HEALTH SERVICES TO OLDER AMERICANS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-SIXTH CONGRESS

SECOND SESSION

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HEALTH SERVICES TO OLDER AMERICANS

FRIDAY, APRIL 11, 1980

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Kansas City, Kans.

The subcommittee met, pursuant to notice, at 1:30 p.m. in the auditorium, city hall, Hon. John C. Danforth, Hon. Robert Dole, and Representative Larry Winn, presiding.

Present: Senators Danforth and Dole; Representative Winn; Mr. Paul Ertel, HEW regional office; Mr. Dean Mordy, HEW regional office; Mr. Bill Blake, HEW regional office; Ms. Susan Jenkins, HEW regional office; and Mr. William Mayfield, HEW regional office.

[The press releases announcing this hearing follow:]

(For Immediate Release: Friday, April 4, 1980)

PRELIMINARY LIST OF WITNESSES ANNOUNCED FOR APRIL 11 KANSAS CITY HEARING

WASHINGTON.— Senators Bob Dole and Jack Danforth today announced a preliminary list of witnesses for the Health Subcommittee of the U.S. Senate's Committee on Finance field hearing they will co-chair in Kansas City, Kans., on Friday, April 11.

The hearing, which will focus on improving the provision of health services to older Americans on a basis consistent with enhanced independence and dignity taking into consideration the current economic crisis, is scheduled from 1:30 p.m. to 4:00 p.m. in the Municipal Building at One Civic Plaza in Kansas City, Kans.

Among those scheduled to testify are: Mr. Boris Steiman, Area Representative, American Association of Retired Persons, Kansas City, Mo.; Mr. Donald Flora, Executive Director, Mid-America Health Systems Agency, Kansas City, Mo.; Mr. David Monson, Office of Aging, Dept. of Social Services, State of Missouri, Jefferson, Mo.; Ms. Barbara Sabol, Secretary, Kansas Dept. of Aging, Topeka, Kans.; Dr. Russell Mills, Ph.D., Associate to the Chancellor, University of Kansas Medical Center, Kansas City, Kans.; Dr. Richard K. Novak, M.D., Senior Docent and Professor of Medicine, University of Missouri-Kansas City School of Medicine Kansas City, Mo.; Mr. Melvin Weissman, Executive Director, Jewish Geriatric and Convalescent Center, Kansas City, Mo.; Honorable Richard L. Berkley, Mayor, City of Kansas City, Mo.; Jim Redding, Administrator Nevada City Hospital, Nevada, Mo.; Mr. Thomas V. Scott, Executive Director, The Visiting Nurse Association Home Health Services of Greater Kansas City, Kansas City, Mo.; Ms. Marilyn Dymer, Director of Nursing, The Visiting Nurse Association, Home Health Services of Greater Kansas City, Kansas City, Mo.; Mr. Ronald Schaumburg, Administrator, Memorial Hospital, McPherson, Kans.; Howard Funston, Chief Executive Officer, Valley View Professional Care Center, Junction City, Kans.

For those not scheduled to testify in person, the Subcommittee will be pleased to receive written testimony from those persons or organizations who wish to submit statements for the record. These should be typewritten not more than 25 double-spaced pages in length, and mailed with five (5) copies by Tuesday,

May 1, 1980, to: Michael Stern, Staff Director, Committee on Finance, 2227 Dirksen Senate Office Building, Washington, D.C. 20510.

"I believe this hearing will provide us with an opportunity to hear hospitals, doctors and other providers of health care representatives of public and private organizations concerned with the health care interests of older citizens," said Senator Dole.

(For immediate release: Monday, Mar. 24, 1980)

DOLE, DANFORTH TO CONDUCT HEARINGS IN KANSAS CITY ON HEALTH SERVICES

WASHINGTON.—Senators Bob Dole and Jack Danforth will conduct field hearings in Kansas City, Kans., on Friday, April 11, on how best to provide needed health services to older Americans, in view of the current economic situation and the clear need to reduce Federal expenditures.

The hearings will focus on both institutional and home-based health care services.

The session, scheduled from 1:30 p.m. to 4:00 p.m., will be an official hearing of the Health Subcommittee of the Senate Finance Committee. It will be held at the Kansas City, Kans., Municipal Building, One Civic Plaza, Commissioner's Chambers, lobby level.

While the number of witnesses presenting oral testimony will be limited, all individuals are invited to attend the hearing. Written statements will be accepted for the record.

Senator DOLE. Let me say, first of all, that I appreciate Senator Danforth coming to Kansas to participate in these hearings.

We started a series of hearings some time ago and were interrupted when we had a big snowstorm in St. Louis. I hope it doesn't do that today, because unfortunately the weather isn't really that good.

Let me make this very brief opening statement and indicate that we're very pleased to have so many people here.

We hope that we can make a good record that will be meaningful and helpful to those in Congress who will be dealing with the problems we seek to address today.

I will make my full statement a part of the record.

[The prepared statement follows:]

PREPARED STATEMENT OF SENATOR BOB DOLE

Population trends for the United States and for Kansas show an increasing number of individuals over the age of 65, although the Nation's 24 million persons age 65 and older are considered a diverse group, there are common characteristics among many of them.

Most live on relatively low incomes; while the majority rely on social security for their major source of income, private pensions, and employment are also important sources. How the elderly spend their limited dollars must be a major concern for all of us.

Health care is certainly a major cost and it is for this reason that we are here today to discuss how we can best utilize our dollars to assist the senior citizens, while helping them to remain independent for as long as possible.

The Government's role in financing health care expenditures for the aged has increased substantially, from 30 percent in 1966, to 68 percent in 1976, however, from 1969 to 1976, the medicare share of the aged's total health bill and its hospital and physicians care components has decreased somewhat.

We must keep an important point in mind while the medicare and medicaid program, were expected to provide protection against health care costs for nearly all aged persons in the Nation, neither the Congress nor the administration assumed that these programs would provide totally comprehensive coverage for the health care costs of the elderly.

The program was designed to serve as a foundation upon which people can build greater protection through private health insurance and employer retirement plans.

So in seeking solutions to the problems before us, we must look to a number of sources, which maximize private enterprise, while making the most effective use of Federal and State funds. And in looking to multiple funding sources, we should also seek out multiple provider sources.

It is true that the medicare and medicaid programs have an institutional bias; A bias that has served us well in the past, as our nation has grown healthier, living longer lives, but perhaps it is time to reexamine this bias.

It is time to look to positive alternatives to institutionalization, while continuing to give attention to improvements in our institutions.

I am hopeful that today's hearing will give us an opportunity to hear from you, on this issue of noninstitutional services in addition to other issues you believe to be problems, and how you believe we can best address them.

I understand that there are a number of bills pending before the Kansas Legislature which deal with various health care issues including coverage of drug costs for the elderly, something that I too have an interest in.

I also understand that one group recently held a series of town meetings to discuss health care issues for the elderly, the outcome of which I am interested in hearing about.

Both Kansas and Missouri have taken significant steps towards making noninstitutional services more available. In fact, I believe the Kansas State Health Plan for 1980, specifically addresses this concern.

It will take such cooperative action, by both the States and the Federal Government if we are to truly design a delivery system which allows people to retain their dignity and, as I noted before, their independence.

However, we must keep in mind the realities of a limited pot of dollars. We must make wise use of what we have, as massive expansion seems unlikely at this time.

I would also like to take note of the fact that we have invited and are pleased to have with us today representatives from the Kansas City Regional Office of the Department of HEW, so they will have an opportunity to hear your comments and suggestions.

Senator DOLE. Before asking Senator Danforth to make a statement, I want to recognize those individuals, that I just mentioned, and thank them very much for coming.

Jack, do you have a statement you'd like to make?

Senator DANFORTH. I have a statement that I would just ask to be inserted into the record. I don't think that people came to hear me make a long speech.

I came here, along with you, Senator Dole, to find out the views of the people in the Kansas City area.

I might say that probably one of the most creative leaders in Washington in the whole area of how to finance health care, particularly for elderly people has been Senator Dole.

A year or so ago, he took the leadership in drafting and introducing the bill which he got Senator Domenici and me to cosponsor, which was then called the "Three D Bill" for Dole, Domenici, and Danforth, relating to catastrophic health insurance, to provide some kind of cushion or insurance for people who are hospitalized for long periods of time, so they do not see their life savings and everything they've worked for and planned for wiped out.

