the prevention of death. For nurses, patient education is a major professional responsibility and occupies an important place in their scope of practice.

My experiences are not unique. Unfortunately, we cannot document the impact and need for professional nursing care in the same fashion as for example physicians, physical therapists and pharmacists. Nursing care is the invisible component of the cost care dollar. In ambulatory care, nursing services are hidden in office overhead. In the hospital they are part of the hotel services. The separation out of nursing care services and therefore costs would permit the identification and evaluation of a major component of health care services. My colleagues in nursing administration assure me that marvelous and oftentimes costly nonnursing items are currently hidden in those general budget categories used to cover nursing services. Separation out of the nursing care costs would therefore lead to a clearer picture of facility overhead and direct care service costs.

We believe that the direct identification and reimbursement of professional nursing care services is an essential component of a cost-effective comprehensive health care plan.

Not all care is provided or should be provided in an institutional or office setting. Firsthand assessment of the home environment is sometimes a critical component in the planning of effective care. As an example, I collaborate with the physicians at our clinic to plan for discharge and provide health assessment and nursing care for homebound patients. I work with the families to teach them the skills and knowledge necessary for the care of the patient. Together, the physician, the family and I work to support the family unit and reduce the length of the hospital stay.

Four years ago when I was a graduate student at Emory University, I organized a clinic for female offenders housed at a State work release center. No community physician had been willing to provide ongoing or comprehensive onsite care for these women. Prior to the start of the clinic the woman had received their health care at the local county hospital emergency room. The decision to seek care was made by the guards, none of whom had any medical or first aid knowledge. I provided health screening and assessment, health education and counseling, and supervised the treatment prescribed by the physician when an emergency room visit was necessary. In addition, group counseling for particularly disruptive women was provided. Health education and first aid training was provided for the guards as well as 24-hour telephone backup consultation. Through these services we reduced the number of nonemergency visits to the emergency room, increased the level of responsible self-care and reduced the anxiety and inappropriate decisions previously made by the officers in regard to the necessity for health care. The response was so positive that the State of Georgia has now signed contracts for three such clinics with the corporation of professional nurses with whom I was then working. These nurses

work in collaboration with local physicians to provide comprehensive nursing and medical care within the scope of the Nurse Practice Act in that State.

The research data I collected during and after my involvement with this practice indicates that the women are receiving professional quality care. The prisoners and guards have increased their own preventive health care practices and the utilization of physician and emergency room services has been reduced to use for actual medical care needs. I believe this is an excellent example of professional nursing care provided within the guidelines of the Nurse Practice Act. This program successfully reduced the cost of health care and increased the proper utilization of physician services. Preventive health care and participation in self-directed care were the basis for this clinic and were readily accepted by the women prisoners, the guards and State correctional administration, and the community based physicians who practiced in the emergency room and in private practice.

Access to care is a crucial variable in the maintenance of health and rehabilitation of the ill. Professional nursing practice is an important component of that access. In the hospital, professional nurses provide the ongoing 24-hour physical and emotional care necessary for recuperation. In the ambulatory care setting, professional nurses provide preventive and restorative care. In addition, nurses provide access to care thorugh home visits. Professional nurses are able to meet the health care needs of a significant proportion of the populace. It is only equitable that they receive independent credit for their role through the identification of nursing service as one of the professions whose members work interdependently with the patient, the physician, and the other members of the health care team.

The examples I have shared with you today are not of the kind that make headlines. They have to do with helping people get trough the day, often dealing with little problems before they become big problems. Careful preventive professional nursing care rarely results in heroic stories. The baby thrives. New mother survives the vicissitudes of early parenthood. The elderly widow gains the courage to carry on alone. Father returns home early from the hospital, and women in trouble have better chances of gaining control of their lives. These are tiny victories. They are critical, however, in containing the cost of health care. It is not just catastrophic events and the suffering which follows to which we must attend. It is also the preventive actions which, taken early, may prevent catastrophies.

Professional nursing, more than any other health profession already serves in most settings where prevention can be practiced. Professional nurses are in our well baby clinics, our schools, our factories and offices, and our military services. Where they are not is on the list of reimbursable services. As a profession we have proven again and again that nursing care counts in getting and keeping people well. As providers of a reimbursable service under comprehensive health insurance we believe that we can have a significant and stabilizing influence on cost effective care.

Thank you.

[Applause.]

[References to Ms. Burr's statement follow:]

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Senator KENNEDY. We appreciate very much Dr. Anderson's and Dr. Thompson's and Ms. Burr's comments. They comment on a number of very important points which deserve elaboration, but I think we will have an oportunity to exchange views on a number of those points perhaps at another occasion. In the time that we do have remaining, which is not very considerable. I thought we would permit the people who have signed up briefly to make a comment.

So I will ask at the start Mr. Williams if he will come up here. Now, we started off early this morning at the hospice center, a very impressive program at the Wadsworth Veterans Hospital in Los Angeles. After this particular meeting we are meeting with the members of the Orange County Medical Society, and we go later in the afternoon to the UCLA campus to meet with those that are involved in medical research, and those who are involved in medical education today.

We have been trying to while we were out here in southern California to take some differing views of health policy which would be before this committee, and that is why we have a very full program.

I will just ask them to make comments of a minute and a half or so, and I will indicate to all the others that we will put their statement in the Senate record if they will just write to us.

So we will ask Mr. Williams, Tilman Williams.

Mr. WILLIAMS. Mr. Kennedy, members. My name is——

Senator KENNEDY. We will give you a minute and a half, so do whatever you like.

## STATEMENT OF J. TILMAN WILLIAMS, REPRESENTING THE CALIFORNIA SCHOOL NURSES ORGANIZATION

Mr. WILLIAMS. My name is J. Tilman Williams. I live in Garden Grove, and today I am representing the California School Nurses organization.

Most of the school nurses are in the schools taking care of the children today because in around here in the municipal area about 20 percent of the kids I understand have flu, but when I get this way. I would like to read the following statement.

It is the rationale for inclusion of funding of school nurse services in the national health insurance program. We believe that the school is the most efficient cost effective community setting for the implementation of meaningful health care for children. Health care for the youth as provided provides for school nurses, includes an implementation of education for health problems, preventive health measures, health maintenance care and necessary therapeutic measures.

In America alone it is estimated that 7 million children from impoverished circumstances never visit a physician's office or hospital outpatient department except in times of dire emergency or extreme illness. Since most children attend public schools between the ages of 5 and 18 years of age as well as increasing number of children under the age of 5 the school nurse is the primary health care provider for the children. Frequently preventive care is neglected or fragmented in traditional health facilities by virtue of the current health care system.

Senator KENNEDY. OK. I am going to take the rest of your statement. We will include it in the record. This is a very valuable point, not only for the nursing aspect but the stressing of preventive health care. We really haven't talked very much about that. It is an essential aspect of our health insurance program, and I am glad we had reference to it. We haven't really been able to develop that point today, but we are very much aware of its importance.

Jim Hargreaves is No. 2. Jim? Here is Jim. OK. You have got 1½ minutes, Jim. [Applause.]

Jim is a prominent number of the National Council of Senior Citizens, president.

## STATEMENT OF JIM HARGREAVES, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. HARGREAVES. Thank you, Mr. Chairman, members of the panel.

Let me indicate I am not going to consume even 1½ minutes. In the interests of time I am going to give a prepared statement that I will leave with you, Senator.

I would simply want to make one comment. The testimony adduced here today ought to convince everyone that our present health care delivery system is a national disgrace, no less. [Applause.]

Senator KENNEDY. Thank you, Jim, you almost persuaded me to give you another minute there. This is a balanced hearing.

OK. Paul Lu. Paul? And then we will hear Hank Casman, is that right?

## STATEMENT OF PAUL LU, RESEARCH ASSISTANT, ORANGE COUNTY SENIOR CITIZENS PROGRAM

Mr. LU. My name is Paul Lu.

I am research assistant for Orange County senior citizens program. I am supporting all services and programs which may benefit senior citizens in Orange County today, and today I am speaking as an individual because of I have identified a special need in the health insurance program which has never been identified by anybody else.

Ten years ago I was working as a planner in a very small, tiny city in Georgia, and the chairman of the planning commission was Jimmy Carter, our current President, and I wrote him a letter, a position paper, 2 years ago regarding the national health insurance. It shows a position that has not been addressed by the committee.

Most young adults, they can purchase health insurance to cover their dependent children but not to cover their dependent parents.

There are many spokesmen who have spoken this morning. We have been penalized because we have sick children, but there are a lot of people who have been penalized because they have sick parents. I am one of the victims. There is a very sad story I am not going to express here, but I do wish the planners in the committee to consider to enforce insurance companies to take them, you know, coverage for their sick parents.

Senator KENNEDY. Well, they will be so included in any bill that has my name on it.

Thank you very much. [Applause.]

We are just going to have our final witness. Hank Casman.

## STATEMENT OF FRANK CASMAN, LOS ANGELES CITY, ORANGE COUNTY

Mr. CASMAN. Frank Casman for Los Angeles City, Orange County. Thank you very much, Senator, and we are delighted to see you here today. You are most welcome in Orange County.

Our people are going through hell. I will tell you right now. And right now and continuing on they are getting more frustrated, more confused and sicker because of the ongoing conditions in mobile parks, apartments. Rental situations are abominable. People are so desperate they don't know where to turn to.

This is bringing on many more troublesome conditions and worry to these people.

I do hope we can get a worthwhile health program to help these people, because it is so badly needed. There are many people in the room who will bear me out because I have been to their meetings. I have been to luncheon meetings. I get around to a lot of affairs.

I started in 20 years ago assisting senior citizens, and I will be 73 in January myself.

But I am saying my fortitude I believe is my heritage. I am 100 percent Polish. [Applause.]

Senator KENNEDY. Now I want to express our appreciation to the mayor, Mayor Erickson. He was kind enough to greet us when we arrived here earlier this morning. We appreciate his making this facility available. We met your assemblymen and those that are involved in community government here. They were kind enough to greet us. We have had tremendous cooperation from all of those at this center. It is a magnificant facility, and we are very, very grateful. Finally I just want to thank all of you, and I would hope that you might let your friends know about this hearing if you have been impressed by what you have heard. And also that you also let our colleagues know in the Congress and Senate of the United States and start getting them straightened out a little bit, too.

Thank you very much.

The subcommittee stands in recess.

[Whereupon, at 1 p.m. the subcommittee stood in recess.]

# APPENDIX

STATEMENT OF THE CANDLELIGHTERS
ON HEALTH CARE INSURANCE
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
HUMAN RESOURCES COMMITTEE
UNITED STATES SENATE

Mr. Chairman and Members of the Committee:

Candlelighters is an organization of parents of children with cancer which includes 100 groups throughout 42 States and Canada. The problem we share is not a small one: after accidents, the second leading cause of death in American children is cancer. Moreover, the financial burden born by each family is second only to the distress caused by the disease itself. A study of 70 families with children in treatment for cancer at the University of Kansas Medical Center demonstrated that in addition to medical expenses (usually covered by third party coverage and installment payments), the out of pocket for non-medical expenses usually averaged more than 15% of the family budget. For half of the families, the figure was over 25 %. These non-medical expenses included loss of pay, transportation to distant medical facilities, food and lodging while away from home, child care, special clothing and special food. (Jan Black's paper, presented at the Candlelighters Foundation National Parents Conference in June 1978 is attached and will provide you with more details on this study.)

A case in point is the pediatric cancer patient in Las Vegas, Nevada. This child's closest oncology care is in California, usually in San Diego, Los Angeles or San Francisco, from 250 to 460 miles away. Ait transportation ranges from $150 to $300 per person round trip and remember that a parent must always accompany the child.



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Visits to the clinic vary in frequency from once every two weeks to once every eight weeks. When the child is hospitalized there are food and lodging costs for the parent(s) and often lost wages.

One family spent over $6000 in out of pocket expenses the first year their child was diagnosed. A few months ago they spent $750 for a five day trip to San Diego for tests. When they have to stay several days, the family makes the trip in a camper to save on lodging.

Another Las Vegas family recently had to spend $2350 in just seven weeks for out of pocket expenses incurred during the treatment of their child's cancer. These expenses were for gas, lodging and food.

In view of the shrinking resources allocated to health, it is important in developing any National Health Insurance program to tie it to development of a system that produces excellence in research and provides an optimum in application of research for all children/adolescents with cancer at the lowest cost to the families and to society. Observations by parents in a variety of treatment settings suggest that this research effort can be combined cost effectively with treatment through a nationwide consortium approach to health care for children with cancer.

The diagnosis, evaluation and treatment of children with cancer must be integrated with basic and clinical reserarch designed to determine the causes, pathogenesis and prevention of their disease and specific, safe, simple and totally effective treatment. Tp deny children with cancer the opportunity to be included in relevant research is to diminish their opportunity for prevention and cure.

Childhood cancer research has proved to be the single most effective model for understanding and treating of many forms of cancer. Pediatric cancers pioneered combined modality therapy utilizing surgery, radiotherapy and chemotherapy, various rescue factor approaches, and adjuvant chemotherapy which have effectively arrested or retarded the development of many adult cancers. Dr. Emil J. Freireich of the University of Texas Systems Cancer Center in Houston has said that drug combinations pioneered in pediatric cancers are now producing remissions in a majority of adults with acute myelogenous leukemia and a "proportion of these patients are being cured. Five years ago if you asked me if we were producing cures, I could only say, 'rarely'." Additional epecific examples include the development of and use of antifols in childhood leukemia which led to curative measures in adult cancers, specifically the use of antifols in women with choriocarcinoma; adjuvant chemotherapy in acute lymphocytic leukemia which is now being used successfully in adult Hodgkins disease, finally the total therapy concept used for childhood ALL is now being used successfully in cooperative study clinical trials involving adult lung cancers.

These applications of the results of research in pediatric and adolescent cancers underscores the importance of preserving, expanding and building upon the research efforts committed to childhood and adolescent cancers.

The proposal Candlelighters suggests would work toward a guarantee that all children with cancer will have ready access to the most expeditious, safe and effective care available as

measured by national standards, that all will have responsible primary physician - advocates, that no family will be economically constrained or burdened by the costs of care, that children's cancer research will proceed vigorously, and that physicians and nurses will be educated about children with cancer.

The consortium approach recognizes the three conventionally defined levels of health care:

Primary (Level I) - located in the child;s community, and providing home and outpatient/office health supervision with particular regard to growth and development, prevention of infectious disease, treatment of minor infections, liaison with school and community, and family counseling by professional and by peer group. This would be provided by a pediatrician, family practitioner, internist or pediatric oncologist.

Secondary (Level II) - The pediatric cancer care facility, usually connected with a children's hospital located close to the child's community and providing outpatient and inpatient care for the particular disease and its complications. This would include: administering anticancer drugs according to protocol; maintaining treatment records, and managing moderately severe infections, bleeding episodes, anemia, nutritional and metabolic disorders. This would be provided by a pediatric hematologist/ oncologist or a pediatrician with additional training or experience in pediatric oncology. Also, this facility should provide access to childlife specialists, psychosocial support by professional or peer group as well as undertaking an education program directed

to medical and nursing students, graduate traineees, and practitioners.

Tertiary (Level III) - A regional children's cancer center. This would be accessible to provide confirmation or correction of initial diagnosis, subcategorization and staging, complete evaluation of the child's needs, through discussion among team members and with child and family, assigment to protocol study with consent of child and parents, initiation of therapy, conduct of any Phase I experimental treatment, basic and clinical research relevant to children's cancer, and training of oncologists in research and practice. The child and/or his specimens and findings would be periodically sent to the center for reassessment, change in therapy, investigative studies not available at the seconday level and documentation of disease course.

Secondary care persons might provide primary care as well, and tertiary regional centers could provide primary and secondary care also. This would be decided in accordance with the residence of the child, the particular cancer and its treatment, and the wishes of the child and family.

For child and adolescent patients not actively participating in a research program, a comprehensive registry of the data for childhood and adolescent cancer should be established. These patients could thus effectively participate in the research effort by providing data on effectiveness of treatment, toxicity of therapy and long term effects of childhood/adolescent cancer. Further the cancer center and secondary care level should provide strong outreach services to the community physician. It goes without saying that due to the profile of pediatric cancer in this country (17% of all cancers) consortium treatment with its care

and cost benefits requires that adequate transportation funds must be provided for those who must travel great distance for treatment.

Finally, Candlelighters is concerned that the results of cancer research be disseminated as promptly and effectively as possible. To this end, the National Institutes of Health or its designates should be responsible for technology transfer with respect to the research it funds.

Okay, to give you a little bit of background of how I got into the financial area, our daughter was diagnosed with cancer in October, 1972, and when the doctor got through telling us about it and I got back to the room and I found out she hadn't died, she was still there, it was only half an hour later, and I got over the initial shock, then I started thinking, how expensive is it? And no one could say except, it's expensive, it is devastating. Well, what does that mean?

We were building our new house at the time, and all I could think of, we are going to lose Kathy and we are going to lose our house. How are we going to stand them both? Unfortunately, eight months later, Kathy died. We did not lose our house, but I lost my draperies, and I lost the carpeting, and I lost my china.

When I got into this after collecting the data I found out where my draperies and carpeting went to, so Karen, if we could have the lights, please. Can you all hear men?

VOICES: Yes.

MS. BLACK: I will quit shaking in a minute, and I am going to read it word for word to make sure you get all of it, because I put a year and a half of work into this data, and I want you to hear it all.

At the University of Kansas Medical Center, we have been investigating the stress the illness imposes upon various family

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members. The financial burden of the illness has emerged as a major source of distress, second only to the disease itself. Of the financial concerns, non-medical costs appear to be the most troublesome. Most patients have at least some third party coverage of medical expenses, and can usually arrange instalment payments for the residual medical costs.

In contrast, the non-medical expenses must be paid as they are incurred and are rarely reimbursed. Despite the recent interest in the high cost of cancer care, there has been little attention to the non-medical out of pocket expenditures. In view of the importance of this issue as reported by our patients, we conducted a pilot study in which six families of children in treatment for cancer reported their non-medical expenses and loss of pay for four consecutive weeks. Half the people spent at least $453.74, including loss of pay and expenses. The result of this pilot study indicated far greater expenses than anticipated and found in a current study.