Several things have happened since that bill was introduced. I might say that last year, we felt that that bill or something like it had an excellent chance of being enacted into law.

A couple of things have happened that deserve consideration.

The first is that we've become increasingly aware, as Senator Dole has noted, that a larger and larger proportion of our population is over the age of 65 and that their health care costs are greater than average.

Second, inflation continues to go up at an unparalleled rate, close to 20 percent. Inflation, in turn, is a problem which has to be addressed by Government.

It drives up the cost of what Government does. For example, medicare expenses of the Federal Government, in 1 year, went up $4 billion just by virtue of inflation to provide the same coverage. In addition to that, as we all now know, we're trying to combat inflation by getting some restraint on the constant growth of the cost of the Government.

We are involved in a truly vicious circle and a seemingly endless circle, of higher costs of health care, a larger number of people who are incurring high costs of health care, and an increasing problem with the economy in general, and inflation in general, and a budgetary tightness, in order to try to do something about the economy.

The time has come to take a fresh look at the whole question of health care and the kind of thing that Senator Dole and others have been talking about for the past year or so. I don't think there are any easy answers, but I think that the problem certainly deserves airing and that this is an excellent forum in which to do it.

[The prepared statement follows:]

PREPARED STATEMENT OF SENATOR JOHN C. DANFORTH

The latest economic indicators show that our Nation now has an annualized inflation rate of 18 percent. The prime lending rate is now at 20 percent and seems to increase weekly.

The economy affects Government and Government affects the economy. The higher the inflation, the more the Federal Government must spend to provide the same level of benefits and services.

For example, in 1979, the Government spent $28 billion in Medicare benefits; in 1980, the price tag for the same level of services will be about $32 billion.

At the same time, Government has a direct impact on the economy. The Federal Government has not had a balanced budget for 12 years. Increased Government spending and budget deficits are major factors fueling inflation. It is imperative that Congress reduce the size of the Government and balance the budget.

Government regulation, which has increased dramatically in the last decade, directly affects productivity. Congress should evaluate existing programs and regulations to assure that their value is worth the cost.

Older Americans are devastated by the terrible economic conditions. Fixed pensions and savings evaporate rapidly in times of high inflation. One of the leading factors in our high inflation is the increasing cost of health care services.

Older people are hospitalized more frequently than young people, and when they are hospitalized, they stay in the hospital longer. Medicare and Medicaid pay a portion of the health care bill for the elderly, but older Americans are paying an increasing part of the bill themselves directly, out of their own pockets. They must purchase hearing aids, eye glasses, drugs and other noncovered services, all of which are increasing in costs.

They must pay deductibles and co-insurance, both of which increase each year with rising medical costs. They must pay the premiums for Medicare supplemental medical insurance and private insurance. Older Americans are now paying more out of pocket for health care than they paid prior to the enactment of medicare.

To compound our problems, we have an aging population. In 1900, there were approximately 3 million Americans ages 65 or older. In 1976, the number was 23 million. Between 1974 and 2000, the elderly population is estimated to increase by over 40 percent.

What I have described is a time bomb. We have an extremely high rate of inflation, which compels a reduction in Federal spending; we have rapidly rising health care costs which are forcing many older Americans against the wall; and we have an aging population, assuring that health care costs are going to continue to go up for the foreseeable future.

All of this leads to the purpose of today's hearing. There are a variety of Federal programs providing assistance to the elderly; we have Medicare and Medicaid, which help pay the health bills. We have Title XX, which provides adult day care services and other help for the elderly. These programs are under the jurisdiction of the Senate Finance Committee, on which Senator Dole and I serve.

In addition, under the jurisdiction of other committees are the Older Americans Act, providing congregate and home delivered meals as well as other services to older citizens, housing programs, energy assistance, and cash and in-kind benefits for the low-income elderly. These programs total many billions of dollars. How can we spend these dollars more efficiently; is there wasteful overlap; a lack of coordination?

Obviously, living at home is less expensive than a stay in a nursing home and less expensive yet than a stay in a hospital. How can we encourage treatment in lower cost settings? Must we add new benefits or can we stimulate lower cost treatment by coordinating existing programs better?

There are currently shortages of Medicare and Medicaid long-term care beds, which necessarily result in instances of people staying longer in acute care hospitals until a long-term care bed opens up. Why do these shortages exist, and what can be done to eliminate them?

What about redtape, what is the cost of Medicare and other governmental regulations? Can we do with less regulation and less waste?

Finally, there is a growing dependence on Washington in our country. How can volunteerism be encouraged, more volunteer meals-on-wheels programs and volunteers willing to assist the elderly with homemaking chores so they can remain in their homes?

How can we move in the years ahead to meet the growing needs of our elderly population, while reducing the size of the Federal Government?

I look forward to hearing the testimony of todays witnesses on these difficult questions.

Senator DOLE. Thank you, Jack. I also want to recognize Jay Lohman, who is the director of medicare services of Kansas Blue Cross and Blue Shield and Pat Hanlon, the city commissioner for Kansas City, Kans., who has been most helpful.

Just to mention a couple of housekeeping things; as is customary at a hearing, there is never enough time and I need to be on a plane to Wichita about 4 o'clock and Jack needs to be going in other directions.

We have a number of witnesses. We hope we can limit the witnesses' comments to 5 minutes. Their full statements will be made a part of the record. For those who are not scheduled to testify, we would be pleased to have their statements as a part of the record.

I will say that even though you don't read or summarize the statement orally, if it is included in the record it will be read and studied; so it is very important we have your comments. If you'd like to leave your comments, there is a table on the side.

In addition, if you would like a copy of the record today, leave, your name and address.

I would like to again say that we're pleased to be here with you. I join Senator Danforth and the staff who've been working so hard on these hearings in welcoming you.

The first panel would be Barbara Sabol, the secretary of the Department of Aging, Department of the Social and Rehabilitation Services, the State of Kansas; David Monson, Office of Aging, Department of Social Services, State of Missouri; Anita Favors, the director of Wyandotte-Leavenworth Counties, Area Agency on Aging.

If you would all come up to the witness table, we will start with you, Barbara.

STATEMENT OF BARBARA SABOL, ACCOMPANIED BY DAVID MONSON AND ANITA R. FAVORS

Ms. SABOL. Senators Dole and Danforth, I do appreciate this opportunity to speak on behalf of the Kansas Department of Aging.

What I would like to do is to divide my comments into three parts, giving you an overview of Kansas elderly speak a little bit about what we are doing in Kansas, and then what direction we feel we ought to be taking.

I'm not going to review a lot of statistics, but we have recently in Kansas completed a needs assessment for older Kansans, in which 2,500 older people were surveyed.

I'd like to give you a brief summary of some of the information we received from that needs assessment.

As Senator Dole has already mentioned, a large number of our elderly people are on low incomes. Twenty-eight percent of our sample reported an annual income between $2,400 and $4,800 a year.

The primary source of income for 51 percent was social security and 80 percent stated that social security was among their three most important sources of income.

Asking them questions about their health, 89 percent reported that their health was average or above, when compared to others, but the single most frequently cited health problem was arthritis. Sixty-eight percent reported they were taking at least one prescription drug. Twenty-seven percent reported that they were taking three or more prescription drugs. Approximately 30 percent said they were on a special diet.

Some 25 percent reported a disabling illness or accident, within the past year, with illness being much more frequent than accident.

I think there were some general conclusions, and there were a lot of other facts that I could tell you from the needs assessment, but I think one general conclusion is that the young old, those up to the age of 75 perceive themselves as relatively healthy.

As the age increased those who thought ill health was a factor of disability, increased.

Those are some of the things that we're doing. I'm very proud to live in Kansas at this time, because we have a legislature that has made a commitment to aging.

Some of the things we've done are: The passage of a resolution calling for secondary institutions of higher learning to make geriatrics and gerontology into an integral component of their curriculum. I think this is an important factor, and will have a direct relationship to cost.

One other thing that we're doing is a program that we're calling "Project Plus," a program to lower the utilization of services. It is carried out under the auspices of the department of health and environment in conjunction with the Kansas Farm Bureau in Manhattan.

It is designed to assist individuals in taking control of their own health problems and look at the behaviors in lifestyle that would increase the probability of constant or chronic illness.

Another very exciting thing is the publishing of a newspaper to give older people information about things impacting on them, to be circulated to all older people in the area.

In addition to those in communities, we're also concerned about those living in institutionalized care.