Parents of children in treatment for cancer by the pediatric hematology section of the University of Kansas Medical Center participated in the study. Families were recruited for the study during a clinic visit or hospital stay. To date, data from 70 families has been collected. This group represents approximately one-half the patients seen for active treatment and or follow-up. Eighty-two percent of those asked have participated in the study. The study population included

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70 family units ranging from three to seven persons with an average of 4.7. Of the 62 families with a father present, 60 fathers were employed and one was retired. Thirty-six of the mothers were gainfully employed outside the home. Half the families had an income of $13,000 or more. The parents ranged in age from 21 to 53 years, with medians of 34.5 and 36.5 years respectively for mothers and fathers.

The patients consisted of 24 girls and 46 boys. Their average age at the time the data was collected was nine years, ranging from less than one year to 18 years. Half the patients had been diagnosed at least nine months. Diagnosis included leukemia, lymphoma, sarcomas, and a variety of other solid tumors. Approximately half of the families were located less than 55 miles from the hospital, but 12 families lived at least 165 miles away.

We asked our parents to complete two questionnaires. The first was a weekly log of non-medical expenditures related to the child's illness. The data was categorized into the same type of expenses as recorded in the pilot study. One was food, and it was extra food brought to the patient, food eaten out or quick preparation food bought for the convenience of family members at home.

Two, lodging for parents while the child is hospitalized. Three, transportation to and from the Medical Center, and this included their parking and their toll fees for

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the expressway. Four, family care, care for siblings while the parents were at the Medical Center with the patient. Five, clothing, the extra clothing bought because of the patient's weight gain or loss, and of course the wigs. Six was miscellaneous expenses, and they included telephone calls to keep distant relatives informed of the child's condition, a room air conditioner brought to ease the discomfort of the patient, or gifts for the patient and or siblings left at home.

Parents also recorded the patient's hospital status, which was the level of care the patient required during the week for data collected. Categories were, one, in-patient treatment, which is hospitalization; two, out-patient treatment; three, no treatment; and four, the change in status from in-patient to out-patient or vice versa.

The patient's performance status was obtained from parental interviews during each week of data collection. A performance scale score was assigned based upon the following modified theories of Karofsky's scale of performance status. The first one was, requires the equivalent of hospital care, unable to care for himself. Two is, unable to go to school, but able to live at home and care for most personal needs. Three, was able to carry out normal activities, no special care needed.

The secondly weekly log, which was completed separately by mothers and fathers, concerned the loss of pay. Items covered include usual paid working hours per day, hours of paid work

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missed, explanation of missed hours as sick leave, vacation, or other, number of hours and amounts of money paid to a substitute worker, actual money lost during the week of the illness, total family income. They also asked mothers how much work they usually did unpaid, and they gave us at least ten hours a day for housework, and I thought that was neat of them.

The loss of pay found was added after collection of expense data was under way, and therefore we only had 32 families who reported loss of pay. Many of the measured expenses are directly tied to contacts with the hospital for evaluation or treatment. In order to avoid seriously inflating cost figures by repeatedly sampling weeks when patients were seen at the center, the following method was used to sample an average week.

One-third of the participants were asked to record expenses beginning one week after they were contacted. A third were asked to begin in two weeks, and another one-third were asked to begin on the day we contacted them. Each family was asked to record expenses for the period of one week every three months or six months, sometimes by the time I got back to them. We wanted to know what makes a difference in these expenses. We found out. We used a complicated statistical technique called multiple linear regression. This type of analysis allows one to ascertain the major factors included in cost, so that the total expenses for a family can be estimated or predicted on the basis



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of a limited amount of information.

Variables to be predicted were the average family expenses in each category, transportation, food, lodging, clothing, family care, and miscellaneous, and the average total non-medical expenditures. The factors we thought might influence cost were sex, age, parental occupation, income, family size, residence, as well as information about the patient's illness, level of care performance status, time since diagnosed, number of body sites of active disease.

Summary statistics were also computed from the data on the loss of pay questionnaire. The non-medical, out of pocket expenses were then added to the loss of pay to yield a combined expenses for those families completing both questionnaires. These combined expenses were expressed as a percentage of the weekly family income. The non-medical out of pocket expenses are presented on the next slide.

Half of our families had weekly expenses of $39.70 or more. The largest category of expenses were transportation, food, and miscellaneous items. There are considerable variations in the expenses borne by these families as is readily apparent from the large standard deviation and wide range. Four factors, the level of care, performance status, family size, and distance from the hospital, have a strong influence on expenses.

Not only is it possible to predict the total expenses, you can also estimate with some accuracy the magnitude of some

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of the larger expense categories. For example, transportation costs can be estimated by level of care, distance from the hospital, and family size. Food expenses are predictable from the level of care age at diagnosis, and distance to the hospital. Miscellaneous expenses, another large part of the total, as well as the smaller categories of clothing and family care, are more difficult to predict.

The level of care was the most important factor for each category of expense. The next slide gives the total expenses for each level of care. Families of children who were hospitalized for the entire week of data collection had the highest non-medical expenses, followed by those whose children spent part of the week as in-patients. Out-patients and children who had no contact with the Medical Center during the week had relatively fewer expenses.

The results of the loss of pay questionnaire are shown here. Half of the 32 families who responded reported no loss of pay. The rest of the families had significant losses. Half lost at least $68.94. The other expenses for these 32 families were similar to those of the entire sample. When the loss of pay data were added to the out of pocket expenses, half of the family had weekly combined expenses of at least $88.20. My draperies just left.

Another way of looking at this figure is that with half the families, the combination of expenses and loss of wages



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represented more than 25 percent of their weekly budget. The average for the whole group was closer to 50 percent of the weekly budget, as you can see on the slide, and this again is for non-medical expenses. This slide shows what the medical expenses should be for an average family, according to a recent article in the New York Times. The average family should spend around 5 to 6 percent for all of their medical expenses. Our families are spending closer to 25 percent of their family budgets for non-medical expenses incidental to the illness of only one person in the family, and we haven't even looked at the medical expenses yet.

The results of the present study demonstrated that the out of pocket, non-medical expenses associated with pediatric cancer are sizable and can represent a significant percentage of a family's total budget. The data not only indicated the magnitude of these costs, but shed light on the factors which contributed to increased expenditures.

For obvious reasons hospitalization, as opposed to outpatient treatment or no contact and distance from the treatment center were associated with higher expenses. As the disease progressed, expenses increased. Costs also increased with family size. The more children in the family, the greater the expense of caring for them in the parents' absence. These data deal with the out of pocket costs and loss of parents' wages when a child has cancer. These costs and losses of income are in

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addition to the financial burdens of the cost of medical treatment which far outweighs non-medical costs. While most families have some third-party coverage, virtually none are covered for all medical costs. When the leftover medical costs are augmented by non-medical expenditures and the family suffers a loss of income at the same time, the result is devastating financially.

An illness should be considered catastrophic if it costs more than 15 percent of the yearly gross family income, that is $50 per each family member. We have demonstrated that the out of pocket costs plus loss of pay have averaged considerably to it, more than the 15 percent. For half of these families, the figure was over 25 percent.

This economic impact has added a significant burden to the family's overall distress when confronted with the uncertainties of cancer in their child. Clearly, no families can pay for this kind of financial assault. Some are forced to make treatment decisions on the basis of financial hardship and all fear this eventuality. Many will be faced with the possibility of bankruptcy when they are trying to assure the best care available.

Even when the financial hardship is less extreme, it has long-lasting negative effects on all members of the family. Because of the depletion of resources over an extended period, parents and siblings are deprived of basic needs as well as luxuries because such a large portion of the family budget goes toward care of the sick child. There are only limited funds



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available to assist with non-medical, out of pocket expenses. The Leukemia Society of the American Cancer Society has been forced in the past year to limit funds to families for transportation and drugs.. In some areas there are other private funds, but no resources for most patients' families. There are no simple solutions for the financial plight of our families. Even the best social work services and financial counseling cannot locate resources where none exist.

There is hope that some of the forthcoming health care legislation will begin to deal with the medical costs of catastrophic illnesses. Clearly, non-medical, but disease related out of pocket costs need similar attention. Thank you for letting us share our research project with you.

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# National Health Insurance in Canada

Health Insurance Association of America

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This paper was prepared for the Health Insurance Association of America by Theodore Allison. It is an expanded and updated version of a paper presented at the 1977 Annual Meeting of the American Risk and Insurance Association. Mr. Allison, a member of the HIAA Technical Advisory Committee, is Assistant Vice President, Metropolitan Life Insurance Company.

In the current public discussion of national health insurance proposals, there are frequent references to the Canadian system. Some suggest that it might be a model for the United States to follow. While the public's interest is rising, the level of knowledge about the Canadian system remains low. This paper describes the operation of national health insurance in Canada and measures its performance in comparison to the health care system in the United States.

National health insurance in Canada refers to two separate government programs. One program provides for prepaid hospital care and the other for prepaid physicians' services. Both programs are financed jointly by the federal and provincial governments. The federal legislation establishing these programs is the Hospital Insurance and Diagnostic Services Act, which became effective July 1, 1958, and the Medical Care Act, which took effect ten years later. The provinces are responsible for program administration and development. To qualify for federal contributions, each province must meet federal standards with respect to basic hospital and medical services.[1]

By 1961, all of the provincial governments had entered into agreements with the federal government, which pays approximately half the cost of provincial programs to provide general hospital care in standard ward accommodations for the population.[2] By 1972 all the provincial governments had agreed to establish medical care insurance programs, known as Medicare. To receive federal contributions, these provincial plans must provide unlimited coverage for appropriate physicians' services to eligible residents, on uniform terms and conditions, regardless of age, income, or health status.[3] Provinces may provide additional benefits, without federal subsidy.

The popular impression in the United States that Canada has a single national health insurance program covering the entire range of needed health care services for all citizens without cost to the individual at the time of treatment is erroneous. Rather than a single program, there are 10 provincial and 2 territorial hospital and medical care insurance programs. These differ in benefits, financing arrangements, and administration.

## Benefit Variations

None of the various benefit packages covers all needed services. Coverage under the provincial plans is provided for all medically necessary basic hospital and physicians' services.[4] Inasmuch as reimbursement for hospital coverage is at the public ward level, patients who wish semi-private or private accommodations must either supplement the mandated coverage with private insurance, or pay an extra charge. Among the more significant health care services and supplies which most of the provincial health insurance programs do not cover, or cover for only certain classes of people, are dental care, outpatient prescription drugs, nursing home care, eyeglasses, hearing aids, and medical appliances.[5]

In three provinces patients share the cost of hospital services at the time they are rendered. In British Columbia, the hospital copayment is $4 per day. In Alberta, the copayment is $5 for the first day; for long-term cases, copayment is $4 per day in auxiliary hospitals after 120 days of care. In Quebec there is a $6 daily copayment for patients age 18 or over in prolonged care units.[6]

There is no direct copayment for physicians' services in the provincial plans. However, some physicians bill patients directly for the difference between their fee and the authorized reimbursement from the provincial plan, thus introducing an element of cost-sharing.[7] When provincial plans include benefits for services provided by practitioners other than physicians, they generally stipulate limits in terms of the number of visits to be covered and/or the maximum payment to be made.[8] Patients, therefore, may be required to make an additional out-of-pocket payment for these covered services.

Services reimbursable under workmen's compensation legislation or acts of the Canadian government affecting veterans, seamen, the Royal Canadian Mounted Police, and others, are not covered.[9] Provincial social assistance programs provide to the eligible needy (i.e., determined by means test) certain health care services not covered by provincial hospital and medical care plans. The federal government contributes to these social assistance programs under the Canada Assistance Plan.[10]

## Financing

General revenues, derived from federal and provincial income taxes and provincial sales taxes, are a major source of financing for the provincial hospital and medical care insurance plans.[11] In addition to taxes, premiums for provincial hospital insurance and/or medical care

insurance programs are collected in 3 provinces and 1 territory, in which 55 percent of the total population reside.[12]

### Administration

At the federal level, the Health Insurance and Resources Directorate is responsible for administering the laws and regulations that govern the provincial programs.[13]

The Hospital Insurance and Diagnostic Services Act eliminated any possible role for private organizations in operating the provincial hospital insurance plans.[14] This responsibility is carried out through either the provincial health agency or a separate public commission. Each hospital must submit a budget in advance of the budget year, for review and approval by the provincial authority, which sets all per diem hospital rates. The hospital receives from the provincial agency reimbursement for its approved costs for the year, with slight adjustments upwards or downwards for days of service in excess of or below the original estimates.[15]

The Federal Medical Care Act does permit provincial authorities to designate carriers as agencies to undertake restricted functions on a nonprofit basis. Carriers may act as mail drops and check writers, forwarding premiums to provincial authorities and paying doctors' accounts for insured services. However, claims review and the decision on how much to pay are made by the public agency. In British Columbia, Saskatchewan, and Nova Scotia, insurance carriers are retained to perform limited functions on a non-profit agency basis.[16]

Medicare payments are based on fee schedules drawn up by each provincial medical association and negotiated with the provincial government. In most provinces the plan's payment is between 85 and 90 percent of the fee schedule. A physician has the choice of dealing directly with the provincial plan and accepting the plan's payment as payment in full or "opting out" and billing his patient directly, often, as indicated earlier, for more than the provincial plan pays.[17]

### Private Health Insurance in Canada

More than 1 of every 2 Canadians have private health insurance to supplement the government plans. The most common coverage offered by insurance companies is known as Extended Health Care. These policies provide payments for a wide range of health care expenses, such as ambulance service and private duty nursing. Most policies also cover charges for non-ward hospital accommodations

and prescribed drugs. In addition, there are policies for supplementary hospital benefits, drug expenses, or dental coverage.[18]

At the end of 1976, approximately 6,921,000 persons had coverage under Extended Health Care policies, with most of them also entitled to hospital benefits. These individuals, added to those covered by Supplementary Hospital policies, brought to 8,601,000 the total number of persons insured against extra charges for non-ward hospital accommodations.[19] To these should be added the 5 million subscribers to the five Blue Cross plans, which cover care in semi-private hospital rooms.[20] More than a third of a billion dollars is spent annually on private health care expense insurance in Canada. Insurance company health care premium income in 1976 totaled $212.6 million.[21] During the same year, the Blue Cross plans received more than $140 million earned subscription income.[22]

### Effects of National Health Insurance

"Though some informed persons have contended that a national health insurance program, with public administration, can provide a powerful administrative mechanism for controlling costs and improving the economy of the health care system, the Canadian experience cannot be cited as an illustration."

> —From the Conclusions of the 1974 symposium conducted by the Sun Valley Forum on National Health

The principal objective of the Canadian national health insurance system is to improve access to good quality care by eliminating financial obstacles for the patient. Initially, cost containment was not a major objective.[23] Now, however, rising health expenditures are of great concern.[24]

Not only has national health insurance exacerbated problems of health care costs, but this and related government programs have created other problems in the health care delivery system. These include excess hospital facilities, high utilization of services, and overspecialization and maldistribution of physicians.[25] In 1974, Marc Lalonde, then Minister of National Health and Welfare, listed several "difficult problems facing those with responsibilities for providing health care services." Among these were the following:

"1. The annual rate of cost escalation has been between 12% and 16%, which is far in excess of the economic growth of the country . . : .

"2. The past twenty years have seen an emphasis on the construction of hospitals and not enough on other needed health

care facilities. As a result, Canada now finds itself with an excess of expensive acute care beds . . . .

"3. Medical services are not yet equally accessible to all segments of the population because health manpower tends to concentrate in cities and is not attracted to rural or isolated locations.

"4. Dental services are not equally accessible to all segments of the population, mainly because of the cost to the patient of dental care, shortage of dental professionals, as well as a maldistribution of available dental manpower.

"5. Present organizational arrangements for providing health care services could be improved to more satisfactorily meet the needs of the population."[26]

These problems are similar to those affecting the health care delivery system in the United States. It is fair to say that almost two decades of national health insurance in Canada generally have not solved, and in many cases have intensified, the health care delivery problems common to both countries. The solutions now sought in Canada are also similar to those advanced in this country, including greater emphasis on ambulatory care, community health planning, and incentives to encourage better distribution of health manpower.[27]

There is one significant difference. In the United States the development of prepaid group practices, or HMOs, is encouraged as a means of containing costs and maintaining quality. Dr. Eugene Vayda of McMaster University, in the May 1977 issue of *Medical Care*, writes that capitation-prepaid group practices "face a bleak future" in Canada.

With tax-financed universal health insurance, members of prepaid health plans may be reimbursed for care rendered by any provider, and utilization of out-of-plan services is substantial. Lost, consequently, are the incentives for economy present in an HMO, where physicians are at risk for the total care of members and the latter must pay extra for out-of-plan services.

Moreover, capital funds for prepaid group practice plans are not available in Canada. As Dr. Vayda reports: "Governments are preoccupied with paying the increasing service costs of the insurance program and have not allocated capital or start-up funds for new programs. In one instance, when funds were committed for a proposed prepaid plan in Ottawa by one Minister of Health, they were withdrawn by his successor."[28]

## Performance of the Public Health Insurance Plans

There are those who argue that a health insurance system funded and administered entirely by the government will be more efficient and less expensive to operate than a pluralistic system involving private insurance companies. The cost of a health insurance program breaks down essentially into two components—the cost of claims, which is the major part, and the cost of administration. Claims costs are the product of *utilization* and the *cost* of health care services. Through careful claims review, private carriers can be quite effective in detecting and discouraging excess utilization of services.

The carriers can exercise far less control, however, over the cost of services. Charges in excess of those which are reasonable and customary can be denied, but the factors underlying the steady inflation of medical care prices are generally beyond the control of private carriers.

In theory, government should be able to control both utilization and the cost of services. Yet, in reality, the Canadian governmental health insurance programs have failed to control utilization, costs, and total health care expenditures, all of which have risen more rapidly than in the United States.

## Utilization

In the 16 years in which the provincial governments have operated public hospital insurance programs, hospital utilization has been consistently higher in Canada than in the United States. In 1975, the last year for which comparable data are available, both the admission rates and average length of stay in non-federal hospitals were higher in Canada. The days of care per 1,000 population were 1,284 in the United States and 1,830 in Canada, which represents a substantial difference of nearly 43 percent. (See Table 4 in the Statistical Appendix.)

Specific data on the quantity of physicians' services in Canada are not available. An analysis by Robert G. Evans, an economist at the University of British Columbia, reveals that from 1957 to 1971 there was an estimated increase of 5.9% per year in the quantity of physicians' services per person.[29] From 1970 to 1971, the first year when all but the Yukon Territory had established a provincial program of medical care insurance, the per capita increase in the quantity of physicians' services was 16.4%.[30]

Although government negotiation of fee schedules has kept physician fee escalation in step with general inflation, the government program has failed to curb patterns of utilization leading to higher total expenditures.