Resolution 1673 was passed, which calls for a task force to be formed to look at the recruitment and training of aids in adult care facilities.

We think this will impact cost, because turnover is very high. It is our feeling that with training we could make a significant impact on cost.

Those are some things we are currentliy doing, but what can we do to help meet the needs of the elderly?

We could say we need to reform the system, which could be true, but I'd like to focus on immediate concerns and steps we could take.

One of the things we're concerned about is breaking the spell of illness. We would like to see changes so that the elderly would not have to move from the medicare to the medicaid program prematurely, because the spell of illness cannot be broken.

In addition, we think another important step that could be made is to look at the way we're implementing regulations.

If we could develop regulations that would give States some flexibility in implementing regulations, based on what the State is structured for, that would help.

For example, in Kansas, most of our facilities are 1-story facilities, whereas, in the urban areas, New York or Chicago, we're talking about highrises of perhaps 10 or 15 stories, therefore, we feel that the State ought to have some flexibility in the way that these life safety codes are implemented.

We think the State needs flexibility relating to reimbursement under the medicaid program, allowing the State to reimburse those services that are most cost effective, rather than spelling out a specific provider.

Perhaps there are other health care practitioners who could meet some of the needs of our elderly in nursing homes, without requiring a specific visit; perhaps a nurse clinician could meet a need rather than a physician.

To move on, there are some issues relating to cost containment that I think are significant.

We need to look at the resources we're putting into issues relating to health promotion. While not impacting on those 75 and above, in the long run, if we can engage in those things that promote health, it will increase the probability of not having chronic conditions and certainly impact on the cost of our health care system.

We need to find ways to reduce the numbers of empty beds in hospitals. We need to find ways to better utilize health departments that are already established, then use those resources to provide services for older people.

The coordination of services is probably the most significant thing we can do to provide adequate services to older people. All of us must do more to better coordinate services.

In closing, I think we have not informed consumers well enough as to the cost of various services. Just as we shop for the best and most in-

expensive green beans and other kinds of things, I think consumers also need to be aware of the costs of medical services and shop for the most effective services.

The other thing I would say is that we need to look at the food stamp program in relationship to health impact. If we're talking about reinstituting the cash outlay for older people using that program, this will be a disincentive for older people to use the program and ultimately, we are going to feel the impact of that in the health care system.

As their nutritional status decreases, this will impact on the health care program.

We need to address some research issues. I think there are some questions, if answered, could impact on the cost of care.

We find that minority elderly are using institutional services less than the majority population. We need to look at ways to assist members of families in care of the older persons.

I think more of the consumers will speak to that specific problem.

In closing, home health services not only provide a benefit to the older people, but provide a benefit to all of us who benefit by keeping older people in their communities and homes for as long as they can.

Thank you very much for this opportunity.

Senator DOLE. Thank you, Barbara. We'll hear the entire panel and then you come back for questions, if you have time.

David.

STATEMENT OF DAVID MONSON

Mr. MONSON. I'm pleased to participate in this hearing. After hearing what Barbara had to say, I'd like to focus on two extremely important areas.

There are two issues that should be addressed immediately at the Federal level. Those issues are the coordination of services and the funding of programs for the elderly without reduction.

Missouri is experiencing one of the most unique opportunities in the United States: that is, the combining of all services for the elderly under titles III and XX, medicaid title XIX, and licensing and certification of Missouri's 955 boarding and nursing homes. There is no other State that has attempted this and thus no model available for this task.

Missouri's Division of Aging has the largest service for a single division or unit providing services to the elderly in the United States, and the largest number of employees of any State agency for the elderly in the United States, which in Missouri is 465.

This unique situation has its difficulties. Various programs, with identical services in most cases, have different planning cycles different budget cycles, and different directions.

To make my point briefly, I'm suggesting that in some way the administrations governing and dealing with services for the elderly combine programs that are now available, including budget, programing, and so on.

The second issue which I think should be addressed immediately is concerning H.R. 3434, a need to establish services for the elderly at the highest level possible.

I think it is important to remember that the elderly are on fixed incomes, making everyday living difficult. Also, H.R. 3434 may hopefully maintain its present level of service within title XX.

Inflation alone has reduced service to such an extent, that even maintaining levels, services will be reduced drastically.

I appreciate the opportunity to discuss these two issues and look forward to answering any questions.

Senator DOLE. Anita.

STATEMENT OF ANITA R. FAVORS

Ms. FAVORS. The testimony I bring to you today represents the concerns of elderly consumers and also the concerns of agencies and organizations attempting to provide services.

Health care for the elderly, this year, has moved up on the priority list. Particular areas of concern are cost of health services, transportation or access to health care facilities, medicare and medicaid coverage.

We are concerned that medicare does not currently allow for the purchases of eyeglasses and hearing aids.

Establishment of day health care centers for the elderly is also a special area of concern.

Some other concerns are as follows:

The current regulation under medicare, which limits the number of home health care visits to 100 under part A and requires an additional hospital stay of 3 or more days. It is the feeling of several in our area that not only does this increase the overall cost of health care for the elderly person, but it also causes unnecessary rehospitalization of a patient for 3 days to renew home care visits.

Also care of terminally ill patients could or should be covered under medicare, which would help the terminally ill patient be cared for at home by a loved one, instead of institutionalized. Along that same line, medicare and other third parties should reimburse for maintenance of the elderly in the home.

Efficiency incentives should be incorporated into the medicare and medicaid financial programs. Presently we have no incentive to keep costs down.

The issue of cutting the food stamp program is one that is of much concern for the elderly. What with the rising inflation rate, this is a most crucial issue, affecting many elderly persons.

I'd like to thank you for this opportunity for testifying.

Senator DOLE. Jack.

Senator DANFORTH. Assuming that our efforts in the foreseeable future in Congress are going to be to try to provide the best possible service without having the kinds of new programs which would bust the budget at a time when the President is trying to balance the budget, and when Congress is trying to restore some sort of sense to the economy—what would be, for each of you, your No. 1 priority?

I take it that some of the themes running through your comments are greater emphasis on home health care, consolidation of programs, allowing State and local governments to make more decisions on how to spend the Federal dollars. If there are going to be few, if any,

increases in the Federal spending on health care, what would be your No. 1 priority within that general limitation?

Ms. FAVORS. One is that we make better use of the funds that we have available by making the best use of our regulations and guidelines and making the best use of our programs.

Mr. MONSON. I think if the various components are maintained at their present level, that they not be reduced, because that would be critical. I think it would help to combine programs; it is a unique situation. Fortunately, and unfortunately, we're the first to try and go through the maze, but I think flexibility and coordination of services, ability to get waivers, that kind of cooperation, may make the difference in maintaining services at a certain level.

In the future, we'll get them to the point of stopping looking at services and look at income and taking the service dollars and put that into an income for the elderly so they can so choose for themselves those services they need, and pay for the services themselves.

Ms. SABOL. I think I would underline what they have said and that is giving flexibility to the State. If we make the assumption that the State best knows their population and the regulations could be written so the State could select their own alternatives, I think we would see in the short run States providing better services.

Senator DOLE. You mentioned alternatives. If you take the intermediate-care facility experience, the medicaid experience, the idea at that time was to provide an alternative to more costly skilled-nursing facilities, but rather than reducing spending, it created a new benefit, increasing the total cost.

We only have so much money. You can understand the dilemma we face in Congress.

Ms. SABOL. At the same time the cost was increasing, the numbers of elderly were increasing and the numbers of old people in the very old group, 75 and above, which is one variable.

The other variable is that for another of those people, the institutional choice was made, because those other services were not available. In some parts of our State, there are people who could purchase services but they're not even available.

We have to look at making the system flexible enough so that States can divert some of those funds for institutional care and do something about the empty beds so we can take that money and use it for other services.

We've got to stop thinking about home services as an alternative to institutionalization, which is simply one service you give to people when the home services no longer meet their needs.

Senator DOLE. I think this is a problem we have in both States. In Newton, Kans., somebody handed me a note that says:

> One of the major weaknesses of the Medicare/Medicaid Program in this area is the lack of extended care facilities. The only extended care facility in Harding County is Noundridge. Seven beds in the facility there have been available. Hospitals and care homes say that they cannot afford to meet requirements for extended care facilities.

That is a problem in that area. That is the other side of the coin.