This failure has been recognized by government spokesmen. In 1976, William A. Mennie, the Director of Health Economics and Statistics in the Canadian Department of Health and Welfare, said, "Provincial health authorities establish the payment schedule, but have interfered minimally with the unit definitions and relative values of different items as determined by the professional associations which retain control over the fee schedule in each province. There is a tendency toward multiplying the units of care, and altering the mix of procedures in favor of high cost items."[31]

### Cost of Services

Data on the expense per patient day in non-federal short-term hospitals clearly reveal that the Canadian government health insurance programs have no unique capabilities in controlling the cost of producing health services. This figure rose at an annual rate of 11.1% from 1962 to 1974. During the same period, expense per patient day in the U.S. rose at an annual rate of 11% (Table 3).

### Total Expenditures

Rapidly rising utilization of health services and substantial inflation in the hospital sector have resulted in increased total expenditures alarming to government officials. This led to legislation in 1977 which places a limit on the federal government's contribution to the provincial programs, thereby shifting responsibility for cost containment to the provinces.

From 1960 to 1975 — years in which the hospital insurance programs have been in effect — per capita expenditures for hospital care rose 424% in Canada. The increase in per capita hospital expenditures in the U.S. during the same period was 382%. From 1970 to 1975, when government medical care insurance programs were in virtually all provinces, per capita expenditures for physicians' services rose 71.4% in Canada. In the U.S. the increase was 65% (Table 2). The rise in per capita total expenditures on health from 1960 to 1975 was 319% in Canada and 311% in the U.S. (Table 1).

Gross National Product (GNP) also rose more rapidly in Canada — 331% from 1960 to 1975, compared with 204% in the United States. As a result, while the percentage of GNP devoted to health was approximately the same in both countries in the early 1960s, over time Canadian health expenditures took a relatively smaller portion of a more rapidly growing GNP. By 1975, health expenditures were 6.9% of GNP in Canada and 8.5% of GNP in the United States (Table 1). It must

be emphasized that this reflects a differential in the growth rate of GNP rather than in the rate of increase in health expenditures.

The Canadian government officials have succeeded in keeping the increase in physicians' fees within reasonable bounds and they have been deeply involved in the fiscal operations of the hospitals. Nevertheless, they have failed to control total health care costs. In administering a service program, a governmental agency is likely to be more sensitive to the political repercussions of applying constraints against consumers or providers than to the economic effect of failing to contain costs.[32] To deny payment for a questionable service adversely affects both the patient and the provider directly; to permit it affects them only indirectly through taxes. Cost containment forces which are missing in a tax-supported program administered by a single governmental agency are (1) the direct concern with costs of employers and individuals who pay the bills, and (2) the competition among carriers which is an inherent part of a pluralistic system.

### Administrative Costs

One might expect that administrative costs would be low for programs which offer standard benefits throughout a province, have automatic or mandatory enrollment in most provinces, pay physicians on the basis of negotiated fee schedules, and reimburse hospitals on the basis of pre-budgeted amounts. However, the proposition that the Canadian program is significantly less expensive to administer is as difficult to prove as it is to disprove. This is so because it appears that no one knows with any degree of precision what the administrative costs of the program actually are.

In 1976, the Director General of Health Insurance reported that "In 1973 the combined administrative costs of the public Hospital Insurance and Medical Care insurance plans in Canada, including the federal costs of administering its share of the program, came to $107,285,000 out of an overall cost of $4,384,332,000. From this you will note that the administrative costs came to 2.51% of the total costs."[33] Overlooking the fact that the figures cited yield an expense ratio of 2.45% rather than 2.51%, the data are further open to question because they are incomplete. The data do not include the expenses of branches of the Health and Welfare Department, other than the Health Insurance Directorate (as it was then known), which are involved to some degree in the health insurance programs. Furthermore, the federal government's data exclude administrative costs for hospital benefits ineligible for federal cost sharing and for some medical

insurance benefits, and the cost of collecting taxes to finance the programs.

Also, it is not known whether the cost figures include other expenses such as fair rental value of government buildings, depreciation of equipment and capital goods, security personnel, and other services often omitted from government accounting.

A former Director General of Health Insurance for the Canadian system, K. C. Charron, M.D., has indicated that administrative costs do not exceed 5%.[34]

It is interesting to compare this estimate with the administrative costs of the Government-Wide Indemnity Benefit Plan which provides comprehensive benefits for 472,500 employees of the United States Government and their families. This program is underwritten and administered solely by private health insurers. It covers a broader range of benefits than the Canadian programs and must utilize more complex methods of reimbursement. Nevertheless, in fiscal year 1977 its administrative expense ratio was 3% plus the carriers service charge of .5%. The total, exclusive of taxes, was 3.5%.[35] In addition, the Government retains 1% as a reserve from which are paid the administrative expenses which it incurs.

In Canada, an additional cost — not generally recognized in discussions of that country's system — is the public's widespread purchase of private insurance to fill in the gaps not covered by the provincial plans. More than one of every two Canadians have private health insurance to supplement the government plans. This leads to an uneconomic use of health insurance dollars, because separate administrative mechanisms must be maintained. Claims, for the most part, are relatively small because they supplement benefits of the public program. Consequently, expenses of claims processing and other administrative functions are disproportionately large in relation to benefits paid.

When these facts are considered, it may fairly be said that public administration cannot be shown to have effected significant reductions in administrative costs for the Canadian national health insurance program below those which might be expected for a comparable private health insurance program in the United States.

### Patient Cost-Sharing

Whether patients should participate in the payment of the cost of health care services provided to them is one of the controversial issues in national health insurance. With varying degrees of success, many countries have been operating under some form of a national health

care program for several years. As reported by the Social Security Administration's Office of Research and Statistics: "Virtually all countries with national health schemes provide for at least a small degree of cost sharing by the patients, usually introduced on the assumption that over-utilization can be discouraged by such charges. As a result the patient either pays a part of the cost of services to the provider or to the social security agency; or, alternatively, he may receive less than full reimbursement for expenses he has incurred. Even under the direct-provision method, with its emphasis on basically free medical services to the whole population, patients are generally required to pay a small fixed fee per medical treatment, prescription, or day of hospitalization."[36]

This is also true of Canada. Although the Federal government is philosophically opposed to cost-sharing, provincial hospital insurance plans covering one-fifth of the population do require cost-sharing for some covered services.[37] Additionally, inasmuch as the provincial plans provide hospital coverage for ward care only, patients who wish semi-private or private accommodations must pay an extra charge. In 1974, 38% of the beds in public, private and Federal active treatment hospitals were in semi-private or private accommodations, and hence were not available without extra charge to residents covered only by the provincial plans.[38]

As indicated earlier, while there is no direct co-payment for physicians' services in the provincial medical care plans, the practice of "extra-billing," that is, charging more than the plan allowance, introduces an element of cost-sharing. However, it appears that the incidence of "extra-billing" is relatively low.[39]

Because of persistent cost escalation, Canadian government representatives are considering the possibility of increased patient cost-sharing. In an account of HEW Secretary Califano's visit to Canada to study the health insurance system, the September 26, 1977 issue of *Washington Report on Medicine and Health* states, "Canadian officials told Califano they are thinking of imposing a 'deterrent' fee, essentially a coinsurance payment, as a brake on overutilization."[40]

Any national health program must promote the efficient use of medical resources. Insurance has the effect of making medical care seem less costly to the consumer. The individual, therefore, has an incentive to purchase more medical care and to choose more costly forms of care than would have been the case without such coverage.

Cost-sharing arrangements are a reasonable method of discouraging overutilization of medical care services. Such mechanisms are flexible; an appropriate income-related, out-of-pocket limit can be

devised that promotes the objective without creating economic hardship.

In 1977, a series of articles on the Canadian health system, written by two analysts from McKinsey & Co., appeared in *The Financial Post* (Toronto). The second article of the series, entitled "Misuse is the Name of the Game", said in part:

> "Health insurance programs, while removing financial barriers, have also removed the incentive for the consumers to accept responsibility for their own health and to use the system wisely. Today, there is no financial reason for individuals to find out what is the most appropriate treatment and to use it only as necessary. Hospital administrators and physicians regularly cite instances of anxious patients seeking diagnoses from several doctors, or admission to several hospitals simultaneously. Doctors also say patients — free from any cost constraints — frequently demand more diagnostic tests or hospitalization although they are told these are not medically necessary or warranted."[41]

### Public Satisfaction

A Gallup poll of Canadian attitudes toward public services conducted in the fall of 1976 found that 84% of Canadians approved the national health insurance program.

A survey of attitudes in the United States toward health care conducted in June 1977, by the social science research firm of Yankelovich, Skelly, and White, Inc., found that over 80% of the public is satisfied with the quality of its health care and health insurance coverage. The same survey showed that only 19% feel a national health program should be run by the government alone. Perhaps all that can be deduced from such polls is that access to health care of good quality is reasonably comparable in both countries. Given this, the vast majority of the public is satisfied.

### Hospital Facilities and Physician Supply

In both the United States and Canada, government programs for hospital construction contributed to an excess supply of hospital beds. These programs were Hill-Burton in the United States and Canada's National Health Grant Program. Overbedding is more severe in Canada than in the United States. In 1974, there were 5.5 beds per 1,000 population in acute care general hospitals in Canada. The comparable figure for community hospitals in the United States was 4.4 per 1,000 (Table 5).

A number of provinces are now trying to lower the bed-to-population ratio. Some small hospitals are being closed — a difficult thing to do, politically. In larger hospitals, beds are being removed from service or acute care beds are being shifted to alternative uses.[42]

The hospital planning guidelines vary by province.[43] In most provinces, the optimal bed supply goals are higher than in the United States. As long as Canada maintains its bed supply at or above these target levels, hospital utilization will almost certainly remain higher in that country than in the United States.

A substantial increase in the number of physicians accompanied the introduction of Canada's medical care insurance plans. The Health Resources Fund Act of 1965 contributed to this by making $500 million available to build or expand health training facilities. Announcement of the government's intention to implement a universal medical care insurance program is also believed to have stimulated an increase in the number of graduates of Canadian medical schools.[44]

Earlier, the introduction of the hospital insurance plans intensified a trend toward medical specialization because salaries of interns and residents were covered under the program, thus making it affordable for more students to specialize. Increased specialization, in turn, led to greater concentration of physicians in urban areas.[45]

As a result of these developments, Canada has a large and growing supply of physicians, with a surplus in certain specialties and geographic areas. The physicians are unevenly distributed by geographic region. In 1973, while there was one active physician for every 575 residents in British Columbia and one for every 585 in Ontario, there was only one physician to serve 1,310 persons in the Northwest Territories and one for each 1,100 persons in the Yukon and Prince Edward Island.[46]

The objective in Canada is to have one active physician for each 600 people. To meet this objective, Canadian medical schools will in the future graduate at least 1,900 physicians a year, up from 1,561 in 1974.[47]

In the light of this proposed increase, it is provocative to consider the words of the Deputy Minister of Health and Welfare, Maurice LeClair: "(T)he most important determinant of total health cost is the number of physicians practicing in the system. The costs attributable to physicians are not only their remuneration but also a sum, greater in amount, reflecting expenditures elsewhere in the system which result from their professional decisions. The physician decides admission to hospital, duration of stay, the use of diagnostic and therapeutic procedures, prescription of drugs, referral to specialists and the pattern

of further examinations. These services together probably represent 80 percent of health costs. In the absence of financial barriers to physicians' services, both the volume of services rendered and the cost per service tend to increase with the number of physicians in practice, contrary to the usual supply and demand relationships. As health economists have observed, the quantity of medical services delivered can be increased almost indefinitely by demands from the consumer and by expansion of the types of care offered by physicians. In a health insurance system with no direct financial burden on the patient, the only deterrents to seeking care are the time and trouble involved, and there is a large untapped reserve of 'beneficial' services which can be offered. A surplus of physicians, therefore, will increase the cost of health services without necessarily improving health."[48]

**FOOTNOTES**

1. Reference 1, pp. 1-2
2. Sylva M. Gelber, "The First Decade: Ten Years of Hospital Insurance," *Medical Services Journal, Canada,* October 1967; reference 1, p. 5
3. Reference 11, p. 1
4. Reference 4, p. 13
5. Reference 9, p. 28
6. Reference 13, pp. 11-15
7. Maurice LeClair, "The Canadian Health Care System," in reference 3, pp. 40-41, 55
8. Reference 5, pp. 333-350
9. The relevant Federal Statutes are listed in reference 11, p. 1
10. Maurice LeClair, *op. cit.*, pp. 29-30
11. *Ibid.*, pp. 32, 38
12. Alberta, British Columbia, Ontario, and the Yukon Territory
13. Reference 8, p. 2
14. Reference 5, p. 311
15. *Ibid.*, pp. 303-305
16. *Ibid.*, pp. 311-312
17. Maurice LeClair, *op. cit.*, pp. 40-41
18. Reference 7, Table 1
19. *Ibid.*, Table 7
20. "The Use of Hospitals by Members of Blue Cross Plans in 1973," Research Series 13, Blue Cross Association, April 1975, pp. 9-10; *The Blue Cross and Blue Shield Plan Fact Book 1977,* Blue Cross Association/Blue Shield Association, Chicago

21. Reference 7, Table 1. Data include premiums for Extended Health Care, Drug Expense, Supplementary Hospital, and Dental coverage only.

22. *The Blue Cross and Blue Shield Plan Fact Book 1977*, Blue Cross Association/Blue Shield Association, Chicago. Amount is understated, because data for 2 of the 5 Plans are unavailable.

23. Reference 3, p. 256

24. John I. Evans, President, The University of Toronto, in reference 3, p. 96

25. Reference 3, p. 261-262

26. Reference 2, p. 28

27. *Ibid.*, pp. 28-29

28. Eugene Vayda, "Prepaid Group Practice under Universal Health Insurance in Canada," *Medical Care*, May 1977, pp. 382-389

29. Robert G. Evans, "Beyond the Medical Marketplace: Expenditure, Utilization and Pricing of Insured Health in Canada," in reference 3, p. 159

30. *Ibid.*, p. 158

31. Reference 1, p. 8

32. A comment by H. L. Laframboise, Assistant Deputy Minister of the Canadian Department of Health and Welfare, at the University of Chicago's Sixteenth Annual Symposium on Hospital Affairs in May 1974, is relevant. He said, "When I say that the public demand for health care is an imperative, it is not something you can play around with, I am simply saying that if political or government people ever withdrew or made less available in a substantial way the things that Canadians are now receiving, there would be hell to pay from a political point of view, and one of the reasons that we have permitted the cost, or we have had to accept the cost escalation of 12 to 14 to 16 percent over an extended period of five years is that we have shown the people a promised land, and there is simply no way that we can abate it." In reference 10, p. 51

33. Letter from R. A. Armstrong, M.D., Director General, Health Insurance, Department of Health and Welfare, Canada, dated February 20, 1976, in reference 12

34. Reported in *Health Services Information*, June 20, 1977, p. 5

35. "Financial and Statistical Data, Fiscal Year 1977" (Preliminary), Bureau of Retirement, Insurance, and Occupational Health, U.S. Civil Service Commission, (n.d.) Table D-2

36. *Social Security Programs Throughout the World, Research Report No. 50*, Office of Research and Statistics, Social Security Administration, U.S. Department of Health, Education and Welfare, 1977, p. xvii

37. Reference 13, pp. 11-15

38. Data furnished by Statistics Canada in response to a request

39. Reference 5, pp. 313-314; reference 10, p. 89

40. In the past, introduction of patient cost-sharing provisions have often proved politically dangerous. "Private health insurance can provide a measure of control over the extent of services to be available by the tool of indemnity and/or fixed co-payment mechanisms. Governments find such fiscal devices almost completely untenable as already demonstrated in several Canadian provinces. Imposition of fixed co-payments

for either basic institutional or personal health care services by the governments of the day have been frequently followed by defeat of that government and either complete or substantial withdrawal of such mechanisms by the succeeding legislatures." Stanley W. Martin, Deputy Minister of Health of the Province of Ontario, in reference 10, p. 15

41. James E. Bennett and Jacques Krasny, "Health Care in Canada: A Series on the Nation's Health," reprinted from *The Financial Post*, 1977

42. Maurice LeClair, *op. cit.*, pp. 64-65, 77

43. *Ibid.*, p. 64

44. *Ibid.*, pp. 24, 74-75

45. *Ibid.*, pp. 56-57

46. W. S. Hacen and Jawed Aziz, "The Supply of Physicians in Canada," *CMA Journal*, February 22, 1975, p. 510

47. *Ibid.*, pp. 514-517

48. Maurice LeClair, *op. cit.*, p. 79

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3. *National Health Insurance: Can We Learn from Canada?*, edited by Spyros Andreopoulos, John Wiley and Sons, 1975. Proceedings of the 1974 symposium of the Sun Valley Forum on National Health.