Ms. SABOL. That is true. I might point out we do have an agency on aging. They started out with home health aides and were able to

impact the numbers of people going into institutional care. Then they added occupational therapy. Through teaching of the family and the patient, many are now only receiving periodical visits from a nurse, because they have become self-sufficient.

Those are the kinds of things we'll have to look at. Home health service has now been diverted from those who have become self-sufficient to those who need it.

Senator DOLE. David, you talked about H.R. 3434 and the level of funding for title XX, $2.9 billion.

Mr. MONSON. Yes; $2.7 billion is a minimum of what we're hoping for; $2.9 billion would give us a chance to at least recoup that inflationary factor that cuts services so drastically.

If we go to $2.5 billion, it will be devastating and destroy services to the elderly; maintaining at $2.7 billion, will at least allow us to try and make up the difference to maintain services at a present level. If we went to $2.9 billion, we could maintain services at a present level.

Senator DOLE. I know Barbara commented on food stamps. I'm advised that the Budget Committee on the Senate side last week reduced that program about $1.4 billion, which seems to me, with my experience in that program, to be rather substantial as a reduction.

We're going to have to do the right thing, those of us who are there to cut spending, just so we don't take it all in the wrong places.

Do you have anything else?

Representative WINN. I'd like to ask about the third party, the ones who don't qualify for medicare or medicaid. Then you spoke about efficiency; how would you combine those two factors?

Ms. FAVORS. Efficiency incentives should be incorporated into the medicare and medicaid to try and keep the costs down.

Representative WINN. Can you give us any examples?

Ms. FAVORS. The example would be of nursing homes who would provide a number of services to an elderly person, and I was saying it was an average-cost in a nursing home; if that nursing home could provide quality services for under this cost, they should be provided with incentive to do so.

Senator DOLE. Thank you, we appreciate your coming and your testimony.

[The prepared statements of the preceding panel follow. Oral testimony continues on p. 32.]

PREPARED STATEMENT OF BARBARA J. SABOL, SECRETARY, KANSAS DEPARTMENT ON AGING

I. OVERVIEW OF KANSAS ELDERLY

There are approximately 397,000 persons 60 years of age and over in Kansas. One third (33 percent) are 75 and over; 8 percent are 85 and over. (It is this 75 and over population that is increasing the most rapidly.)

Based on a recently completed needs assessment survey in which 2,500 Kansans aged 60 and over were interviewed, 28 percent report an annual income between $2,400 and $4,800. Primary source of income for 51 percent is social security, and 80 percent stated that social security is among their three most important sources of income.[1]

Based on the respondents' answers to questions concerning health, 89 percent rated their health as average or above when compared with others of their own age but familiar patterns did emerge. For example, the single health problem most frequently cited was arthritis; and 68 percent reported that they were

taking at least one prescription drug, and 27 percent said they were taking three or more prescription drugs. Approximately 30 percent said they were on a special diet with the largest number specifying a salt-free diet, which is often true for persons with heart problems. Some 25 percent had suffered a disabling illness or accident in the past year with illness mentioned more frequently than accidents.[3]

The majority of the respondents indicated they were able to perform many activities satisfactorily. Eighty-four percent stated they found it easy to get around the house or prepare a meal; 69 percent had no difficulty in getting up and down stairs; and 89 percent indicated they could meet their personal care needs without help.[3] However, as age increased so did the difficulties. Twenty-one percent of those 75 and over said they had some difficulty in getting around the house (as compared to 9 percent of those 65–74) and 16 percent of those over 75 said they had some difficulty in meal preparation. (Only 6 percent of those 65–74 years old indicated this was the case.)

Most respondents, 84 percent, said they were covered by Medicare and 15 percent said they had Medicaid.[4]

General conclusions that can be drawn from the information in the survey:

(1) The "young old," those up to age 75, are relatively healthy and do not attribute inability to meet their needs to their health. However, as age increases, so does the percent of those who see ill-health as a factor in disability and, in fact, the number of identified chronic conditions that cause trouble do increase with age.

(2) The older persons become, the higher the probability they will experience physical and mental impairment. In a recent study conducted in Winnebago County, Illinois, 34 percent of the individuals studied who were classified as "confused" also had four or more chronic disorders. Of those who had no chronic disorders, only 4 percent were classified as "confused."[5]

(3) The higher the probability of physical and mental impairments, the higher will be the need for health and supportive services. Many older people live alone, and it is believed that if certain services were available to them they could continue to meet many of their needs and indeed, that their health might not deteriorate as rapidly.

II. WHAT KANSAS IS DOING TO FOCUS ON SERVICES FOR ITS OLDER CITIZENS TO HELP MEET THEIR HEALTH NEEDS

We are proud to live in a State that has shown a real interest in its older citizens. Governor Carlin and the Legislature have demonstrated this interest and have had a great deal of cooperation from older persons themselves, as well as from local units of government. Several of the latter, for example, have initiated a mill levy with the funds thus generated to be spent for programs for the elderly.

There is a concerted effort underway to develop a "continuum of care" of services that would enable older people to continue to live in their communities in their own homes for as long as they can and care to be. For some, institutionalization is a dreaded alternative.

Other illustrations of interest in the well-being of its older citizens that Kansas can point to include:

(1) The creation of a Department on Aging in 1977[6] charged with such responsibilities as:

(a) receiving and disbursement of Older American Act funds;

(b) evaluating programs, services, and facilities for the aged within the state and determining the extent to which these and other programs and services are meeting the needs of the elderly;

(c) making appropriate recommendations to the governor and the legislature for the coordination of all such programs and services;

(d) developing a comprehensive plan to meet the needs of the State's senior citizens;

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[1] Statewide Summary Report: Needs Assessment Survey of Non-Institutionalized Older Kansans, winter 1979/80 (see attachment), p. 10.
[2] Ibid., pp. S–25, 29, 30, 32, 37, 20.
[3] Ibid., p. S–20.
[4] Ibid., p. S–34.
[5] Dennis Frate and Dennis Haffron, "The Medical Management of Elderly Patients: The Health Team Approach," American Public Health Association, Washington, D.C. (no date).
[6] See attachment, art. 59.

(e) promoting community education regarding the problems of older persons; and

(f) keeping informed of the latest developments in national research and programs on problems and needs of aging.

All of these responsibilities are to be under the direction of a secretary appointed by the governor who would be a member of the cabinet. The secretary is to be guided by an advisory council representative of the older residents of the state.

(2) Passage of Senate Concurrent Resolution No. 1622, February 19, 1979, which calls for encouraging the governing authorities of institutions of post-secondary education to make geriatrics and gerontology training and research integral components of health related programs in the educational institutions.[7]

This resolution points out that health professionals are unprepared to serve the needs of an older population that is rapidly becoming the largest patient population. Robert N. Butler, M.D., and currently director of the National Institute on Aging, has been a long-time advocate for such training and believes that the lack of such training is costing us dearly both in quality of health services and in dollars.[8] The Senate Concurrent Resolution supports this view by pointing out that symptoms of health problems among older persons are different than those among younger people, and the health professional without this knowledge may not prescribe the most appropriate care.

(3) The legislature that has just adjourned has passed legislation (Senate Bill No. 692) that establishes a toll-free telephone system to assist persons in obtaining information about and access to services available to older Kansans.[9]

(4) In 1979, Title XX (Social Security Act) funds spent for older Kansans increased. Approximately $2,864,861 or 11 percent of Title XX funds received by the state purchased homemaker services for 7,500–8,000 older persons and home-delivered meals for several hundred homebound elderly. (These figures do not include staff time.) The projections for 1980, show that $4,216,336 of Title XX funds are planned for purchasing the same types of services. This would mean that 14 percent of total Title XX funds would be purchasing services for older Kansans. As required, the state is, of course, supplying matching funds.

(5) In 1979, the Kansas legislature also gave $875,000 to the Department on Aging to be distributed throughout the state to bolster the nutrition program in 1980. The same amount of money has been requested in the 1981 budget.

(6) Sixty-six counties now have home health services. The Department of Health and Environment has recommended that all 105 counties should have such services by 1983.[10]

(7) A program labeled Project Plus (Program to Lower the Utilization of Services) has been carried out by the Kansas Department of Health and Environment, in cooperation with the Kansas Farm Bureau in Manhattan.[11] The program is designed to help Kansans take control of their own health by learning to recognize and change those parts of their lifestyle which may be hazardous to their health. Such things as overweight, smoking, and poor dietary habits will be stressed. Nothing that relates directly to the elderly has yet been developed; yet in a sense all of these are related to promotion of better health.