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5. *National Health Insurance Resource Book*, U.S. House of Representatives Committee on Ways and Means, August 30, 1976

6. "Financing Health Insurance in Ontario," Ontario Budget, 1976

7. Canadian Association of Accident and Sickness Insurers, "1976 Survey of Health Insurance Benefits in Canada," 1977 (mimeo)

8. Annual Report of the Minister of National Health and Welfare on the Operation of Agreements with the Provinces under the Hospital Insurance and Diagnostic Services Act for the Fiscal Year Ended March 31, 1976, published 1977

9. Joseph G. Simanis, *National Health Systems in Eight Countries*, Office of Research and Statistics, Social Security Administration, U.S. Department of Health, Education and Welfare, 1975

10. *Government Involvement in Health Services Delivery: The Canadian Experience*, Proceedings of the Sixteenth Annual Symposium on Hospital Affairs, May 1974, University of Chicago, 1975

11. Annual Report of the Minister of National Health and Welfare Respecting Operations of the Medical Care Act for the Fiscal Year Ended March 31, 1976, published 1977

12. "Costs of Operating the Canadian Governmental Health Insurance System," unpublished memorandum of the Health Insurance Association of America, February 26, 1976

13. Annual Report of the Minister of National Health and Welfare on the Operation of Agreements with the Provinces under the Hospital Insurance and Diagnostic Services Act for Fiscal Year Ended March 31, 1976, published 1977



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## STATISTICAL APPENDIX

**TABLE 1 — Total Health Expenditures
United States and Canada, Selected Calendar Years**

**TABLE 2 — Per Capita Expenditures and Percent Increase for
Selected Components of Personal Health Care
United States and Canada, 1960 — 1975**

**TABLE 3 — Trend in Cost Per Patient Day in Non-Federal Short-Term Hospitals
United States and Canada, 1962 — 1974**

**TABLE 4 — Trend in Utilization of Care in Non-Federal Hospitals
United States and Canada, 1960 — 1975**

**TABLE 5 — Hospital Beds Per 1,000 Population in Non-Federal Hospitals
United States and Canada, 1962 — 1974**

### Table 1

### Total Health Expenditures
### United States and Canada, Selected Calendar Years

| Year | UNITED STATES | | | CANADA | | |
|---|---|---|---|---|---|---|
| | Total Expenditures | Percentage of GNP | Per Capita Expenditures | Total Expenditures | Percentage of GNP | Per Capita Expenditures |
| | (millions) | | | (millions) | | |
| 1975 | $130,771 | 8.5 | $601.16 | $11,372 | 6.9 | $498.09 |
| 1974 | 111,574 | 8.0 | 517.71 | 9,668 | 6.6 | 430.09 |
| 1973 | 100,264 | 7.7 | 468.21 | 8,303 | 6.7 | 375.28 |
| 1972 | 90,917 | 7.9 | 427.98 | 7,470 | 7.1 | 341.91 |
| 1971 | 81,294 | 7.7 | 386.11 | 6,887 | 7.3 | 318.92 |
| 1970 | 72,962 | 7.5 | 350.10 | 6,081 | 7.1 | 285.17 |
| 1965 | 40,468 | 5.9 | 204.61 | 3,352 | 6.0 | 169.57 |
| 1960 | 26,895 | 5.3 | 146.30 | 2,131 | 5.6 | 118.99 |
| | Percent Increase | | | | | |
| 1960-1975 | 386% | | 311% | 434% | | 319% |

SOURCE: *National Health Expenditures in Canada, 1960—1973,* Health and Welfare, Canada, April 1975; unpublished data furnished by Health and Welfare, Canada, July 25, 1977; "National Health Expenditures, Calendar Year 1974," Social Security Administration, Office of Research and Statistics, *Research and Statistics Note,* No. 5 — 1976; Robert M. Gibson and Marjorie Smith Mueller, "National Health Expenditures, Fiscal Year 1976," *Social Security Bulletin,* April 1977.

NOTE: Calendar year 1975 data for the United States calculated as the average of data for fiscal years 1975 and 1976.

## Table 2 — Per Capita Expenditures and Percent Increase for Selected Components of Personal Health Care United States and Canada, 1960—1975

| | United States | | | | | Canada | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Selected Components of Personal Health Care | | | | | | | | | |
| Years | Total | Hospital Care | Physicians' Services | Dentists' Services | Prescribed Drugs[1] | Total | Hospital Care | Physicians' Services | Dentists' Services | Prescribed Drugs |
| 1975 | $418.90 | $238.18 | $113.26 | $37.72 | $29.74 | $377.34 | $247.16 | $82.74 | $22.29 | $25.14 |
| 1974 | 359.52 | 202.00 | 96.09 | 32.99 | 28.44 | 320.48 | 206.90 | 71.62 | 19.80 | 22.15 |
| 1973 | 322.65 | 176.99 | 88.65 | 30.82 | 26.19 | 279.37 | 175.01 | 65.81 | 17.40 | 21.15 |
| 1972 | 292.46 | 161.05 | 80.45 | 26.47 | 24.49 | 254.71 | 157.68 | 62.66 | 15.06 | 19.32 |
| 1971 | 266.80 | 145.11 | 75.21 | 24.07 | 22.41 | 235.75 | 146.05 | 57.24 | 13.80 | 18.66 |
| 1970 | 243.59 | 131.69 | 68.65 | 22.79 | 21.46 | 210.42 | 132.53 | 48.26 | 12.33 | 17.30 |
| 1969 | 218.29 | 116.78 | 61.22 | 20.35 | 19.94 | 188.94 | 118.94 | 42.85 | 11.37 | 15.79 |
| 1968 | 192.97 | 102.44 | 54.36 | 17.98 | 18.22 | 169.61 | 107.00 | 38.01 | 10.23 | 14.33 |
| 1967 | 174.07 | 89.72 | 50.86 | 16.61 | 16.88 | 149.67 | 93.88 | 33.62 | 9.17 | 13.01 |
| 1966 | 154.50 | 77.89 | 45.77 | 14.82 | 16.02 | 133.80 | 83.24 | 30.19 | 8.80 | 11.57 |
| 1965 | 142.00 | 68.79 | 44.21 | 14.20 | 14.80 | 120.87 | 74.29 | 27.70 | 8.13 | 10.75 |
| 1964 | 133.65 | 65.04 | 41.31 | 13.56 | 13.74 | 109.82 | 67.28 | 25.65 | 7.65 | 9.24 |
| 1963 | 121.71 | 60.81 | 35.79 | 11.83 | 13.28 | 101.61 | 61.95 | 23.91 | 7.22 | 8.53 |
| 1962 | 115.19 | 56.16 | 34.24 | 11.77 | 13.02 | 92.74 | 56.63 | 21.82 | 6.53 | 7.76 |
| 1961 | 108.05 | 53.09 | 31.55 | 11.06 | 12.35 | 87.02 | 51.94 | 21.25 | 6.39 | 7.43 |
| 1960 | 103.14 | 49.46 | 30.92 | 10.75 | 12.01 | 80.53 | 47.18 | 19.82 | 6.12 | 7.40 |
| | Percent Increase | | | | | | | | | |
| 1960-75 | 311.2% | 381.6% | 266.3% | 251.0% | 147.6% | 368.6% | 423.9% | 317.5% | 264.2% | 239.7% |
| 1966-75 | 171.1 | 205.8 | 147.4 | 154.5 | 85.6 | 182.0 | 196.9 | 174.1 | 153.3 | 117.3 |
| 1960-65 | 37.7 | 39.1 | 43.0 | 32.1 | 23.2 | 50.1 | 57.5 | 39.8 | 32.8 | 45.3 |
| 1974-75 | 16.5 | 17.9 | 17.9 | 14.3 | 4.6 | 17.7 | 19.5 | 15.5 | 12.6 | 13.5 |
| 1973-74 | 11.4 | 14.1 | 8.4 | 7.0 | 8.6 | 14.7 | 18.2 | 8.8 | 13.8 | 4.7 |
| 1972-73 | 10.3 | 10.0 | 10.2 | 16.4 | 6.9 | 9.7 | 11.0 | 5.0 | 15.5 | 9.5 |
| 1971-72 | 9.6 | 11.0 | 7.0 | 10.0 | 9.3 | 8.0 | 8.0 | 9.5 | 9.1 | 3.5 |
| 1970-71 | 9.1 | 10.2 | 9.7 | 5.6 | 4.4 | 12.0 | 10.2 | 18.6 | 11.9 | 7.9 |
| 1969-70 | 12.0 | 12.8 | 12.1 | 12.0 | 7.6 | 11.4 | 11.4 | 12.6 | 8.4 | 9.6 |
| 1968-69 | 13.0 | 14.0 | 12.7 | 13.2 | 9.4 | 11.4 | 11.2 | 12.7 | 11.1 | 10.2 |
| 1967-68 | 10.9 | 14.2 | 6.8 | 8.2 | 7.9 | 13.3 | 14.0 | 13.1 | 11.6 | 10.1 |
| 1966-67 | 12.7 | 15.2 | 11.2 | 12.1 | 5.4 | 11.9 | 12.8 | 11.4 | 4.2 | 12.4 |
| 1965-66 | 8.8 | 13.2 | 3.5 | 4.4 | 8.2 | 10.7 | 12.0 | 9.0 | 10.6 | 7.6 |
| 1964-65 | 6.3 | 5.8 | 7.0 | 4.7 | 7.7 | 10.1 | 10.4 | 8.0 | 6.3 | 16.3 |
| 1963-64 | 9.8 | 7.0 | 15.4 | 14.6 | 3.5 | 8.1 | 8.6 | 7.3 | 6.0 | 8.3 |
| 1962-63 | 5.7 | 8.3 | 4.5 | 0.5 | 2.0 | 9.6 | 9.4 | 9.6 | 10.6 | 9.9 |
| 1961-62 | 6.6 | 5.8 | 8.5 | 6.4 | 5.4 | 6.6 | 9.0 | 2.7 | 2.2 | 4.4 |
| 1960-61 | 4.8 | 7.3 | 2.0 | 2.9 | 2.8 | 8.1 | 10.1 | 7.2 | 4.4 | 0.4 |

SOURCE: Robert M. Gibson and Marjorie Smith Mueller, "National Health Expenditures, Fiscal Year 1976," *Social Security Bulletin*, April 1977; "National Health Expenditures, Calendar Year 1974," Social Security Administration, Office of Research and Statistics, *Research and Statistics Note*, No. 5 - 1976; preliminary estimates received from Health Expenditures and Resources Section, Health and Welfare Canada, July 25, 1977; *National Health Expenditures in Canada, 1960-73*, Health and Welfare, Canada, April 1975; "National Health Expenditures, Calendar Years 1929-71, "Social Security Administration, Office of Research and Statistics, *Research and Statistics Note*, No. 3 - 1973 and unpublished data from Social Security Administration; *Prescription Drug Data Summary, 1972*, Social Security Administration, Office of Research and Statistics, DHEW Publication No. (SSA) 73-11900; *Expenditures on Personal Health Care in Canada, 1960-71*, Health and Welfare, Canada.

NOTE: Calendar year 1975 data for the United States calculated as the average of data for fiscal years 1975 and 1976.

**Table 3**

**Trend in Cost Per Patient Day in Non-Federal Short-Term Hospitals[1] United States and Canada, 1962-1974**

| | United States | | Canada | |
|---|---|---|---|---|
| Year | Expense per Patient Day Community Hospitals | Percent Increase | Expense per Patient Day Public General Hospitals | Percent Increase |
| 1974 | $128.05 | 11.8% | $93.23 | 14.6% |
| 1973 | 114.49 | 8.9 | 81.32 | 11.1 |
| 1972 | 105.09 | 13.8 | 73.17 | 11.6 |
| 1971 | 92.31 | 13.9 | 65.58 | 9.8 |
| 1970 | 81.01 | 15.7 | 59.74 | 11.2 |
| 1969 | 70.03 | 14.1 | 53.73 | 10.9 |
| 1968 | 61.38 | 13.5 | 48.44 | 11.6 |
| 1967 | 54.08 | 12.3 | 43.40 | 12.6 |
| 1966 | 48.15 | 8.3 | 38.56 | 13.2 |
| 1965 | 44.48 | 7.0 | 34.05 | 9.8 |
| 1964 | 41.58 | 6.9 | 31.00 | 8.5 |
| 1963 | 38.91 | 5.6 | 28.58 | 8.4 |
| 1962 | 36.83 | — | 26.36 | — |
| | Average Annual Increase | | | |
| 1962-74 | | 11.0% | | 11.1% |
| 1965-74 | | 12.5 | | 11.8 |
| 1962-65 | | 6.5 | | 8.9 |

[1]Such hospitals provide primarily for the diagnosis and short-term treatment of patients for a wide range of diseases or injuries.

SOURCE: *Hospital Statistics* 1971, 1974, and 1975, American Hospital Association; *Preliminary Annual Report*, 1973, Hospital Statistics, Statistics Canada; unpublished data from Statistics Canada, July 25, 1977.

## Table 4
## Trend in Utilization of Care in Non-Federal Hospitals[1] United States and Canada, 1960-1975

| | United States | | | | Canada | | | |
|---|---|---|---|---|---|---|---|---|
| Year | Admissions Rates per 1,000 Population | Days of Care Rates per 1,000 Population | Average Stay Per Admission | Occupancy Rate | Admissions Rates per 1,000 Population | Days of Care Rates per 1,000 Population | Average Stay Per Admission | Occupancy Rate |
| 1975 | 158 | 1,284 | 8.1 | 75.2 | 168 | 1,830 | 10.9 | 77.7% |
| 1974 | 156 | 1,287 | 8.3 | 75.7 | 173 | 1,870 | 10.8 | 78.9 |
| 1973 | 152 | 1,266 | 8.3 | 75.8 | 169 | 1,842 | 10.9 | 78.8 |
| 1972 | 148 | 1,247 | 8.4 | 75.6 | 168 | 1,860 | 11.1 | 78.7 |
| 1971 | 147 | 1,257 | 8.6 | 77.1 | 168 | 1,897 | 11.3 | 79.9 |
| 1970 | 146 | 1,286 | 8.8 | 78.3 | 165 | 1,880 | 11.4 | 79.6 |
| 1969 | 142 | 1,288 | 9.0 | 79.1 | 159 | 1,850 | 11.6 | 79.4 |
| 1968 | 139 | 1,272 | 9.1 | 78.5 | 158 | 1,846 | 11.7 | 79.7 |
| 1967 | 139 | 1,270 | 9.1 | 78.2 | 157 | 1,804 | 11.5 | 78.7 |
| 1966 | 140 | 1,217 | 8.7 | 77.2 | 153 | 1,794 | 11.7 | 80.4 |
| 1965 | 139 | 1,180 | 8.5 | 76.8 | 153 | 1,778 | 11.6 | 81.4 |
| 1964 | 138 | 1,179 | 8.5 | 77.1 | 153 | 1,762 | 11.5 | 80.8 |
| 1963 | 136 | 1,160 | 8.5 | 76.8 | 153 | 1,754 | 11.5 | 81.8 |
| 1962 | 133 | 1,135 | 8.5 | 76.1 | 152 | 1,722 | 11.3 | 82.3 |
| 1961 | 130 | 1,107 | 8.5 | 75.3 | 151 | 1,674 | 11.1 | 83.2 |
| 1960 | 130 | 1,101 | 8.5 | 75.9 | 148 | 1,640 | 11.1 | 82.0 |

[1]United States figures include all non-federal long and short term, general and other special hospitals except psychiatric and tuberculosis hospitals. Canadian figures include the same type of facilities but exclude privately operated (proprietary) hospitals, which in 1970 accounted for only 3.5 percent of non-federal beds, and which had above-average lengths of stay.

SOURCE: *Hospital Statistics,* 1976, American Hospital Association; *Preliminary Annual Report 1974-1975,* 1976, Hospital Statistics, Statistics Canada, *Hospital Beds* 1965, 1967 and 1972, Hospital Statistics, Statistics Canada; *Quarterly Estimates of Population for Canada and Provinces* 1968-1976, April 1, 1976, Statistics Canada.

## Table 5
## Hospital Beds Per 1,000 Population in Non-Federal Hospitals United States and Canada, 1962-1974

| | United States | | Canada | |
|---|---|---|---|---|
| | Non-Federal Hospital Beds Per 1,000 Population | | | |
| Year | Total[1] | Community Hospitals[2] | Total[1] | General Hospitals[2] |
| 1974 | 4.7 | 4.4 | 6.6 | 5.5 |
| 1973 | 4.6 | 4.3 | 6.4 | 5.4 |
| 1972 | 4.5 | 4.3 | 6.5 | 5.4 |
| 1971 | 4.5 | 4.2 | 6.4 | 5.4 |
| 1970 | 4.5 | 4.2 | 6.4 | 5.3 |
| 1969 | 4.5 | 4.1 | 6.3 | 5.3 |
| 1968 | 4.4 | 4.1 | 6.3 | 5.4 |
| 1967 | 4.4 | 4.0 | 6.2 | 5.3 |
| 1966 | 4.3 | 4.0 | 6.1 | 5.3 |
| 1965 | 4.2 | 3.9 | 6.0 | 5.1 |
| 1964 | 4.2 | 3.8 | 5.9 | 5.1 |
| 1963 | 4.1 | 3.7 | 5.9 | 5.0 |
| 1962 | 4.1 | 3.7 | 5.7 | 5.0 |

[1]See fn. 1 on Table 4
[2]See fn. 1 on Table 3

SOURCE: *Hospital Statistics,* 1972, 1975, American Hospital Association; *Hospital Indicators,* 1974, Hospital Statistics, Statistics Canada; *Hospital Beds* Volume 1, Years 1967-72, Hospital Statistics, Statistics Canada

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October 16, 1978

NATIONAL HEALTH INSURANCE AND
COVERAGE FOR LONG TERM OR
CATASTROPHIC ILLNESS

TO: Senator Edward M. Kennedy, Chairman
Subcommittee on Health & Scientific Research
United States Senate

FROM: The National Cancer Foundation, Inc. and
Cancer Care, Inc.

James P. Erdman, President
Irene G. Buckley, Executive Director

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Doris B. Nash, Public Affairs Associate

October 13, 1978

TO: Senator Edward M. Kennedy, Chairman
Subcommittee on Health & Scientific Research
United States Senate

FROM: The National Cancer Foundation, Inc. and
Cancer Care, Inc.

RE: National Health Insurance and Coverage for Long Term or Catastrophic Illness

We are most gratified that you have reopened the issue of a National Health Insurance program by holding hearings during the week of October 9, 1978, following your presentation to the Senate, on October 2, of your proposed National Health Insurance Plan. Since we could not arrange to present in-person testimony at your hearing, we are submitting written testimony, and we trust that it will be given full consideration.

We wish to address those aspects of National Health Insurance with which our social service agency has special expertise, specifically the needs of patients and families that are coping with catastrophic illness. Our concern is with those who must struggle with the staggering problems and costs generated by a catastrophic illness such as cancer.

Our opinions are based on 33 years of experience with the delivery of comprehensive social services to normally self-maintaining advanced cancer patients and their families. Our services include social work counseling and assistance with planning for the care of the patient. Our focus, as a social agency,

is not only on the patient's illness, but also on the family as a whole. We strive both to help the patient live to the very end with dignity and comfort, and to help the family and/or spouse cope more adequately with the patient's illness so that family or personal breakdown may be prevented. Consequently, we offer individual counseling as well as group counseling for both patients and the bereaved.

An integral part of our service is financial assistance, when needed, to help defray the cost of services in the home - when it is medically feasible to maintain the patient at home. We want to emphasize, at this point, that over the years we have consistently found that most advanced cancer patients, if they can be at home at all, can be cared for by homemaker-home health aides, and do not necessarily need skilled nursing care. We want to relate this basic and important fact to the issue of home health services under Medicare, and how these services have continued to be narrowly defined in previous National Health Insurance proposals. If a National Health Insurance program is to truly offer coverage for catastrophic illness - and it should - the concept of covered home-based services to the ill must be broadened.