(8) The Kansas Department on Aging works closely with all eleven of the Area Agencies on Aging in the state. The Department takes the responsibilities outlined by the legislature seriously and cooperates in every way possible with these local agencies. The largest program throughout the state is, of course, the nutrition program. In fiscal year 1979, 1,852,925 meals were served in 83 counties in Kansas. Most of these were served in 202 congregate sites. That number should be increased in 1980, since there is more federal money available. Nutrition services are, of course, believed to be helpful in maintaining health, not only because of the known health hazards of unbalanced diets, but also because the social contacts provided on a daily basis are believed to be beneficial to health.

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[7] S. Conc. Res. No. 1622, attached.

[8] R. N. Butler, M.D., "Medicine and Aging: An Assessment of Opportunities and Neglect," testimony given before the U.S. Senate Special Committee on Aging, and published by National Institute of Health, No. 79-1699, September 1979.

[9] Senate Bill No. 692, attached.

[10] Department of Health and Environment, Joseph F. Harkins, Secretary, The Health of Kansas, February 1980, app. B–5.

[11] Ibid., app. B–1.

A variety of other programs are provided through the Area Agencies that have been determined to be helpful by the older persons residing in those areas. Some programs are required by the federal regulations; others are developed to meet needs identified in the areas.

One of the most successful new programs begun last fall was a monthly newspaper, Active Aging, that is being mailed free to approximately 44,000 older persons in Sedgwick, Harvey, and Butler counties. It carries national and state information relative to older persons, as well as information on area services and events. It has received national publicity through an Associated Press article, and inquiries concerning it have come from a number of states.

(9) The Kansas legislature has also provided Food Sales Tax refunds to older persons and those who were blind or disabled whose annual income was below $10,000. It is estimated that 180,000 elderly persons received the refunds in 1979 which should have helped to meet the increased costs of food.

(10) The Kansas legislature last year provided funds for local health departments to make periodic visists to nursing homes. That funding has been continued, though not increased.

CONCLUSIONS

All of these measures are seen as benefits to help the non-institutionalized elderly in their homes and communities if that is their preference; and most of the studies have indicated that this is the case. At the same time, Kansas has not ignored the needs of some 20,000 older persons residing in 361 adult care homes and nursing homes. Of these, the great bulk (320) are licensed as Intermediate Care Homes; only 38 are licensed as Skilled Nursing Homes; and two are classified as Personal Care Homes. There has been a recent move to classify some homes for the mentally retarded; but for the most part, these have a younger population than do the nursing homes.

Forty-eight percent of Medicaid expenditures in Kansas in 1979 was for health services to the elderly; over half of that for nursing home care. Total Medicaid expenditures for nursing home care was approximately $65 million.

Evidence of this interest is expressed in three pieces of legislation in which the Department cooperated with groups of older people in advocating for their passage. Briefly, those were:

(1) Senate Concurrent Resolution No. 1673 [12] which states that the legislature recognizes the need to maintain a high quality of care for residents of adult care homes and will therefore begin planning for a comprehensive recruitment and training program for aides. Such planning will be carried out by a task force with representatives recommended by the Secretary of Aging, Commissioner of Education, Secretary of Health and Environment, Secretary of Human Resources, State Board of Regents, and Secretary of Social and Rehabilitation Services, and State Board of Nursing. The focus will be on development of a pre-employment training program.

(2) Senate Bill No. 590 which was passed and requires the reporting of certain information such as abuse or neglect, or exploitation relating to residents of adult care homes. The purpose is to provide protective services to residents. Reports will be made to the Department of Social and Rehabilitation Services who will initiate an investigation within 48 hours, but no reports shall be deemed public records, and identification of persons involved shall remain confidential. If needed, protective services will be made available to the resident.

(3) Also passed was Senate Bill No. 2975 which establishes the office of long-term care ombudsman under the supervision of the secretary of Aging and authorizes the ombudsman to enter any long-term care facility and have access to residents at any time without prior notice. Reports are confidential except on order of the court, but will be made to SRS and Health and Environment. This act serves to put Kansas on record as supportive of the Administration on Aging requirement for an ombudsman program.

III. WHAT SHOULD WE BE DOING TO BETTER MEET THE HEALTH NEEDS OF THE ELDERLY?

Although Kansas is concerned about its older residents and their needs and has done much to meet those, there is more that could and should be done. It is unfortunate that it is a fiscal/dollar crunch that spurs us to action in develop-

[12] S. Con. Res. No. 1673, attached.

ing better ways to keep people in their homes and communities. There are human costs as well as dollar costs resulting from unnecessary institutionalization. Adult children seldom want to see their aged parents placed in a nursing home, nor do they look forward to that solution to their own health needs when they become old.

In keeping with the focus of these hearings, I would like to focus on some specific changes that I believe would be helpful in better meeting the needs of the elderly and have the potential for saving dollars as well.

(1) "Breaking the spell of illness" condition practiced in Medicare.

According to the following testimony offered by Mr. Joe Harkins, Secretary of the Kansas Department of Health and Environment:

(Pages 9A and 9B)

BREAKING A "SPELL OF ILLNESS."

I'd now like to comment on a matter of great concern to us in Kansas regarding the administrative method the Health Care Financing Administration follows in determining what facilities are deemed capable of breaking a spell of illness for Medicare patients. It is important to point out that Medicare regulations specifically define skilled nursing homes. Reimbursement for Medicare patients is restricted to such skilled nursing facilities. Notwithstanding this fact, the Health Care Financing Administration has developed an administrative definition for skilled nursing care which is not consistent with the rules and regulations and, in fact, defines all intermediate care facilities in the state of Kansas as skilled nursing facilities. It is no accident that this separate and, in our opinion, inappropriate definition of skilled nursing facilities has been invented by the Health Care Financing Administration as a technique to limit benefits to Medicare recipients to less than they are entitled to. This is a complex issue and I will try to explain it in the simplest terms possible.

When a Medicare recipient is discharged from a hospital to a bona fide skilled nursing facility as defined by Medicare regulations, the spell of illness is appropriately unbroken. Thus the spell of illness period continues for that individual.

If, on the other hand, the same patient would be discharged from a hospital to an intermediate care facility (for which no Medicare reimbursement is provided), the Health Care Financing Administration's second definition of skilled care applies and the spell of illness continues to be unbroken. As a consequence, the elderly resident of an intermediate care facility has a spell of illness continue even though they are discharged from a hospital back to their permanent place of residence, which is not by federal definition a skilled nursing facility. This matter has been brought to the attention of Health Care Financing Administration officials on several occasions and they have told us it is no accident that a separate and conflicting definition of a skilled nursing facility has been invented. They have, in fact, advised us that it was invented for the specific purpose of limiting costs in the Medicare program. In reality this procedure simply forces Medicare recipients to spend their own resources for purchases of medical care and they end up being driven into poverty by high medical care costs and eventually find themselves dependent upon the state welfare program.

I completely understand and appreciate the desire of the Health Care Financing Administration to be fiscally prudent. I cannot agree with nor accept the practice of circumventing the intent of the federal legislation, however, by this administrative practice. There would be a significant increase in costs for the Medicare program if this administrative practice ceases. It would be our recommendation, however, that if the Medicare program needs modification in order to provide an adequate level of necessary services to the elderly, that the Congress take steps to see that this happens prior to entering into other costly health insurance programs for groups other than the nation's elderly. I would strongly recommend that Congress place priority on making the programs we have in place work correctly before giving serious consideration to extending eligibility to other groups who are not as needy as the elderly.

(2) Review of regulations governing Title XVIII (Medicare) and XIX (Medicaid). There is a need for regulations and certain minimal standards, but there is also need of flexibility that would allow states the opportunities to protect and serve the old who need it and at the same time meet the tests of effectiveness and efficiency. We must recognize that there are costs associated with regulations.

Examples:

(a) Life Safety Codes: Fire safety codes are necessary; however, these are written to apply to multi-storied facilities such as those found in large cities like New York, Chicago, and Philadelphia. In Kansas, very few adult care facilities are more than one story and the state should have the flexibility in implementing the regulations tailored to the type of facility.

(b) Provision of mental health services that are reimbursable under Medicaid. Title XIX appears to allow payment to a psychiatrist or psychologist to provide care to an older person in a facility but does not cover the cost if the service is provided by a community mental health center. The latter would not be as costly and the state should have the flexibility to choose the most cost-effective service that meets the resident's needs.

(c) Physicians are required to visit the nursing home resident every sixty days. Older persons should be examined as often as their condition requires, but there are differences in conditions and therefore in needs. The states should have the flexibility to design a system that meets those individual needs. Case management is one method that has been proposed and meeting the social needs of the resident might be or more important to the individual's health. Furthermore, it is possible that a nurse clinician or a physician's assistant could provide some routine health checks for those residents whose conditions have become stabilized. This is particularly important in the rural areas where physician services are in short supply.

(3) There should be ways of developing more coordination with local health departments. There was a bill introduced in the legislature in Kansas this year that would have provided more money for local health departments. The Department of Aging supported that bill because we are well aware that more money would mean more health service in communities in Kansas, and increasingly, the population in most of those communities is one that is growing older.

IV. COST CONTAINMENT

(1) Prevention of disabling illness has been stressed as an ideal means of reducing health costs for years; until recently, it has not received much actual attention. That is now changing and is taking on a positive image in promotion of health. The physical fitness programs, the anti-smoking campaigns, the "eating right" slogans should have long-range effects on health costs. These promotions should result in less costly bouts with serious illness.

(2) Encouraging competition in the delivery system through encouragement of Health Maintenance Organizations. This has apparently been quite successful in cutting hospital utilization in some places.[13]

(3) Informing consumers of costs of various prescription drugs, hospital services, and treatments, and physicians' fees.[14] Comparison shopping could then take place. Consumers have a right to know which of these is the least costly.

(4) Find ways to reduce the number of empty beds in hospitals. Harder quotes estimates of 200,000 to 300,000 empty hospital beds in the U.S. costing between $1 to $10 billion dollars a year. In Kansas, he states, on any given day there are 4,200 empty hospital beds costing the taxpayers between $50 and $150 million dollars a year.[15]

(5) Better use of local health departments for screening with reimbursement under Medicare and Medicaid would be using a less costly service already in place and supported out of tax dollars.

Finally coordination of service, social and medical, should produce higher quality service and potentially lower the cost. Better training of health professionals which includes greater knowledge of the ills of the elderly and a willingness to work with other service deliveries is being tried on a limited scale in some places. It is being tried in one county in Iowa and although cost figures aren't yet available, health professionals, social service deliverers, and the recipients of service all seem highly enthusiastic about the project and its possibilities. Services are fitted to person needs, and careful monitoring of the project, including cost, is taking place.

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[13] Walter McClure (Minnesota's Interstudy group) in a speech before a Wichita, Kans., group of business and labor leaders, May 1979.

[14] Robert C. Harder and Christopher J. Smith, "Strategies for Controlling the Cost of State Medical Assistance Programs," Public Welfare, spring 1979, 39–49.

[15] Ibid.

V. SUMMARY

Given the changing composition and age structure of the Kansas population, it stands to reason that changes in health needs will occur and services need to change to meet these. All chronic disease will not respond to "curative" practices. Research has shown that most older folk do not fear death; they do fear the process of dying. Much of our modern high cost technology is designed to prolong that process.

We need to provide services that enable the old to live out their days as comfortably as possible and if they are helped through a variety of services to continue to live those lives as they want to and with some sense of security, it is entirely possible their health problems will also be lessened.

The 86 year old woman who has high blood pressure, blackouts caused by some unidentified "blockage", severe arthritis, says,"I go dancing three times a week—if I didin't I'd give up." She may die of her "blockage" sometime while she is dancing, but if so, she will die happy!

The health system made it possible for so many persons to live to become old; it now needs to find ways to adjust itself to their needs. But other systems need to do the same. Some of the regulations in the Older Americans Act need to be more flexible such as the one in the 1978 Admendments that reduced payment for social services under III-C; and the Medicare regulation that requires a three-day hospital stay before admission to a nursing home even for recuperative purposes unnecessarily inflating costs. This could be changed.

Some research needs to be done that might yield practical knowledge that we currently do not know: For example:

1. Why is it that a smaller percentage of minority elderly are institutionalized than is true of the total population? Is this all due to the fact that lower life expenctancy for minorities means that far fewer reach the age of vulnerability? Or is it possible that differing family arrangements exist that result in the family providing care for its older members? If the latter is true, is it possible that these families have developed patterns that would be useful to the total society?

2. Are we overlooking possible benefits of family support systems by providing disincentives rather than incentives to those systems? For example, Medicaid will pay for the care of an older person in a nursing home; it would not reimburse families for providing comparable care. As a matter of fact, very little public support is provided for adult day or respite services.

There questions need to be answered; only through learning more than we now know about older families and their coping mechanisms will we have guidance on the social and economic practicality of proposals.

OVERVIEW OF RESULTS

Employment and Economic Circumstances	Data Reference
Statewide, 85 percent of those in the target population are not employed for pay. Among those not employed, 23 percent report Social Security as their only source of income; 10 percent express a desire to work.	(S-1)
Among older Kansans who are employed (15%), a majority (54%) work as laborers, and 19 percent work in clerical or sales jobs. For most (65%) their current employment does not represent a change in the kind of work done before retirement.	(S-2)
Ninety-six percent say they have never been laid off or denied a job because of their age. A few (4%) have applied for unemployment compensation on at least one occasion since reaching age 60.	(S-3)
The largest group (28%) report annual incomes of between $2,400 and $4,800. Six percent report incomes of less than $2,400 and 15% report incomes of more than $13,000.	(S-4)
Fifty-one percent report social security is their primary source of income. A total of 80% list social security among their three most important sources of income. Income from savings or investments is listed among the three most important sources by 36% but is much less frequently listed (by 9%) as the primary source. Pension or retirement payments from former employers is listed as the primary income source by 12% and as one of the three most important sources by 28%.	(S-5 thru S-7)
Asked how additional income would be spent if it were suddenly available, the largest number say they would spend it for travel or entertainment. Among the basic necessities, housing is most frequently mentioned (by 18%) as the item on which additional income would be spent.	(S-8)

Article 59.—DEPARTMENT ON AGING

Cross References to Related Sections:
Adult care homes, see 39-923 et seq.
Aged persons, county aid, state participation, see Kan. Const. Art. 7, § 4.
County program for aged persons, see 19-2678.
Fish and game licenses, exemptions for aged, see 32-104b.
Homes for aged, see 19-2106 et seq.
Homestead property tax relief, see 79-4501 et seq.
Housing for aged persons, tax exemptions, see 79-201b.
Meal services for the aging, use of school lunch facilities, see 30-711a.
Municipal housing law, see 17-2337 et seq.
Personal representative, appointment to receive and manage old age assistance payments, see 59-2801 et seq.
State parks motor vehicle permits, exemptions for aged persons, see 74-4509a.

75-5901. Citation of act. This act shall be known and may be cited as the Kansas act on the aging.

History: L. 1977, ch. 288, § 1; April 28.

75-5902. Definitions. As used in this act, unless the context clearly requires otherwise, the following terms shall have the meanings ascribed to them in this section:

(a) "Department" means the department on aging created by K.S.A. 75-5903.

(b) "Secretary" means the secretary of aging.

(c) "Council" means the advisory council on aging created by K.S.A. 75-5911.

(d) "Aged" or "senior citizen" means a person sixty (60) years of age or older.

(e) "Services" means those services designed to provide assistance to the aged such as nutritional programs, facilities improvement, transportation services, senior volunteer programs, supplementary health services, programs for leisure-time activities, housing and employment counseling, other informational, referral and counseling programs to aid the aged in availing themselves of existing public or private services or other similar social services intended to aid the senior citizen in attaining and maintaining self-sufficiency, personal well-being, dignity and maximum participation in community life.

History: L. 1977, ch. 288, § 2; April 28.

75-5903. Department on aging established; secretary of aging; appointment and confirmation; department to receive and disburse federal older American act moneys. (a) On July 1, 1977, there shall be and is hereby created a department on aging. The department on aging shall be administered under the direction and supervision of the secretary of aging. The secretary shall be appointed by the governor, with the consent of the senate and shall serve at the pleasure of the governor. In appointing the secretary the governor shall consider, but is not limited to, persons suggested by the council and persons with responsible administrative experience in the field of gerontology. The secretary shall be in the unclassified service under the Kansas civil service act and shall receive an annual salary to be fixed by the governor with the approval of the state finance council.