Merely to call a National Health Insurance "comprehensive" is not enough - what is crucial is what benefits are actually included. We have found, in studying past National Health Insurance proposals, that most have excluded something that we believe is basic to the care of those stricken with catastrophic and long-term illnesses - namely, care-in-the-home services.

The cost of an illness can not be determined merely by the cost of the doctor, hospital, drugs, and eventual burial. What must also be considered is the cost of maintaining the patient at home, and the many "hidden" costs attendant upon this.

These costs may be manageable for well-to-do families - or with extended families - equipped to offer a great deal of help and support. But, for so many others, the very process of caring for the patient, while trying to maintain the family, proves to be an incredible drain and strain, both financially and emotionally.

Our strong position on the need for coverage for a broad variety of home-based services is supported not only by our lengthy experience, but also by our research study, published in 1973, "THE IMPACT, COSTS AND CONSEQUENCES OF CATASTROPHIC ILLNESS ON PATIENTS AND FAMILIES."

The research was based on a survey of 115 self-supporting middle to low income families known to the agency, in which a family member had died from advanced cancer within the preceding 16 months. The study documented the financial impact of the illness upon these families, and revealed that they can be reduced to poverty in less than two years, despite the fact that there was health insurance coverage.

While the median illness - related costs, six years ago, were $19,054, the median medical insurance payments, <u>including</u> those from major medical policies, were only $8,000. Thus, there was an $11,000 gap between costs and insurance coverage. And the hardship was compounded by the fact that the median income of these families was only $8,000.

It is our confirmed belief that a National Health Insurance program will not be adequate to meet the needs of the catastrophically ill unless:

1) It gives recognition to the lengthy duration of such an illness. The duration of the illness for the 115 patients in our research study ranged from less than one year - there were only 25 in this group - to five years and over. The median for the group was 24 months!

2) It offers sufficient coverage for the special needs of such patients.

What, then, are the special needs of catastrophically ill patients, and what creates them?

When an illness continues for an extended period, particularly when there is little hope for recovery, the patient spends a relatively brief time in the hospital. Recent Department of Health, Education and Welfare statistics show that the average hospital stay for cancer patients is only 13.6 days. Such patients are usually dismissed when hospital care is no longer of any benefit to them either to return home, or to be transferred to a nursing home or a terminal care institution.

We have found that most advanced cancer patients want to return to their homes, if such a plan is medically feasible. But usually the plan can not be implemented without at least some supportive services in the home.

Only if a National Health Insurance program provides a variety of home-based services, as well as other out-patient benefits, can it be considered as adequately covering the needs

of the catastrophically ill. Among the services and out-patient benefits that are necessary are the following:

1. Homemaker-Home Health Aide.
2. Housekeeper.
3. Home Attendant.
4. Nurse.
5. Domestic.
6. Social Worker.
7. Special Equipment.
8. Psychiatrist.
9. Laboratory Tests.
10. Patient Transportation.
11. Special Treatments.
12. Blood Transfusions.
13. Dental, Eye and Hearing Care.
14. Special Diets.
15. Medicines.
16. Dwelling Modifications.

We want especially to emphasize that of all the home-based services mentioned above, homemaker-home health aide service is the one most frequently needed. Only a few of the patients known to us need skilled or other nursing care. Since this has proven to be true with advanced cancer patients, it seems logical to expect that it is the same for other types of long-term or catastrophic illnesses. We hope that Senator Kennedy's new National Health Insurance proposal gives full recognition to this and provides coverage for this category, rather than staying with the

current Medicare model for home health services.

Medicare's focus on acute, short-term care has proven to be severely inadequate. The elderly ill, fortunate enough to receive help to secure realistic home-based services, have not received them from Medicare. Instead, help has had to come from Medicaid, Title XX, Older Americans Act funds, or from the funds of voluntary homemaker-home health or other social service agencies. However, this fragmentation in existing funding sources causes further problems and confusion in the delivery of needed services.

Realistic home-based services - that is, a broad variety of such services - must be made available to all who need them. Families should not be forced to become near-paupers by spending down to Medicaid-eligibility levels in order to qualify for medical assistance. Further, this is a process which in and of itself proves degrading and humiliating to most people, delays the delivery of assistance and services, and is also administratively costly.

Cancer Care, Inc. also believes that social services must play an integral role in the delivery of health care services, particularly where the patient has a long-term or catastrophic illness.

At the least, social work counseling is needed to help the patient and the family work out a suitable plan. But, beyond this, counseling services are often needed to help the patient and the family deal with the emotional problems engendered by the illness.

We must not ignore the fact that catastrophic and/or long-term illnesses have profound emotional ramifications for both the patient and his family or spouse. They frequently cause or exacerbate family difficulties and create emotional problems for the members of the family. In addition to social work counseling, psychiatric or psychological services might also be needed at times. These should be made easily available for patients and families through coverage for the services of qualified members of these professional disciplines. These services are frequently preventive of more serious emotional problems or family breakdown. The whole community benefits when its most vital unit, the family, can be helped to survive the impact of catastrophic illness.

We appreciate this opportunity to express our views, and would be pleased to respond to any questions you may have.

# # # # # #

SCAN Senior Care Action Network

December 20, 1978

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*Secretary to the Board*
Sam Ervin
Executive Director

Senator Edward Kennedy
Senate Office Building
Washington, D. C.

Re: National Health Insurance Program
Hearings, Garden Grove, CA, Friday, December 15, 1978

Dear Senator Kennedy:

On behalf of the SCAN directorate and our program participants, I wish to thank you for the opportunity to have our comments made part of your hearings on National Health Care.

You will, I believe, find the information included useful in determining components of new legislation. I must emphasize the importance of transportation. Medical services, even though available, are of little benefit if you can't get to them. SCAN is providing this essential transportation for needy elderly in the Long Beach area.

We urge you to include transportation as an allowable cost in future legislation involving health care.

Sincerely,

Sam L. Ervin

SAM L. ERVIN
Executive Director

Encls. Testimony
SCAN Brochure

SLE:ma

Long Beach Area Geriatric Health Care Council, Inc. — 1045 Atlantic Avenue — Long Beach, California 90813 — (213) 436-2266

TESTIMONY

To be included as part of the public hearing
on the National Health Insurance Program held at
Garden Grove, CA on Friday, December 15, 1978,
Senator Edward Kennedy presiding

by

Sam L. Ervin
Executive Director
SENIOR CARE ACTION NETWORK (SCAN)
LONG BEACH AREA GERIATRIC HEALTH CARE COUNCIL, INC.
1045 Atlantic Avenue
Long Beach, California 90813

Long Beach

Metropolitan Long Beach, an area of 49.6 square miles south of Los Angeles, may well be a laboratory of the future. 72,000 of its residents are 60 years of age or over. This is over 21% of the total population of 350,000. 8% are 75 or over. These percentages are double the national proportions.

Long Beach, which was a retirement mecca as early as 1930, now has the density of elders that other areas should expect to have in the future. More than 22% of Long Beach elders lived on incomes below federal poverty levels even before double digit inflation. It is estimated that an additional 10,000 exist within 100% to 125% of the poverty level, and 60% live alone. The current total population of Long Beach is comprised of 73.9 Caucasians, 11.7% Hispanics, 9.4% Black and 2.9% Asian and Pacific Islanders.

At present, the majority of elders live in and around the "downtown" area of Long Beach. This section is roughly 1/10 the total area of the city. However, significiant displacement and dispersal of the elders concentrated in this downtown sector has begun and is accelerating due to large-scale redevelopment efforts.

With large numbers of elders already moving to many other sections of the city, service delivery will become a greater challenge. At the same time, inflating housing costs will further jeopardize Long Beach elders economically.

In short, Long Beach elders face an array of problems similar to those in other urban areas: crime, poverty, lack of access to affordable and adequate health care, housing and transportation, inappropriate institutionalization, and inadequate levels of a number of critical supporting services.

Development of the Geriatric Health Care System

Several years ago, a few active older persons in Long Beach began to urge the development of a coordinating agency in Long Beach to address the well-researched problem of fragmentation in existing health care and social services, particularly on behalf of the isolated, hard-to-reach and vulnerable elders.

In 1976, the City of Long Beach contracted with USC's Andrus Gerontology Center to undertake a year long intensive effort of research, planning and community development culminating in a three volume plan for a single entry intake and case coordination program. The system plan was the result of the broadest community-wide deliberation and cooperative effort, including consumer and provider task forces, the City of Long Beach, the Area Agency on Aging of Los Angeles County, the Ethel Percy Andrus Gerontology Center of the University of Southern California, St. Mary Medical Center, Long Beach Memorial Hospital, Pacific Hospital, Community Hospital of Long Beach and numerous other health and social service organizations.

One year ago the Long Beach Area Geriatric Health Care Council, Inc. was established as the community-based coordinating unit for the

service delivery system and as the broker-advocate for individual elders in need of services. SCAN's Board of Directors is composed of 12 seniors, 12 administrators and physicians from health care institutions and 12 directors of social service agencies. An Advisory Council for each of these groups provides even broader participation in program and policy development.

The SCAN System

For the individual elder, SCAN acts as coordinator and advocate for a range of services, based on an in-depth personalized needs assessment. At the same time, SCAN is the focal point for a system of services, organizations and senior groups. SCAN's multi-level approach to coordination affords an accurate process for identifying the vulnerable and frail elders, and then linking them with a full range of supports vital to their survival in non-institutional settings.

SCAN's major responsibilities include case coordination, guidance of an integrated network of private and public facilities, advocacy for the individual and systems advocacy.

The Social Resource Coordinators, who are the front line SCAN staff, evaluate each participant with a comprehensive needs assessment questionnaire and with the participant's authorization carry out a case plan to insure provision of needed services. The assessment instrument is designed to provide clear identification of frail and vulnerable elders. Single entry intake provides for maximal accessibility to the system. Entrance into the system is further enhanced by a coordinated team which performs focused outreach. The resource pool includes every social service agency that can be of help to elders and the four

major hospitals in the city of Long Beach. This unique alliance of public and private facilities maximizes SCAN's impact in the community. For example, SCAN links elders who have Medicare and whose incomes are within 25 percent of federal poverty levels with geriatric health care providers that do not require either co-payments or deductible and accept Medicare payment as total reimbursement for all services needed.

SCAN's Medical Component

Each of the four major private hospitals in Long Beach has committed itself to development of differing geriatric services as part of the system. Three hospitals have agreed to accept SCAN referrals for health screening and assessment. Two of these will refer the participant to a private physician if indicated, and all three will provide in-patient care as needed for Medicare only if the participant is eligible under SCAN's criteria. Two of the hospitals will also attempt to refer eligible participants to physicians who will also accept Medicare as full payment.

SCAN is a "managing partner" in St. Mary Medical Center's screening clinic, providing for the social assessment and case management, while St. Mary's provides a physician, nurse and other personnel for the health assessment and physician referrals. Once an individual is referred to St. Mary's, a complete health and social service assessment will be done and appropriate treatment initiated. St. Mary's also is developing a special meals program and other geriatric services.

Two of the hospitals have developed home care programs, one has an adult day health center and one an alcohol rehabilitation program. All four hospitals have joined in funding SCAN to operate a special Medical Services Route for elders.

SCAN coordinates prevention oriented health education programs for elders with a number of health and home health care providers.

The new Long Beach Senior Center is a major development in the system, providing full health screening and a dental clinic through the City's Department of Public Health and other departments and contributors.

SCAN is able to link participants with the full range of medical and auxiliary services. SCAN has specific written agreements with St. Mary Medical Center, which also provides some of SCAN's funding, Long Beach Community Hospital, and two home health providers.

The Long Beach Medical Society convened a committee to assist in development of the System, and has a representative on the Board. Broad-based physician acceptance has greatly assisted the program.

SCAN and City of Long Beach

The City supports SCAN financially through CETA, Title III of the Older American's Act and CSA funds, by providing for thorough coordination of all City provided and funded services with SCAN, including day centers, the new Senior Center, CSA funded agencies, neighborhood centers, the departments of Human Resources, Recreation and Public Health.

SCAN's Social Service Coordinators

SCAN has developed above 20 written agreements with agencies designed to promote an integrated pattern of service delivery. These agreements encompass the following services:

Outreach to isolated, vulnerable elders
Information and Referral
Specialized transportation programs
Homemaker/Chore Services
Congregate meals and Meals on Wheels
Adult day care, both social and health oriented
Telephone reassurance
Employment services
House-cleaning donated by private business
Legal assistance
Crime prevention and escort program
Volunteer development and placement

A range of other services.

Case Coordination

The assessment process focuses both on the problems of the person and the existing or available supports in their environment - friends, relatives or volunteers. The comprehensive approach used emphasizes meeting the needs of the "whole" person and providing necessary supports to their independence insofar as possible. SCAN's Social Resource Coordinators work with the family or significant others to supplement or replace agency supports. However, it should be noted that 60% of those assessed thus far live alone, and most of these have no one to provide dependable assistance.

SCAN has now assessed and linked with services 1200 elders, whose median age is 76, and 80% of whom have incomes under $5,000.

Volunteer Component Being Developed

A Task Force on volunteers has been established and will be meeting by February 1, 1979 to fully develop a volunteer component for the agency.

B. In addition to the in-house involvement of volunteers, RSVP in Long Beach has taken an active role in SCAN's development and will become the major volunteer recruitment and placement agency.

RSVP will not only recruit and coordinate volunteers over 60, but will accept referrals of prospective volunteers from service agencies as part of a plan of socialization and activity to prevent premature institutionalization.

Catholic Social Services has committed the cooperation of its Parish Outreach Project to assisting identified vulnerable elders to remain in their own homes, and to further develop this component in cooperation with SCAN at the neighborhood level.

Emerging Concern

As SCAN has developed its coordinated network of health and social services, one major problem in service delivery has appeared in the form of a shortage of available services. Even though Long Beach has an unusual array of services, the number of elders in need being referred to services by SCAN has created an overload for some agencies. As an example, Family Services Association of Long Beach provides Homemaker services and has had to hold new referrals to a minimum because of an increase in people needing service being found by SCAN's outreach and assessment program. Family Services as a result of the increased demand for services has begun a Homemaker Registry for those able to pay and thus is seeking to expand its capacity.

Recommendations

1. Strengthen cooperation between aging service programs at the local level by:

   a. providing clear guidelines for coordinated community approach to Area Agencies on Aging, and

b. requiring all federally funded agencies serving elders to develop written agreements with an identified local coordinating unit.

2. Promote coordination between health care and social services development in aging by requiring cooperative efforts by federally mandated planning agencies.

3. Encourage the development of local, community-based case coordination projects which mobilize and integrate institutional, private business and neighborhood-based resources and supports on behalf of elders.

4. Develop a system to insure a close and continuing relationship between the geriatric services of the hospital and other community support services. The hospital provides a significant base for the delivery of an integrated pattern of services. SCAN provides the network for identifying "at-risk" elders and insuring their access to such services. Provisions for access must include attention to transportation.

CALIFORNIA MEDICAL ASSOCIATION

731 Market Street / San Francisco, California 94103 / 415·777-2000

November 20, 1978

Mr. Richard Froh, Staff Assistant
Senate Human Resources Subcommittee on
Health and Scientific Research
United States Senate
Washington, D. C. 20510

Dear Mr. Froh:

Enclosed please find ten copies of written testimony by Nicholas P. Krikes, MD, President of the California Medical Association which we would like to submit as part of the record for Senator Kennedy's National Health Insurance hearing in Garden Grove, California on Thursday, November 30, 1978 at 10 a.m.

While we are not requesting an opportunity to speak at the hearing, we would appreciate it if this testimony could become part of the official hearing record.

Thank you for your assistance.

Sincerely,

Susan Hogeland
Staff Coordinator

Enclosures

TESTIMONY OF
NICHOLAS P. KRIKES, MD, PRESIDENT
CALIFORNIA MEDICAL ASSOCIATION
before the
SENATE HUMAN RESOURCES SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
ON NATIONAL HEALTH INSURANCE

Honorable Edward M. Kennedy, Chairman
Garden Grove, California
November 30, 1978

I am Dr. Nicholas P. Krikes, president of the 26,000-member California Medical Association.

The California Medical Association has been involved in the discussion over national health insurance for the last 20 years. Over that period, a number of principles have been developed which we feel must be addressed by any national health insurance program.

But first, I must make a distinction between national health insurance programs and national health service programs. The CMA definition of the former is "private insurance to assure access to quality health care for everyone who may need it." The definition of the latter, we feel, is "federalized medicine," i.e., health care services and providers controlled by the central government. Under national health insurance, the excellent standard of care enjoyed by most Americans today could be maintained. Under a national health service, health care would be rationed and the quality of care seriously jeopardized because of overdemand on the system and the initiation of "standardized" medicine.

While Senator Kennedy's latest proposal falls somewhere between NHI and the NHS, we believe it more closely resembles the latter. The goals which he hopes to achieve are admirable -- indeed, utopian: comprehensive health services available to all; escalating health care costs controlled; a significant role for a publicly-regulated private insurance system; promotion of system reforms to emphasize preventive medicine and encourage development of alternative delivery systems; enhanced quality of care; protection against catastrophic costs, and more. For less.

2.

It appears the senator believes the health care system operates in a vacuum. He thinks that by severely limiting the amount of money available to provide services, while expanding eligibility and benefits, health care can be all things to all people -- and still be $31-billion cheaper than today's system would be in 1985. It sounds like the ultimate in economic wizardry.

Let me explain. Although complete details are not available yet, Senator Kennedy's program calls for payment of insurance premiums to private companies. So far, so good. But the premiums would be set by a public authority -- the omnipotent national health administration and policy body -- without experience rating. By mandate, these premiums must cover a comprehensive set of benefits. Employers would pay 75% of the earnings-based premium; employees 25%. The health care consumer's only responsibility in the system would be paying the 25% of the premium if employed; if not, the federal government -- the taxpayers -- would pick up the tab. There is no system of copayment for services.

Hospital budgets and physicians' fee schedules would be fixed via negotiation with a state authority that acts on behalf of the national public authority in each state.

The health care consumer would have no incentive not to overutilize services, yet the insurance companies and the providers would be given a limited amount of revenues to pay for and provide those services. This is the fatal flaw of government health programs: a limit on funding, but not on demand.

The inevitable result of Senator Kennedy's proposed system, we believe, would be rationing and decreased quality of care.

IS NHI THE ONLY ANSWER?