On and after July 1, 1977, the department on aging shall be the single state agency for receiving and disbursing federal funds made available under the federal older Americans act (public law 89-73) and any amendments thereto or other federal programs for the aging.

History: L. 1977, ch. 288, § 3; April 28.

75-5904. Transfer of powers, duties and functions; preservation of orders and directives. (a) On and after July 1, 1977, all the powers, duties, functions, records, property and personnel of the existing services to the aging section of the department of social and rehabilitation services are hereby transferred to and conferred and imposed upon the secretary of aging created by this act, except as otherwise provided.

(b) The secretary of aging created by this act shall be a continuation of the services to the aging section of the department of social and rehabilitation services and shall be the successor in every way to the powers, duties and functions of the section, except as herein otherwise provided. On and after July 1, 1977, every act performed in the exercise of such powers, duties and functions by or under the authority of the secretary of aging shall be deemed to have the same force and effect as if performed by the services for aging section of the department of social and rehabilitation services in which such functions were vested prior to July 1, 1977.

(c) On and after July 1, 1977, wherever the services to the aging section of the department of social and rehabilitation services, or words of like effect, is referred to or designated by a statute, contract or other document, such reference or designation shall be deemed to apply to the secretary of aging.

(d) All orders and directives of the services to the aging section of the department of social and rehabilitation services in existence immediately prior to July 1, 1977, shall continue in force and effect and shall be deemed to be duly issued orders and directives of the secretary of aging, until reissued, amended or nullified pursuant to law.

History: L. 1977, ch. 288, § 4; April 28.

75-5905. Certain officers and employees transferred to new department; civil service and retirement benefits preserved; civil service laws applicable. All officers and employees who were engaged immediately prior to July 1, 1977, in the performance of powers, duties and functions of the services to the aging section of the department of social and rehabilitation services and who, in the opinion of the secretary of aging, are necessary to perform the powers, duties and functions of the department on aging, shall become officers and employees of the department on aging. Any such officer or employee shall retain all retirement benefits and rights of civil service which had accrued to or vested in such officer or employee prior to July 1, 1977, and the service of each such officer and employee so transferred shall be deemed to have been continuous. All transfers and any abolishment of positions of personnel in the classified service under the Kansas civil service act shall be in accordance with civil service laws and any rules and regulations adopted thereunder.

History: L. 1977, ch. 288, § 5; April 28.

75-5906. Conflicts as to disposition of powers, functions, duties, funds, property or records resolved by governor. (a) On and after July 1, 1977, when any conflict arises as to the disposition of any power, duty or function or the unexpended balance of any appropriation as a result of any transfer made by this act, or under authority of this act, such conflict shall be resolved by the governor, and the decision of the governor shall be final.

(b) On and after July 1, 1977, the department on aging shall succeed to all property and records which were used for, or pertain to, the performance of the powers, duties and functions transferred to the department on aging under the provisions of this act. Any conflict as to the proper disposition of such property or records arising under this section, and resulting from any transfer made by this act of powers, duties and functions to the secretary of aging, shall be determined by the governor, whose decision shall be final.

History: L. 1977, ch. 288, § 6; April 28.

75-5907. Rights saved in legal actions and proceedings. (a) No suit, action or other proceeding, judicial or administrative, pertaining to services for the aging or the powers, duties or functions of the services to the aging section of the department of social and rehabilitation services, lawfully commenced, or which could have been commenced, by or against the secretary of social and rehabilitation services in such secretary's official capacity or in relation to the discharge of such secretary's official duties, shall abate by reason of the governmental reorganization effected under the provisions of this act. The court may allow any such suit, action or other proceeding to be maintained by or against the secretary of social and rehabilitation services.

(b) No criminal action commenced or which could have been commenced by the state shall abate by the taking effect of this act.

History: L. 1977, ch. 288, § 7; April 28.

75-5908. Powers and duties of secretary. In addition to powers and duties otherwise provided by law, on and after July 1, 1977, the secretary shall have the following powers and duties:

(a) To evaluate all programs, services and facilities for the aged within the state and determine the extent to which present public or private programs, services and facilities meet the needs of the aged.

(b) To evaluate and coordinate all programs, services and facilities for the aging presently furnished by state and federal agencies, and make appropriate recommendations regarding such services, programs and facilities to the governor and the legislature.

(c) To function as the sole state agency to develop a comprehensive plan to meet the needs of the state's senior citizens.

(d) To receive and disburse federal funds made available directly to the department, including those funds made available under the federal older Americans act of 1965 (public law 89-73) and any amendments thereto, for providing services for senior citizens or for purposes related thereto and to develop and administer any state plan for the aging required by federal law.

(e) To solicit, accept, hold and administer in behalf of the state any grants, devises, or bequests of money, securities or property to the state of Kansas for services to senior citizens or purposes related thereto.

(f) To provide consultation and assistance to communities and groups developing local and area services for senior citizens.

(g) To promote community education regarding the problems of senior citizens through institutes, publications, radio, television and the press.

(h) To cooperate with agencies of the federal government in studies and conferences designed to examine the needs of senior citizens and to prepare programs and facilities to meet those needs.

(i) To establish and maintain information and referral sources throughout the state in conjunction with other agencies.

(j) To provide such staff support as may reasonably be required by the council.

(k) To establish state policies for the administration of the department; for the disbursement of federal older Americans act funds within the state; and for state administration of federal older Americans act programs consistent with relevant federal law, rules and regulations, policies and procedures.

(l) To keep informed of the latest developments of research, studies and programs being conducted nationally and internationally on problems and needs of aging.

(m) To adopt such rules and regulations as may be necessary to administer the provisions of this act.

History: L. 1977, ch. 288, § 8; April 28.

75-5909. Secretary may organize department and assign functions, powers and duties; secretary to meet with council. (a) On and after July 1, 1977, the secretary may create and establish offices, divisions and administrative units as necessary for the efficient administration and operation of the department and may assign functions, powers and duties to the several offices, divisions and administrative units in the department.

(b) On and after July 1, 1977, the secretary shall meet regularly with the council to advise the council on all matters relating to the policy and administration of programs and services to the aging provided by the department.

History: L. 1977, ch. 288, § 9; April 28.

75-5910. Appointment of subordinate officers and employees; duties and powers. Except as otherwise provided in this act, and subject to the Kansas civil service act, the secretary shall appoint all subordinate officers and employees of the department and all such subordinate officers and employees shall be within the classified service under the Kansas civil service act. The secretary may appoint one personal secretary and one special assistant who shall be in the unclassified service and shall receive compensation fixed by the secretary and approved by the governor. Personnel of the department shall perform such duties and exercise such powers as the secretary may prescribe and such duties and powers as are designated by law.

History: K.S.A. 75-5910; L. 1978, ch. 332, § 56; July 1.

75-5911. Advisory council on aging; appointment of members. (a) There is hereby created the advisory council on aging. The council shall consist of nineteen (19) members. Fifteen (15) members shall be appointed by the governor, one member shall be appointed by the president of the senate from among the members of the senate, one member shall be appointed by the minority leader of the senate from among the members of the senate, one member shall be appointed by the speaker of the house of representatives from among the members of the house of representatives and one member shall be appointed by the minority leader of the house of representatives from among the members of the house of representatives. At least ten (10) members of the council shall be senior citizens and shall represent insofar as possible different geographical, social and ethnic groups.

(b) As the terms of members expire and as vacancies otherwise occur in the membership positions of the advisory council on aging, members of the council shall be appointed so that the council shall consist of at least one member from each planning and service area and the remaining members shall represent varying geographic regions in the state. No provision of this act shall affect the term of any member of the advisory council on aging appointed prior to the effective date of this act.

History: K.S.A. 75-5911; L. 1978, ch. 375, § 1; L. 1979, ch. 299, § 1; July 1.

75-5912. Same; terms of members. (a) Of the members first appointed to the council, as designated by the governor at the time of each appointment, three members shall serve on the council for a term of one year; three members shall serve for a term of two years; and five members shall serve for a term of three years.

(b) Of the four members appointed to fill the positions on the advisory council on aging which are created by this act, as designated by the governor at the time of each appointment, two members shall serve on the council for a term of three years and two members shall serve for a term of one year.

(c) Any member appointed to fill a vacancy occurring prior to the expiration of the term for which his or her predecessor was appointed shall be appointed for the remainder of such term.

(d) Upon the expiration of the initial terms set forth in this section, members appointed to subsequent terms shall be appointed for a period of three years. Members shall be eligible for reappointment.