Citizens of the United States enjoy the highest standard of health care in the world. It is a system which can be improved. CMA, AMA and other health organizations have been working together to solve our health system's problems, including ways to contain costs, improve planning and assure peer review of quality and utilization.

3.

But given the financial times our nation is experiencing, this is no time to throw the baby out with the bathwater, even if the baby isn't perfect.

In a recent Los Angeles Times article, Charles C. Edwards, former HEW assistant secretary for health, points out that if 24-million people in our country are without health insurance (some by choice), it is critical to ask whether a mandatory program that involves more than 200-million other people and that drastically changes our entire health-care system is the most appropriate way to cover these 24-million -- 10% of the population?

Several trends in the nation's economy and the public's mood mitigate against the type of program proposed by Senator Kennedy:

1) The voters across our country have been emphatically demonstrating their displeasure with overtaxation and government overspending. They're asking that federal and state governments limit both expenditures and involvement in our lives -- not increase them. In our own state, the economic realities of inflation were confronted by Proposition 13, which reversed the increase in property taxes.

2) Our entire economy is incredibly sensitive at this point to all manipulations. President Carter's recent actions to implement voluntary wage and price controls and to bolster the U.S. dollar abroad are examples of economic fine-tuning he feels are essential to address what is overwhelmingly agreed to be the number one problem in our nation: inflation. Pumping millions more into health care could only further exacerbate inflation.

3) Hospitals and physicians have been working together voluntarily for over a year to lower the rate of health-care cost increases. There is evidence that our "Voluntary Effort" is succeeding and this has been hailed by the Carter Administration. In California, CMA has produced and distributed hundreds of thousands of pamphlets on keeping health care costs down; this effort recognizes a joint cost-consciousness responsibility between physician and patient, a concept Senator Kennedy's program fails to address.

4.

4) Federal participation or financing in any program inevitably leads to higher costs -- such as illustrated by Medicare and Medicaid (Medi-Cal in California). Health-care costs and general inflation alone do not account for the increasingly larger chunk of the federal budget going to health care. Common sense tells us that if you expand eligibility, increase benefits and don't require a copayment (as in Medi-Cal) you'll increase utilization and thus total costs. In fact, HEW statistics show that those with incomes under $3,000 a year now see physicians with greater frequency than anyone else -- about six times per year compared with the national average of five visits per year. People with incomes of $3,000-$7,000 are the next most frequent users; and by 1976, blacks were seeing physicians as often as whites.

But to further explain the failure of the Medicaid and Medicare programs, one must look into the reimbursement policies of state and federal governments. After the government increased eligibility and coverage, it could only pay health care providers about 50 percent of the usual customary fees (in Medi-Cal) for services so that costs could be kept down. Government made it economically and bureaucratically unattractive, and in some cases literally impossible, for providers to participate in these programs.

ALTERNATIVES

I think we can answer the question of "Is NHI the Only Answer?" by saying that in the case of Senator Kennedy's proposal, it isn't the answer at all.

A more reasonable approach in these economic hard times would be to control inflation, correct Medicaid's defects and provide widespread catastrophic coverage under private health insurance. A complete takeover of our health-care system by the federal government is undesirable. A ratio of nine administrators per physician, as is the case in Great Britain under the National Health Service, is ridiculous but probable under the new bureaucracy that would be required to administer Senator Kennedy's NHI plan. And rationing of health services -- which would be required because of the huge new demand for services that would be created by NHI -- is certainly not desirable because it would keep those who really need health care from getting it.

5.

For some time, the California Medical Association has sponsored state legislation to provide catastrophic health insurance for all Californians.

We have also advocated an approach to national health insurance like that proposed by the American Medical Association. Among the principles we believe must be addressed by any such program are:

1) Access to adequate coverage for all -- no one should lack health care simply because he or she cannot afford it.

2) Freedom of choice -- freedom to join or not join any plan; freedom to choose one's own physician and health facility; and, very importantly, freedom of a physician to give sound medical treatment without undue bureaucratic interference. This is essential for the preservation of quality care. I might point out that Senator Kennedy's plan calls not only for national negotiation of physicians' fees, it calls for a national quality control commission which will develop quality standards of practice.

Under such a system, standardized medicine could -- but certainly shouldn't -- replace a physicians' judgment in health matters.

3) Sensible financing is imperative. Senator Kennedy estimates that his program would cost $31-billion less in 1985 than if our present system continues unchanged. His is an interesting contradiction to an accepted economic fact: the fires of inflation are not cooled by pouring on more money.

Senator Kennedy makes no mention of the inflationary costs of the governmental bureaucracy that would be needed to implement and evaluate NHI; no mention of the inflationary effects that the mandatory employer contributions to NHI would have on the costs of consumer goods; and no mention of how private insurance companies would survive under his no-profit system.

We believe that financing medical care through voluntary private insurance is the best means to assure individual freedom and responsibility. Prepaid closed-panel plans (Health Maintenance Organizations) should be available as an unsubsidized option. Under the private plan, government assistance could be provided to individuals unable

6.

to pay for medical care, and the government could pay part or none of the costs for others, depending upon income.

But it would be foolish to radically alter our system of health-care delivery and payment -- without pilot or demonstration projects -- because a few economists and planners favor an untested alternative system.

4) Comprehensive care must be provided; it must include hospital and medical care, ambulatory services, prescriptions, dentistry and nursing, plus catastrophic coverage.

5) Professional standards and monitoring of quality and appropriateness of care are essential, but this monitoring must be done by health professionals with the training and experience to do the job properly. The government does not have either this expertise or the necessary continuing daily experience in delivering health care.

6) Participation by physicians at every level of planning and administration in an NHI system is imperative.

I have observed the British National Health Service firsthand. It is, I believe, a notable example of admirable aspirations gone awry. The British have learned the hard way that health care financing alone doesn't solve everyone's medical problems. Neither is health-care financing self-limiting. They learned that there was a tremendous backlog of demand for care and it still hasn't been satisfied thirty years later. They learned that despite their desire to equalize health care treatment and facilities throughout their country, inequality remains; physician shortages and archaic facilities plague them still. And today there is a notable rise in private insurance plan membership and in the utilization of private physicians -- despite the availability of "free" NHS care.

I hope we can and will learn from them, for if we ignore their experience, our current cost problems will pale by comparison, and our patients too, will wait weeks and months and years for surgery designated "elective" by the government.

7.

The public has expressed an interest in improved access to care but there is no public mandate to radically change the present high standard of health care received by an overwhelming percentage of our citizens. I am confident that the unrealistic political pressures that demand more for less will not prevail. If they should do so, the ability of private physicians to offer the finest possible care would be severely impaired, and our patients would suffer. And we surely don't want that to happen!

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The National Health Federation

212 WEST FOOTHILL BLVD. • MONROVIA, CALIFORNIA 91016 • P.O. BOX 688

CHARLES I. CRECELIUS
*President*

(213) 357-2181
(213) 359-8334

December 4, 1978

Senator Edward M. Kennedy, Chairman
Subcommittee on Health and
Scientific Research
Senate Office Building
Washington, D.C. 20510

Dear Senator Kennedy:

Thank you for your letter of November 30 in response to a series of form letters sent by National Health Federation members and friends concerning coverage of holistic practices in your national health insurance proposal.

When I passed out these form letters for signatures at our regional convention in Atlanta, Georgia, November 18 and 19, one member raised her hand and asked what she should do if she were totally opposed to any form of national health insurance. I told her to simply sign the letter but write along the margin that she was totally opposed to any form of national health insurance.

Her question started me to think. I asked the audience of about 600-800 how many were totally opposed to any form of national health insurance.

I was shocked when apparently every hand in the audience was raised.

Until that moment, I had assumed, in error, that the majority of our members would accept national health insurance if it fairly included all alternate holistic approaches to health.

It may well be that Georgia and the surrounding states are not representative of the entire NHF membership, but if we find a similar majority at our Long Beach annual convention in January, NHF will, naturally, change our emphasis to total opposition to any form of national health insurance.

If a majority of our members do not agree with those at the Georgia regional, then our position will probably stay the same as that expressed in the letters recently forwarded to you.

December 4, 1978
Senator Edward M. Kennedy
Page 2

I am carefully reviewing your national health insurance outline and will send you our opinions as soon as I have checked them with the members of the executive committee.

We are sorry your hearings were cancelled last week in Los Angeles.

Sincerely yours,

Clinton R. Miller

CLINTON R. MILLER
Executive Vice-President

CRM:jc

cc: Dan Maziarz, NEW AGE CAUCUS director
William Brown, D.C.
American Chiropractic Association
International Chiropractic Association
NHF Executive Committee members

P.S. I respectfully request that you include this letter as a part of the NHF's testimony at the forthcoming hearings in Los Angeles.

Testimony before the Senate Committee on Human Resources
Subcommittee on Health and Scientifc Research
Los Angeles, California

Statement by:
James Carbray, President
National Council of Senior Citizens

December 15, 1978

Senator Kennedy and Members of the Subcommittee, I am James Carbray, President of the National Council of Senior Citizens. NCSC is comprised of over 3,8000 affiliated clubs and area and state councils, representing over three and one-half million older Americans across the length and breadth of this country. We have appeared before Congressional committees innumerable times since 1961 to testify on the subject of preeminent importance to our constituents--health care. We are pleased to be here today to add our voice in support of the proposed framework for the universal and comprehensive National Health Insurance Act of 1979.

In the early years, led by former Congressman Aime Forand of Rhode Island, the National Council came to Congress in hopes of fulfilling one dream of America's elderly--relief from the tremendous burden of health care costs. Four years after the founding of the National Council of Senior Citizens, after countless appearances on Capitol Hill, hundreds of demonstrations and a flexing of political muscle through the election process--Senior Power--a major portion of that dream was realized through an Act of Congress. Medicare was signed into law by President

Johnson who memorialized our efforts by stating that "without the help of the National Council of Senior Citizens, there would be no Medicare."

Despite the compromises made during the debate over Medicare and despite the significant shortcomings of the Medicare program, we believed then and we continue to believe to this day that Medicare has improved the quality of life of America's older citizens. There is no dollar amount that accurately reflects the sense of security an older person gains as a result of knowing that if he or she should become ill, the money will be there to pay for it.

Unfortunately, that sense of security has been eroded over the past decade. While Medicare continues to provide some insurance to the elderly against financial loss due to health care costs, its major benefits go to health care providers: It provides open-ended assurance of payment on a cost-plus basis for hospitals and doctors.

Medicare, despite the claims of its early opponents, has not brought us socialized medicine. Nor has Medicare handcuffed the hospitals or the doctors. To the contrary, Medicare has provided a public financing mechanism where none existed before. Medicare did ease access to the health care delivery system. But it did not change that system. Needed delivery reforms were and are still absent! The inclusion of deductibles, coinsurance and copayments, and the lack of a comprehensive benefit package has diminished its value to participants. Additionally, it has reinforced the incentives

in the health care delivery system for inefficiency in the use of health resources. Medicare's lack of impact on delivery reforms and cost-effective care was and continues to be its weakest point.

Finally, what was originally intended to be a simple financing mechanism, turned into a program so complicated that the intended benefactor often was lost in a morass of rules, regulations and paper shuffling. Beneficiaries are no longer even sure what is covered. Unfortunately, they have become increasingly aware of what is not covered.

After 12 years of experience, Medicare has failed to relieve the economic ruin and tragedy which inevitably accompanies unexpected ill health.

What does Medicare pay for today? On average, only 38 per cent of the health bill. For victims of stroke and major surgery patients, for example, coverage is likely to be far below average and financial catastrophe is a likely outcome in addition to the tragedy of catastrophic illness. Medicare has become a program which sets limits on protection instead of limiting the financial burden of older people.

Through the extraordinary increase in the deductible under Part A from $40.00 in 1966 to the recently announced figure of $160; the simultaneous escalation in coinsurance amounts, and the rise in the premium under Part B from $3.00 a month to $8.20 a month in the same time period, Medicare has become a program which limits access to health care and sick care.

Through the failure of the assignment procedure for reimbursement of physicians and the lack of any hospital cost controls, Medicare has become a program which contributes to the erosion of its own adequacy. It feeds inflation in the health care sector.

A close look at the flaws in the assignment mechanism provides a good example of a mistake that must not be repeated.

Briefly, the assignment procedure was created to provide a physician reimbursement mechanism with purported cost controls. Under the assignment system, a doctor accepts Medicare's customary, reasonable and prevailing charge as payment in full (less the deductible and coinsurance).

However, doctors are not obligated to accept assignment in order to treat a Medicare patient. By refusing assignment, a doctor instead of billing Medicare, bills the Medicare patient directly. As a consequence, three serious problems arise. First, in billing the patient directly, the burden of being reimbursed by Medicare falls directly on the patient. Second, the doctor is no longer constrained to limit his charges to HEW's "reasonable" rate. Third, that portion of the bill which is in excess of the reasonable charge not only must come out of the patient's pocket, but the reason that Medicare does not reimburse the full amount of the bill is also left unexplained. Thus, patients are left in the dark as to whether they are paying unusually high physician rates or for uncovered services.

While it is implied that the physician and the patient can agree between themselves as to the method of payment, the fact is that the patient has no bargaining power in a situation where presumably the assignment method is discussed. The reality of the situation is that the physician can determine the method of reimbursement which is to be used.

Furthermore, the physician can make that decision with respect to every Medicare patient he sees and force direct billing in one case and assignment in another. He can even use the direct billing method with respect to one episode and the assignment method in another with the same patient.

Studies, such as those conducted by the Triangle Research Institute and the Robert Nathan Associates, show that, in general, doctors force the assignment method where there is a risk of collection. Consequently, it is more likely to be used in cases where the bill is large. Therefore, the assignment system far from being a cost containment apparatus is in reality a collection mechanism with the government as a collection agent.

But the problem does not end here. More and more doctors are refusing assignment altogether. Currently, less than half the physicians treating Medicare patients are accepting assignment.

The problems outlined above are not limited to the assignment procedure. The lack of universality, uniformity, comprehensiveness and the ultimate lack of effective cost control as witnessed in the assignment system are flaws which show up throughout the Medicare program.

It is this experience with Medicare--the nation's largest public health insurance operation--which we draw upon in hopes that it will make self-evident to the Congress the elements of a national health plan that will not duplicate in the future the mistakes of the past.

Senator Kennedy, as you are aware, the National Council has supported your efforts and those of the Committee for National Health Insurance for ten years. NCSC and the more than three and one-half million seniors we represent has had as its number one priority the enactment of National Health Security--reconfirmed as late as our National Convention in June 1978.

We supported National Health Security because it was unique among the many National Health Insurance proposals. It met the six major criteria by which health care proposals should be evaluated:

(1) universality of coverage;

(2) comprehensiveness and uniformity of benefits;

(3) reform of health care delivery;

(4) adherence to social insurance principles in administration and financing;

(5) effective cost and quality controls, and

(6) strong consumer representation.

We are equally supportive of the framework for National Health Security's successor--The National Health Insurance Act of 1979. The basic design appears consistent with the principles that our experience indicates are of overriding importance.

The National Health Insurance Act of 1979 adequately protects the social entitlement principle long endorsed by the National Council. Universality of coverage accompanied by a single uniform entitlement card will insure equal access and equal treatment for all at the point of service delivery regardless of the source of payment.

While the financing of the National Health Insurance Act of 1979 will be primarily off the federal budget, the basic right of all Americans to receive high quality health care is unchanged from the Health Security program.

Although Medicare will be retained in name under the National Health Insurance Act of 1979, the proposed framework does contain systematic changes in the coverage, reimbursement practices and cost and quality controls in the delivery system so that the present inadequacies in Medicare are significantly altered and improved.

Specifically, NCSC applauds the decision to discard the onerous deductibles and coinsurance provisions of Medicare. To seniors, the deductibles have presented an unnecessary burden and all too often

a barrier to adequate health care. Similarly, the coinsurance provisions of Medicare have become intolerable as the total cost of a day in a hospital or a visit to a doctor has steadily increased.

Without cost-sharing, the National Health Insurance Act of 1979 could achieve a breakthrough in guaranteeing health care as a right by assuring that appropriate levels of care will be available to all citizens. We believe the administrative efficiencies which would result from the elimination of deductibles, co-payments and coinsurance will, on balance, effect a saving to the system, both in dollar terms and in terms of more efficient use of medical resources and better health.

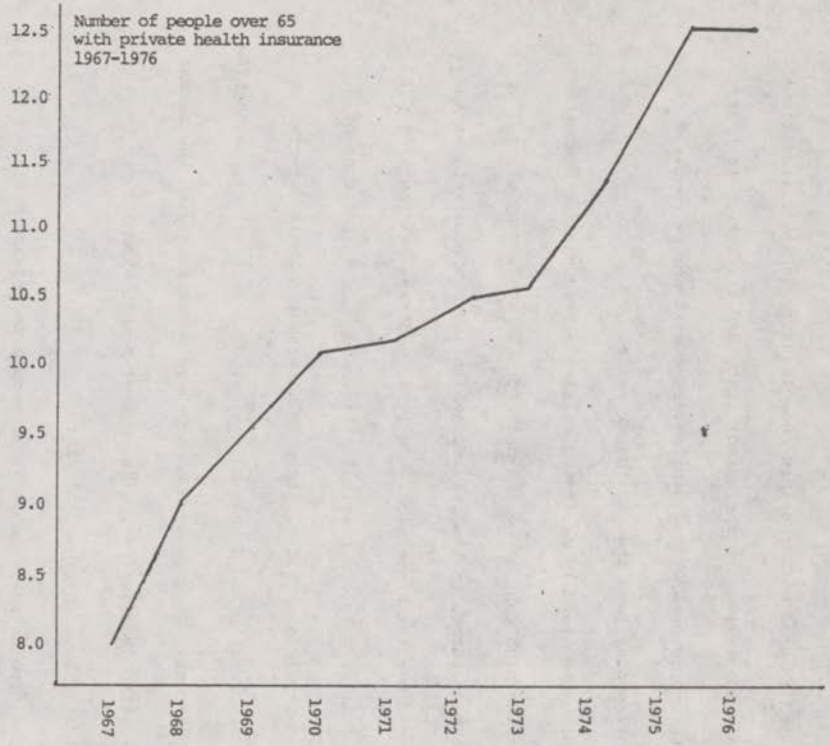
As delighted as we are to see the elimination of the cost-sharing mechanisms of Medicare, our members will be equally pleased by the long overdue reform of the current reimbursement system. The framework for the National Health Insurance Act of 1979 which prohibits providers from charging patients additional amounts above those that are negotiated in the budgetary process, obviates the need for a physician assignment procedure which has so plagued the Medicare program since its inception. In addition, prohibitions against direct billing of the patient eliminates unnecessary and costly administrative operations. At the same time, it relieves the patient from needlessly complicated paperwork and the frequent need to pay a bill prior to reimbursement.

The National Council of Senior Citizens is also happy to be able to tell its constituents that seniors will no longer feel

pressured to deal with the insurance industry in their traditional role as underwriters to the extent that they are forced to today. Private supplementary "Medigap" coverage will not be required to cover financial gaps that no longer exist.

With the steadily declining ability of Medicare to meet the increasing high cost of health care for the aged, many older people have turned to the private health insurance market for increased financial protection. In 1974, Medicare paid only 62 per cent of older people's hospital bills, and only 52 per cent of covered physicians' bills. It paid nothing for their out-of-hospital prescription drugs and medical devices, and next to nothing (3.3 per cent) for nursing home expenses. Yet even with the advent of so-called "Medigap" policies, out-of-pocket expenditures by the elderly have continued to rise.

The growing reliance of older people on private health insurance over the past ten years is graphically demonstrated in the attached table. The table indicates that the number of people over 65 years of age who purchased one or more private health insurance policies rose from slightly over eight million persons in 1967 to over twelve and one-half million persons by 1976--an increase of over fifty per cent participation. (The increase in the over 65 population was less than four per cent.) Unfortunately, the table says nothing about the rise in dollar outlays for private supplemental insurance. Our guess is that




Source: Health Insurance Institute and Health Insurance Association of America; Source Book of Health Insurance Data for the years 1967-1976

the increase in expenditures on private health insurance is likely to be even more dramatic than the increase in the number of people buying such insurance.

Today, "Medigap" policies account for over a billion dollars in private premium payments by older people. No single policy completely fills the gaps. Almost 25 per cent of policyholders have multiple policies which duplicate coverage to a greater or lesser extent. The average loss-payment ratio of the "Medigap" insurance carriers (i.e., the relationship between the number of dollars paid out in benefits to the number of dollars collected in premiums) averages around 50 per cent.

For most people, Medigap coverage is a "bad-buy," but lack of coverage is a risk most people can't afford to take--whether it's a bad buy or not! For those who are "lucky" enough to be paupers or near-paupers, Medicaid fills the gap.

Certainly, the message is clear. Liberalization of Medicare to "fill the gaps" by removing deductibles and coinsurance and by adding in-home care to avoid unnecessary and high-cost hospitalization or long-term institutionalization will be cost-effective. The money is now being spent in the private market capriciously and wastefully. A rational National Health Insurance system with built-in cost controls is a far more efficient way to "fill the gaps."

Senator Kennedy, members of the Committee, as the debate on National Health Insurance progresses, you can be sure the Council will actively press for and testify on behalf of the proposed measures.

Paul H. Lo
3130 S. Linda Way
Santa Ana, Ca. 92704

February 28, 1977

Dear Honorable President Carter:

It was my greatest honor to be invited to participate in your inauguration last month. Marian and I met you and Mrs. Carter in the ball room of the Washington Hilton Hotel. We were delighted also to be invited by Mr. Frank Moore, your Congressional Liaison and my former boss in the Middle Flint Area Planning and Development Commission, to take a tour of the White House on January 22, 1977. Fortunately we also met Vice-President Mondale and Mrs. Mondale on their way to the White House. We remember every momnet of the excitement.

As I indicated to you before, I have committed myself to planning and research of beneficial services for seniors. Recently I read an article that Congressman Patterson is proposing a bill, H.R. 2631, to provide tax credit to those taxpayers who house their parents, or relatives, who are 61 years and older. I am very much in favor of this proposal, because it will not only bring the family back together as it used to be, but it will also reduce the feeling of loneliness and uselessness of seniors.

According to nation-wide research 5% of all seniors (approximately one million) were living in institutions of all kinds in 1975 and one third of all the elderly (6.5 million; 1.5 million men and 5.0 million women) lived alone or with non-relatives. All those people have contributed a lot to our country in the past, but they are suffering loneliness and hopeless institutionalized treatment. The misfortune of these seniors lies in the following factors:

1) Financial situation : Not all children dislike to house their parents. They do not house them simply because they cannot afford to. In the majority of young families, both couples have to find a job in order to keep up with inflation. Nobody can afford to have someone to take care of their own folks in their home. Therefore, I would like to suggest you allocate more funds to Title V of the Older Americans Act to establish either multi-purpose centers or Senior Day Care Centers. This has been done successfully in San Francisco "On Lok", (an adult day care center or Chinese for "Happy Peaceful Abode). They provide health services for those who are not in need of 24-hour supervised care. It allows senior citizens who qualify to retain their independence, identity and dignity, rather than being incarcerated needlessly in nursing homes. It also allows them to receive needed health and social activities with their peer groups during the day time and enjoy the family atmosphere in the evening.

   One of the most remarkable aspects of this innovative program is its cost. Medi-Cal reimburses "On Lok" an average of $321.19 per month per participant and social security contributes approximately $132.94 for a total public sector cost of about $454.13. In contrast, the same person

in a nursing home would receive $636.70 reimbursement from Medi-Cal and Social Security. It saves nearly $182.57 per month per person or $2,202.84 per year. In addition, the happiness, dignity and human satisfaction that senior citizens gain is immeasurable.

2) Fundamental Education : HEW estimated in August, 1976 that there are approximately 1.4 million parents who could afford to contribute to the support of families now collecting AFDC (Aid to Families with Dependent Children). How can these irresponsible parents who default on their child-support payments expect their children to take care of themselves when they get older? Therefore, I would like to urge you to develop some family education system before a couple is married. In some Oriental countries a person would be considered very disgraceful if he did not house his parents or support his children. A cure for this problem should start with fundamental education.

3) Welfare Concept : I have heard many young adults state that they do not need to plan anything for their future; the government is going to support them anyway when they get older. I feel that the government should help those who help themselves along through their life, either by establishing retirement preparation systems or by strengthening the Social Security system.

4) Insurance System : Young adults can buy health insurance to cover their dependent children, but not their dependent parents. This is another factor separating families. I feel that if the government can force insurance companies to accept the health coverage of dependent parents, maybe with a minor subsidy to the sponsored children. Then, the expenses under Medicaid and Medicare will be drastically reduced and the medical malpractice would be eliminated.

5) Compulsory Retirement : Many senior citizens' physiological age is younger than their chronological age. The compulsory retirement system on reaching a particular birthday, regardless of their ability to work would hamper older Americans from alloting their time and talents and deprive our nation of the highest use of their knowledge, skills and potential. Therefore, I would like to suggest a flexible retirement system based on physical condition and medical reports.

6) Employment Discrimination Against Aged : Although there are Affirmative Action Plan, Assurance of Compliance under Title VI of the Civil Rights Act, the discriminational practice against the aged is still not uncommon. A stronger enforcement and monitoring system is needed.

I understand that you are in the process of establishing a special team to deal with seniors' problems. Since I have been in this field for years, I would like to offer my availability to you for your consideration.

You know my capability and loyalty to you in the past and during the campaign period. I will continue to support you and your administration to be the best one in our history. Marian joins me in sending our best wishes to you and your family.

Sincerely yours,

Paul H. Lo

Paul H. Lo

# RATIONALE FOR INCLUSION OF FUNDING OF SCHOOL NURSE SERVICES

# IN THE

# NATIONAL HEALTH INSURANCE PROGRAM

Presented to
Senate Sub-Committee on Health and Health Research
December 15, 1978
Garden Grove, California

We believe that the school is the most efficient cost-effective community setting for the implementation of meaningful health care for children and youth. Health care in the schools as provided by prepared school nurses includes identification of health problems, preventive health measures, health maintenance care and necessary therapeutic measures.

In America alone it is estimated that seven million children from impoverished circumstances never visit a physician's office or hospital outpatient department except in times of dire emergency or extreme illness. [1]

Since most children attend public school between the ages of 5 and 18 as well as increasing number under age 5, the school nurse is the primary health care provider for these children.

Frequently preventive, curative and restorative services are neglected or fragmented in traditional health facilities by virtue of the current health care system. As a consequence, health defects that contribute to learning difficulties and mental health problems are not identified and remediated.

Using schools as the site where extensive health care for children is provided has captured the interest of many health professionals nationwide. The suitability of the school as a site for delivery of health services and for other community purposes besides education is now under evaluation and mechanisms for the financial support of these school health services are being developed. [2]

Health Education and Welfare Secretary Califano stated in his speech to the participants of the National School Health Conference in May 1977, "The President is interested in exploring these possibilities for using schools to provide a full range of services to children and families, including health and social services as well as education. [3]

We believe that it is imperative that school nurse services be included and financed in a National Health Insurance Program on a per capita basis.

Sally Williams
Education Chairperson
CALIFORNIA SCHOOL NURSES ORGANIZATION P.O.Box 625, San Gabriel, CA 91778

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1. Profile of Children. 1970. White House Conference. Superintendent of Document, U.S. Government Printing Office, Washington, D.C. 20402, p. 34.
2. Igoe, Judith B. M.S., and Silver, Henry K. M.D. Improving Health Care in the School Setting. Nurse Practitioner, September - October 1977, pp. 7-9.
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Orange County
Mental
Health
Association

2110 East First Street, Suite 101
Santa Ana, California 92705

(714) 547-7559

December 15, 1978

Senator Edward M. Kennedy

Dear Senator Kennedy,

By the most conservative of opinions, there is no doubt that mental illness and emotional disabilities are our country's NUMBER ONE health problem. In terms of human suffering, the toll is great. The impact on our national economy is immense.

In 1971, the National Institute of Mental Health, under contract to the U. S. Department of Health, Education, and Welfare, published a report on the cost of mental illness in the United States. The information in this report was updated and published, giving figures for 1974. "The cost of mental illness in the United States, measured conservatively, was $36,786 billion in 1974. Of this amount, the cost of direct care alone amounted to $14,506 billion. The remainder of the cost of mental illness was attributable to related activities (research, training, and fellowships, facilities development and management expenses) and to indirect costs due to death, disability, and patient care activities." 1.

Information on alcoholism is equally staggering. It is estimated that it costs the nation $15 billion annually. Industry picks up a $10 billion tab for lost worktime. The illness costs an additional $2 billion in health and welfare service benefits, and a further cost of $3 to $5 billion results from property damage, medical expenses, overhead costs of insurance and wages lost.

The actual cost of drug abuse is found not just in the number of people lost to a productive society. It feeds millions of dollars into organized crime,

causes millions of dollars in property loss, and places a burden of responsibility on the rest of society to reclaim its members.

The Orange County Association for Mental Health feels strongly that any National Health Insurance program must include coverage for mental health related problems. We agree with the Presidential Commission "that any plan enacted should include a 'reasonable' array of mental health emergency, outpatient and inpatient care, with emphasis on treatment ' in the most appropriate and least restrictive setting.' "

Sincerely,

Nancy T. Harris
Executive Director

1. Levine, Daniel S., Ph. D. and Shirley G. Wilner. Mental Health Statistical Note 125 U. S. Department of H.E.W./Public Health Service/Alcohol, Drug Abuse and Mental Health Administration, page 1.

HOSPITAL COUNCIL OF SOUTHERN CALIFORNIA
6255 SUNSET BOULEVARD, SUITE 617, LOS ANGELES, CALIFORNIA 90028 • (213) 469-7311

STATEMENT OF STEPHEN W. GAMBLE, PRESIDENT

HOSPITAL COUNCIL OF SOUTHERN CALIFORNIA

ON

NATIONAL HEALTH INSURANCE

December 15, 1978

Mr. Chairman, in behalf of the 235 members of the Hospital Council of Southern California, I respectfully request that this statement be made part of the record of your hearings today in Orange County.

The subject which you and your colleagues are addressing is of major interest to hospitals both within the context of current cost containment initiatives in our industry and in our role as the key organizational component and resource for health care delivery on a community level. Few are more acutely aware of and sensitive to the human and financial suffering of families who face a catastrophic illness without adequate insurance protection than the hospital administrator.

The enactment of Medicare and Medicaid in 1965 greatly increased the protection of two of the most vulnerable segments of our economy--the aged and the poor. And the extension of similar benefits to others in need is generally seen as highly desirable.

The American Hospital Association has introduced or endorsed several measures that would combine direct government financing with an expansion of catastrophic coverage under private health insurance. Our industry also has testified on numerous occasions on the inadequacies of the present system and the need for a more comprehensive delivery system which emphasizes health prevention and maintenance as well as the treatment of acute illness.

Thus, it is our contention that the public policy issue before us is not whether a national health insurance program is desirable but what form it should take and how--and if--it should be introduced into an economy already fueled by intense inflationary pressures.

We cannot afford to ignore the lessons of Medicare/Medicaid which, although interim measures, have become the most costly health care financing programs ever undertaken by any nation in the world. The Federal contribution which began with $3.3 billion in 1965 reached $39.1 billion in 1978. That fact alone should caution us to examine more realistically the costs of the programs we propose and their long-range impact on the economy and the high quality health status Americans now enjoy.

STEPHEN W. GAMBLE, *President*

Public attitudes toward government financing have also undergone dramatic changes since the mid-1960's. And nowhere is that change more apparent than in California where voters overwhelmingly supported Proposition 13 and most recently voted to allow the Board of Supervisors in Los Angeles County to contract with private industry for services which have been performed by County workers.

I would hasten to add that these measures and the outcome of other tax limitation referendums in national elections earlier this month are not a rejection of government services or an indictment of government employees. They are a rejection of the notion that 1) the public tax base, like the proverbial well, never runs dry and 2) that public services must be publicly administered to represent public interests.

We believe it is encumbent upon government at all levels and those of us in industries which receive tax monies in payment for government-contracted services to take a hard look at our operations, our priorities and our spending practices. We in the hospital field began that process some time ago and in October, 1977, formalized our indivdualized efforts into an industry-wide program. Known as the Voluntary Effort, this cost-containment initiative has drawn wide praise most recently from the President's Council on Wage and Price Stability.

Chairman Barry Boswell who met with the national steering committee on the Voluntary Effort last month noted that "hospitals are one of the few industries in which deceleration has succeeded and this is significant considering the rate of inflation in the rest of the economy." He went on to say that the design of the Voluntary Effort "addresses the unique problems of its field better than any industry the Council on Wage and Price Stability has seen."

In his October, 1978, White Paper outlining the Administration's anti-inflationary program, President Carter recognized the goals of our Voluntary Effort by adopting them as his standard in achieving reductions in Federal health spending which is escalating at the rate of 25 percent annually.

What is most curious to those of us in the hospital industry, however, is the inconsistency of a national policy that advocates restrictive controls on hospitals while deploring mandatory wage and price controls in general as "an extreme approach that creates serious inequities and inefficiencies."

Perhaps, just perhaps, there might be some justification for this contraposition by the White House and in your own national health insurance proposal if the Voluntary Effort had failed. Not only has it <u>not</u> failed, but it is surpassing the expectations of its most ardent critics.

The rate of growth in hospital expenditures during the first seven months of this year was the lowest since 1974, having achieved a 2.8 percentage point reduction. We expect that momentum to continue and as it does to give additional weight to the President's faith in a voluntary mechanism in the fight against inflation.

Undoubtedly, President Carter's relunctance to use mandatory wage and price controls is based on the country's experience in the early 1970's which he notes "is replete with examples of economic distortions and is illustrative of how mandatory controls sow the seeds of their own destruction."

Section 223 of the Medicare law which limits hospital reimbursement for routine inpatient services is an example of the distortions and inequities that result from broad brush attempts at regulation. This is expecially true when those attempts are directed at an individual industry such as ours which is both highly complex and heterogenous.

Simply put, the per diem costs used by Medicare in determining reimbursement penalizes hospitals which have a shorter length stay even though their overall costs may be in line with the national average. The bottom line here in California is that $12 million in unreimbursed Medicare costs had to be passed on to the private paying patients--all because the department of Health, Education and Welfare persists in administering a standard justified by its uniformity not its equity.

The result is that Californians are forced to subsidize Medicare expenditures above and beyond the citizentry of other states. We have suggested time and time again that an alternative approach using per case costs should be investigated, only to be ignored by the vast Medicare Bureau that administers the program.

It is, undoubtedly, this same lack of responsiveness and accountability that leads a majority of voters to reject in poll after poll a Government-controlled health care system. It is certainly this kind of experience replicated in institutions throughout the country that makes us doubt the efficacy of a government-administered national health insurance plan.

Dr. Charles C. Edwards, former assistant secretary of the Department of Health Education and Welfare and current president of Scripps Clinic and Research Foundation in San Diego, has suggested that "a correction of inequities in the Medicaid system together with better catastrophic coverage under private health insurance would close the gap without the need for a massive Federal takeover of the entire health insurance system." Certainly, that view merits the same kind of scrutiny that is being given to the Administration's proposal and the national health insurance plan under discussion in these hearings.

In summary, we wish to emphasize the concern and commitment of our industry in working to moderate the costs of hospital and health care. Much progress has been made and will continue to be made with the cooperation and active involvement of other providers, insurers, the business community and health care consumers. We believe this Voluntary approach is not only sound but it recognizes the complexity of the health care system and the necessity of long as well short-term solutions. Any other approach will certainly lead to rationing of care which we can't believe you want any more than we do.

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS
STATE OF CALIFORNIA, INC.

Mary Lou Conroy, CMA-A, President ■ 604 Glenwood Way, Upland, California 91786

URGENT MESSAGE TO THE CITIZENS OF ORANGE AND LOS ANGELES COUNTIES

*We need LESS, NOT MORE government interference in health care!*

*The Federal government has NEVER produced any product; it cannot produce health care - only the medical profession can!*

*The government hospitals are classic examples :*

*The Veterans Hospitals administration operates with chronic shortages, chronic OVER-BUDGET, chronic inefficiency*

*All other government health care facilities are chronically mis¬used*

*Remember the gas shortage a few years ago?*
*Medical care, under a government health program, will be "doled out"-RATIONED, and services allocated. If you think the lines at the gas stations were long - WAIT AND SEE what is in store for you under a national health insurance program!*

*National health insurance IS NOT FREE! It is another means of transferring your TAX DOLLARS through big government at a SUBSTANTIAL LOSS! It will make the present FEDERAL DEFICIT MUCH WORSE!*

*The Medicare/Medicaid government programs, as they are presently administrated, allow chronic mis-use and abuse by the patients. The present federal administration of these programs demonstrate over-bearing, over-staffing and generally inefficient use of YOUR TAX DOLLARS!*

*WHAT GOVERNMENT AGENCY IS A MODEL? The United States Postal Service? Amtrak? The Dept of Health, Education and Welfare, whose budget has INCREASED 400% in the last ten years???*

*What about the GSA? The General Services Agency, with poor contract controls, and NO ABILITY to dismiss incompetent employees, serves as an excellent EXAMPLE OF BIG GOVERNMENT' ADMINISTRATIVE CAPABILITIES!*

*Are the decisions controlling medical care - YOUR MEDICAL CARE - to be left to civil service employees- maybe the postal workers???*

*Can you allow another layer of unresponsive, untouchable BUREAUCRACY to MANIPULATE and CONTROL YOUR HEALTH?*

*Government health controlled medical care in Great Britain and Canada:*
*The demand is STAGGERING*
*The long wait for medical care is SHOCKING*
*The TAX COST to the citizens is PROHIBITIVE -*

*IN EXCESS OF 60% AT EVERY INCOME LEVEL!!!*

*CAN THE CITIZENS OF THE UNITED STATES REALLY AFFORD NATIONAL HEALTH INSURANCE??*

# STATEMENT FOR INCLUSION

# RECORD

U.S. SUBCOMMITTEE ON HEALTH

AND SCIENTIFIC RESEARCH

Senator Ted Kennedy, Chm.

Oral Hearing: Garden Grove, CAlifornia

Friday, December 15, 1978

by

Joan Taylor, B.A., M.A.L.S.
455 South Irving Blvd.
Los Angeles, California
Phone 213 934 9377, for
CENTER FOR ORAL HEALTH FACTS

U. S. SUBCOMMITTEE ON HEALTH
AND SCIENTIFIC RESEARCH

Oral Hearing: Garden Grove, California
Friday, December 15, 1978

Senator Ted Kennedy, Chm.
Members of Subcommittee:

I am Joan Taylor, as individual testifying of American dental care and markets and that monopolistic health mode failure to inform, maintain, protect and restore oral health, occlusion of teeth and lower jaw relation to skull and spine: an upper body, face and head health factor.

I am woman age 50, with bachelor and master's degree in college library administration, a B.A. 1948 from Marymount College, Salina, Kansas; an M.A.L.S. 1967 from Kansas State College, Emporia Kansas. I was completing academic doctoral degree in university library administration, with urban study, at University of Miami, Florida, 1971 when dental malpractice in Kansas, Missouri and Arizona destroyed my life health, employment, appearance; and dental and medical trade constraints show no compunction to offer me full, complete restoration to optimal health, after malpractices by dentists from 1972-1974.

I completed a year of law in 1975, until forced to stop, as criminal abuse maimed me, with massive mayhem.

(I do not wish record to include facts or letters to Kansas federal court by investigator and attorney-investigator, as detraction from primary goals of the Oral Hearing).

I had prior 17 years' experience in school library administration, also curriculum planning and development of new school programs; development of elementary school libraries and secondary school libraries; and both university library administration and university urban research unit administration. In 1965 I assisted a $100,000 tax reform after hospital board members' frauds, Beloit Kansas; from 1973-6 I was Board member of Missouri Assn of Consumers. All my life effort has been curtailed after dental malpractices 1972-4 and crime 1975-8.

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U.S. Subcommittee on Health
Hearing Friday December 15, 1978
Garden Grove, California Community Center

1.
I request the committee incorporate plan : for massive public education and information on the occlusion of teeth; and the correct, healthful, lower jaw relation to skull and spine, held by teeth lengths and bone position in proper, healthy occlusion.

An American -and world- public is uninformed of facts of oral health, the occlusion of teeth, yet the teeth come together each time one swallows, 24 hours a day! Try it, and feel the four (4) back teeth, each jaw side, sixteen (16) teeth touch, as you swallow (not counting wisdom teeth).

A dentist destroys body tissue and life health as he drills down teeth lengths of the four (4) back teeth, each jaw side. NAME THE EXCEPTION: a person whose back teeth are long, straight, undrilled by a dentist; or, teeth, if drilled, rebuilt by long, erect, straight tooth crowns and composite resins. Teeth lengths control a lower jaw (chin) fit into skull, on spine. If a doctor cut off your child's fingertips, you would know terrible human outrage, human mutilation. Yet daily, dentists drill down children's teeth lengths, a body tissue needed as each fingertip. The mutilation means your child's facial crippling for life, in present dental care markets.

Facts of oral health and good occlusion, much simplified, are these, as advanced in various editions of Gray's ANATOMY, other medical and dental texts; dentist Norman Cranin's excellent editions of FAMILY GUIDE TO DENTAL HEALTH; dentist Dan Collins's (President's Council of Dental Research) editions of YOUR TEETH; and many other dentist-authored books and anatomy editions.

In good health, the six (6) front teeth, both jaws, are in a straight row, flanked by four (4) adult posterior (back) teeth each jaw side; a "4-6-4" tooth alignment in the bone, not counting wisdom teeth. A child has a "2-6-2" alignment, 6 front teeth flanked by 2 posterior teeth, each side.

Upper teeth are slightly larger than, and extend slightly over, lower teeth. The center midlines between two center teeth of both jaws should be exactly upright, to exactly balance the skull, face bones on each side. After the midline, each upper tooth extends backward past lower jaw counterpart tooth, an "interlocking brick" pattern for good health.

Each tooth and root is upright, erect, touching the next. Know a lower jaw profile, by holding your hand in front of you, fingers straight, thumb up, as "lower jaw" profile outline. Thumb is a lower jaw condyle, to fit in skull. See the "square jaw" outline of good health profile, teeth upright. Turn your hand downward to see lower jaw after teeth lengths of back teeth are destroyed, and lower jaw closes incorrectly to upper jaw, each time one swallows, 24 hours daily, each few seconds.

If a child's teeth are drilled down, the lower jaw does not meet the upper jaw in proper occlusion; All permanent teeth then are pushed from correct bone alignments and come in various crooked alignments, malocclusion, AFTER DRILLING.

If an adult's teeth are drilled down, the lip, tongue and cheek muscles which close each time one swallows, "lock" at incorrect angles and push the teeth from all directions, and destroy the bones of jaws, and bone alignments for teeth.

If bone loss occurs for jaw bones, all facial bones lose support and balance from teeth and jaw bones. The facial crippling is evident; the face thins, temples show bone loss.

Dentists admit this bone loss, as periodontal disease, is at record 80% conservative to 97% levels in American populace. So -this is what we got -when we got the friendly neighborhood dentist! Record levels of periodontal disease!

Dentists -once teeth length is drilled from teeth- are reluctant to replace that teeth length by crowns or composite resins, a safe material to extend those tooth lengths drilled down.

Dentists, after teeth lengths of posterior teeth have been drilled down excessively or extracted, then cut out parts of the chin, to allow the short tooth stumps to meet. Bone is rigid, unless the chin is cut short, the short teeth will not meet.

The tongue is doubled up, after the chin is cut short. After teeth are drilled away, the chin is placed to one side! The tongue is off-center and crowded and pushes all teeth outward, each time the victim swallows, 24 hours a day.

When teethlengths are drilled down, the person mouthbreathes, as the tongue has no room. All this further destroys the bone. Sinus, eye, nose injuries can and do occur when teeth are drilled away. All face bones have no support.

Speech, diction, breathing, posture, deglutitation (swallowing) all need long, straight, erect teeth lengths, in correct bone position. Facial appearance and health demand these long teeth, a firm jaw line, to hold all facial muscles and chest and back muscles and bone in alignment. A dental drill-can destroy all.

Facial appearance, proportion, bone structure depend on good occlusion and teeth lengths, bone alignment. Head balance on skull and spine demands long, straight, upright teeth.

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I have simplified some facts of oral health, occlusion of teeth and proper lower jaw (chin) relation to skull for this committee. Every American should know these simple facts of oral anatomy - yet I doubt if any person does know this.

This U.S. Subcommittee has a grave responsibility to fund a massive, US-wide public information media approach to the occlusion of teeth and lower jaw relation to skull and spine. These facts are readily understood -for most people, a 1-hour or 2-hour illustrated lecture is sufficient, or at least, a firm basis for full understanding of oral anatomy, the health, bones and muscles of the head, face, mouth and teeth, upper body skull and chest affected most by the occlusion of teeth.

This U.S. Submommittee has serious public need; the massive, extensive facial cripplings, downturned mouths, cut-off chins, and butchered-down teeth are eloquent proof of man's inhumanity to man, with a profit motive, and victims left injured by a licensed-for-profit dental trade, of slight educational and technical training; and most of crude cultural level. It is travesty that a most intimate body part -the mouth- can be left to such untrained, butchering and drilling away of body tissue.

The scars of dental malpractice are evident - one can not hide the face.

Appearance, personality, career, self-confidence and health are controlled by a dental drill. An ignorant public is left vulnerable. A dental trade makes more money by malpractice, than by good care. Yet economics of dentistry could escalate past the present $10 billion dollar a year (conservative estimate) to effect the restorations to excellent centric occlusion and centric jaw relation to the skull, IF oral, orthopedic and plastic surgeons would rebuild the jaw bones, and re-align the teeth to correct bone positions; and dentists would crown or add composite resins to attain full, long, straight, erect teeth lengths and roots.

This U.S. Subcommittee can use these hearings to probe into medical failures to inform, restore correctly the jawbones cut away by dentists octors who don't inform a victim of an "off-center chin, by dentist's drilling away teeth lengths and imbalancing every face bone and skull balance in spine" deserve no public "respect". Medical-dental lobbying -when facial cripplings are the rule- deserve no hearing.

2.
I request this U.S. Subcommittee study dental costs, monopoly practices (as FTC suit 1977 charged), and failure to render optimal health care for the occlusion, widespread malpractices of economic profits to dentists.

If a dentist drills down a child's teeth lengths, particularly those of the back teeth, the dentist destroys a child's health lower jaw (chin) relation to the skull and spine. Then, each time the child swallows, lower jaw teeth in the chin close at an incorrect angle to face bones and upper jaw teeth. This destroys, drains away jaw bones, and removes support for all face bones. Teeth, drilled short, are pressed outwardly by the tongue which has insufficient space after teeth lengths drilled away, and teeth are pressed inwardly by cheek, lip and chin muscles in wrong positions after teeth lengths drilled away. Teeth then "move" in all directions, into crooked bone alignments, to "match" crooked, drilled-to-points occlusal surfaces.

A child then requires orthodontia, a $1,500-$5,000 expense, often gauged by parental affluence or tax-payer subsidies, or union plans. Despite orthodontia, the child may later need periodontia, a $1,500-$5,000 expense to drain away pus from bone loss which occurred as result of teeth lengths drilled away. With periodontia, as child matures into middle age, needless extractions and prosthetics may be "sold" by the dentist, another $1,500-$4,000 expense. This past $4,000-$15,000 expense may be condemned by a dentist who offers a $10,000-$25,000 "rehabilitation" or "reconstruction" by crowns, and ogen, gold and other metallics which can harm internally.

Despite this $30,000 mouth" for dental profit, NO DENTIST WILL RESTORE TEETH LENGTHS DRILLED DOWN BY ANOTHER DENTIST. Crowns and composite resins, with rebuilt jaw bones could accomplish this simply, but dental trade constraints refuse good health to dental victims.

Dentists look to economics of the "$30,000 mouth" with aid of dental insurance plans, taxpayer subsidies, unions in 1980's.

Dental injury is responsible for virtually all dental costs, as above, after teeth lengths are drilled away. Endodontists ask $250-$300 to drain pus from root canal of one (1) tooth, yet that pus usually formed when prior dentist drillled incorrectly and failed occlusion, to "pressure" the tooth until infection reached the nerve, tooth root.

This subcommittee must speak to the millions of facially-crippled, by poor dentistry of Ameria.

3.
The American Dental Association, by LA Times, 1974 words, matches the American Medical Association political contributions almost dollar for dollar, with ADA placing two-thirds (2/3ds) of the monies on Congressional races and lobbying. The failure of Congressional committees to explore dental cripplings shows the good investment made by ADA's Political Action monies. I also bring to your attention the monies by dentists' political funds, to nearly match physicians' and surgeons' political monies is of note: dentists work on only a small body portion, yet their political contributions "match" physicians who work on all body parts!

More money is made by malpractice than by good care in dentistry. No dentist is ever forced to provide good health for any injured victim of another dentist. A victim is always refused full restoration to good health after dental injury to drill down teeth lengths. (Name and illustrate any exception) A facial crippling by a dentist can not be hidden, as one can not hide the face. Victimizations are at 97% levels, by even the most perfunctory facial evidence: the off-center chins, the drilled-down posterior teeth lengths; the chin cut away, clearly shown in profile; the lack of facial bone support by poor dentistry; the terrible ill-fitting dentures, travesty after mutilation by dentists.

The anatomy books do not show man with the "off-center chin" of poor dentistry.

4. A PRACTICAL SOLUTION: INFORMATION OF OCCLUSION
This U.S. Subcommittee on Health could fund a nationwide teacher-training course in oral health for all elementary, secondary, junior college, colllege undergraduate and extension courses, to quickly inform a public of oral health, facts of occlusion of teeth and lower jaw relation to skull and spine. I appear here, to ask these funds, and Subcommittee support for this American need in health markets. A public informed of good oral health will demand good oral health; and then a dental trade will supply it. Denturists, those licensed to make dentures, could lead the way to correct, healthy occlusion after dentists' mutilations and prosthetic malocclusions. Certainly, dentists abdicated their role in every sense of the word, by countless, needless extractions.

An educational administrator, a doctoral administrator as anatomist, a dental hygienist and dental technician and/or denturist could adequately inform a public the facts of oral health, in rudiments. Biochemists, nutritionists, naturopaths who have studied the ill health caused by metallic dental fittings also complement this program.

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Medical expertise, to inform public the correct jaw relations to skull, refinements of anatomical landmarks, musculature and bone correlations, can further assist public to good oral health. Surgeon enthusiasm to rebuild jaw bones to full oral health can be decisive aid, to assist after tragic harm; and force correct and full dental restorations.

Legal expertise - a national lack - to recognize malocclusions by dental drill, iatrogenic and visible, is poignant national need. In catastrophic health care markets, a victim has no financial position. The "average" reconstruction after dentist has drilled down teeth lengths to gumline, and cut into the jaw bones, at 1978 prices could mean $25,000.00 care for oral or plastic surgery and 28 dental crowns to regain lengths.

Public knowledge -of the facts of oral health, occlusion of teeth and lower jaw relation to skull- is the real, immediate answer. Please fund the media and teacher-training courses I ask. Do not place dentists in charge of dental reform. States are too fragmented, often weak politically, to effect this reform. Only Congressional action allows a real public knowledge. I am dental victim -of four (4) dentists who worsened each others damage to me in two (2) years 1972-4, after my prior forty years of good health, centric occlusion, ~ Then- 78 dentists and doctors refused me correct care after iatrogenic dental injury 1974-8. As dental victim, senselessly facially paralyzed from expression and smile, I ask your immediate efforts to study dental malpractice, reform and, foremost, public information of oral health by massive media and teacher-training courses I have proposed here,

Joan Taylor

Joan Taylor (signed)
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December 15th 1978
Garden Grove Ca

The Honorable
Edward Kennedy
U.S. Senator.

Here is the figures on a Hospital bill that may be of interest in your drive to help poor people and I hope Vets of W.W.1 who need help.

I Was in Palm Harbor General Hospital July 6 to 13-1978 for the purpose of Cracking a Stone and Washing it out of My bladder.

Hospital Charges Was — $2635.00
Medicare paid Men Hospital 2314.70
Ballance Charged to Me Was $320.30 + $144 for intrance on 1st day.

The Doctor Bill Was — $1098.00
Medicare paid only 606.40
Ballance charged to Me was $491.60

Anesthesiologist Charged — 132.00 to stick a Needle in My back
Medicare paid — 72.00
Ballance Charged to Me $60.00

Total Cost to Me $320.30
144.00
491.60
60.00
$1015.90.

4 Insurance policies that I carry was short $30.00 Covering My part of the Bill

4 Insurance policies re expensive
My age is 85 yrs.

People needs protection from this Kind of Ripoff

Truly yours
Vernie M Jones Vet of W.W.1
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December 15, 1978

Senator: Any bill should include
concern of the tax paying Undocumented
indigent people in this country in the interest of
Human Rights.

Health Quality Care for
Uncarcerated Persons.

Thank You
Manuel Vanegas

UNITED STATES SENATE SUBCOMMITTEE ON HEALTH

PUBLIC HEARING

DECEMBER 15, 1978

GARDEN GROVE, CALIFORNIA

WITNESS: Maxine Cataline, Low-Income Senior Citizen, enrolled in Senior Community Service Employment Program (Title IX, Older Amer. Act.)

Edith Pamer, Low-Income Senior Citizen, enrolled in Senior Community Service Employment Program (Title IX, Older Amer. Act.)

COMMENT: Being low-income Senior Citizens, we are concerned about the continual rising costs of medical services and the inability of Federal Medicare Programs to relieve the financial burden of obtaining adequate health care.

To support our concerns we offer the following points:

1. Since Medicare only pays 80% of "allowable" charges and not 80% of total charges, the patient is left with a balance that can total hundreds of dollars, especially in cases where major surgery is involved. This is a tremendous burden on those whose income does not exceed $300 per month. There are no clear guidelines as to what is or is not allowable under Medicare and in reality, payments are closer to 60% rather then 80%.

2. Although Medicare is designed for the elderly, there are no provisions for the corrective items most needed by the elderly. Items such as eye glasses, dentures, and hearing aides are not covered by Medicare, however, these are the expensive items most needed by older people.

3. Allowable costs for office calls has not kept pace with the spiraling costs for office visits. Average payments are normally 50% of the doctor bill which inhibit the older person from seeing a doctor when sickness occurs and the result is the person continues to get worse. To compound the problem, there is no allowance for prescriptions and many elderly go without needed drugs.

4. By disallowing annual or routine physical examinations, Medicare is discouraging older people from establishing a good program of preventative medicine. According to many doctors, preventative health care can reduce not only the incident of serious disease, but actually reduce the total costs of medical care.

Although Medicare covers all hospital costs, it is not nearly adequate in covering other health costs, especially those inherent in the aging process. We must strive for a major modification to our Medicare Program or else institute a program of National Health Insurance.

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