(e) Members appointed by the president of the senate, the minority leader of the senate, the speaker of the house of representatives and the minority leader of the house of representatives shall serve at the pleasure of the person holding the office held by the person appointing such members.

History: K.S.A. 75-5912; L. 1978, ch. 375, § 2; L. 1979, ch. 299, § 2; July 1.

75-5913. Same; chairperson; procedure; compensation; meetings. (a) The chairperson of the council shall be designated by the governor. The council shall provide for its organization and operating procedure including the selection of such other officers as deemed necessary.

(b) Members of the council attending meetings of the council, or attending a subcommittee meeting of the council authorized by the council, shall be paid amounts provided in subsection (e) of K.S.A. 75-3223 and amendments thereto.

(c) The council shall meet at least twice a year or as often as the chairperson of the council or the secretary of the department deems necessary, or upon written request of five (5) members of the council, but in any case, the council shall not meet more than twelve (12) times in any one year.

History: L. 1977, ch. 288, § 13; April 28.

75-5914. Same; powers and duties. The council shall have the following powers and duties:

(a) Provide advocacy for the aging in the affairs of the department, the governor's office and other public and private, state and local agencies affecting the aging.

(b) Review and comment upon reports of the department to the governor and the legislature.

(c) Prepare and submit to the governor, the legislature and the secretary an annual report evaluating the level and quality of all programs, services and facilities provided to the aging by state agencies.

(d) Review and comment upon the comprehensive state plan prepared by the department.

(e) Review and comment upon disbursements by the department of public funds to public and private agencies.

(f) Recommend candidates to the governor for appointment as secretary for the department.

(g) Consult with the secretary regarding the operations of the department.

(h) Serve as the advisory committee to the governor and the department on aging as required and defined in the rules and regulations, part 903.50(c), issued under the federal older Americans act of 1965 (public law 89-73) and amendments thereto.

History: L. 1977, ch. 288, § 14; April 28.

75-5915. Transfer of appropriations; liability for accrued compensation of officers and employees transferred to department. (a) On July 1, 1977, the balance of all funds appropriated and reappropriated to the department of social and rehabilitation services for the services to the aging section of said department shall be and is hereby transferred to the department on aging and shall be used only for the purposes for which the appropriation was originally made.

(b) On July 1, 1977, liability for all accrued compensation or salaries of officers and employees who, immediately prior to said date, were engaged in the performance of powers, duties or functions of the services to the aging section of the department of social and rehabilitation services, and who become officers and employees of the department on aging, shall be assumed and paid by the department on aging.

History: L. 1977, ch. 288, § 15; April 28.

Session of 1979

Senate Concurrent Resolution No. 1622

By Committee on Education

2-19

A CONCURRENT RESOLUTION encouraging the governing authorities of institutions of post-secondary education to make geriatrics and gerontology training and research integral components of health related programs in said educational institutions.

WHEREAS, The quality of medical care has increased the average life expectancy of American citizens, but yet health professionals and paraprofessionals are almost totally unprepared to serve the needs of older persons; and

WHEREAS, Nationally, the over-65 age group constitutes only ten percent of the total population but it uses twenty-five percent of the nation's health resources and requires the largest fraction of all governmental health expenditures, and the number of Americans aged 60 and over will escalate to twenty-five percent of the total population by the year 2000; and

WHEREAS, The medical and other health-related fields are unprepared for this age shift in health care and medical needs since there is an almost complete lack of training for specialists in the specific health problems of the older age group as shown by a recent survey which disclosed that only one educational institution, out of 147 responding, has any mandatory medical training in geriatrics and gerontology, and there is only one endowed chair of geriatric medicine in the United States, at the New York-Cornell Medical Center in New York City, and that was established only about two years ago; and

WHEREAS, Most health insurance programs do not provide coverage for elderly persons, and the private health care system does not have adequate capacity to provide a full range of geriatric services; and

WHEREAS, Symptoms for appendicitis, heart attack, and other diseases, manifest themselves differently in an older person than they do in a younger person and many otherwise well-informed physicians who are unfamiliar with geriatric medicine are not

qualified to care for elderly patients; and

WHEREAS, The elderly pay taxes to support the educational institutions and, therefore, have a right to expect a medical field capable of ministering to their medical needs and integrating the growing body of knowledge in the field of geriatrics and gerontology into health related curriculums simply expands our recognition of human developmental stages and will train our health professionals to work with and understand the whole human being: Now, therefore,

Be it resolved by the Senate of the State of Kansas, the House of Representatives concurring therein: That the Legislature, in recognition of the facts contained in the preamble of this resolution and in an effort to bring about change in the vital area of geriatrics and gerontology training and research, hereby encourages and urges the governing authorities of the various institutions of post-secondary education within this state to provide for the educational institutions under their control and supervision to make training and research in geriatrics and gerontology an integral component of the overall education and training provided by said educational institutions in the health-related disciplines of medicine, nursing, social work, pharmacy and allied health fields.

Be it further resolved: That the Secretary of State is hereby directed to transmit a copy of this resolution to the State Board of Regents, the State Board of Education, the Board of Regents of Washburn University, the Boards of Trustees of the community junior colleges, the Boards of Education of Area Vocational Schools, and the Boards of Control of Area Vocational-Technical Schools.

As Amended by Senate Committee

Session of 1990

SENATE BILL No. 692

By Senator Smith

1-30

AN ACT establishing a toll-free telephone system to assist persons in obtaining information about and access to services available to older Kansans.

Be it enacted by the Legislature of the State of Kansas:

Section 1. (a) The secretary of aging shall establish a telephone system to assist older Kansans, friends and relatives of older Kansans and other persons in obtaining information about and access to services available to both institutionalized and non-institutionalized older Kansans. The telephone system shall be designed to permit any person in the state to place a toll-free call into the system.

(b) The secretary of aging shall:

(1) Publicize the existence and purpose of the toll-free telephone system established by this section and the telephone number of such system;

(2) develop policies and procedures to document requests for assistance and monitor follow-up on such requests;

(3) develop policies and procedures to maintain confidentiality of requests for assistance;

(4) develop a program to train and coordinate the use of older Kansans within the toll-free telephone system;

(5) provide as part of the toll-free telephone system a call-forward system to assist in providing access to information; and

(6) develop a handbook of information to answer requests and for further referral.

~~(c) Notice of the existence of the toll-free telephone system established by this section and the telephone number of such system shall be displayed prominently in every adult care home~~

~~in this state.~~

(c) Upon written notification by the secretary of aging, every adult care home, as defined in subsection (a)(1) of K.S.A. 1979 Supp. 39-923, title XX adult residential home licensed under K.S.A. 1979 Supp. 75-3307b, recuperation center, as defined in subsection (g) of K.S.A. 1979 Supp. 65-425, intermediate care facility, as defined in section 1905(c) of the federal social security act, skilled nursing facility, as defined in section 1861(j) of the federal social security, and any other institution or facility which is licensed or certified by the state, which offers health, social or dietary care to elderly persons on a regular basis, and which is financed in whole or in part by funds from the federal government, the state of Kansas, or any political subdivision thereof, shall prominently display notice of the existence of the toll-free telephone system established under this section and the telephone number of such system.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

(Corrected)

[As Amended by Senate Committee of the Whole]

As Amended by Senate Committee

Session of 1960

Senate Concurrent Resolution No. 1673

By Committee on Education

2-28

A CONCURRENT RESOLUTION relating to a comprehensive recruitment and *[*~~pre-~~*]*employment training program for adult care home aides.

WHEREAS, Any proposed program calling for pre-employment training of adult care home aides must necessarily provide for the gradual phasing in of the program; and

WHEREAS, The quality of care for residents of Kansas adult care homes ~~suffers due to a need for pre-employment training of~~ *is materially affected by the availability of trained* aides, the lack of which results in unnecessary human suffering; and

WHEREAS, There is a continuing deficiency of unlicensed nursing personnel, generally known as aides, in Kansas adult care homes due to high turnover, absenteeism and the lack of a sufficient labor pool; and

WHEREAS, Frequent job turnover and employee absenteeism are detrimental to the care of adult care home residents and increase the costs of care; and

WHEREAS, ~~Trained adult care home aides do not receive adequate compensation for the difficult work which they do, thus resulting in a low level of~~ *The level of compensation of trained aides is a very important factor in personal turnover and* job satisfaction; and

WHEREAS, The educational institutions of Kansas, both secondary and postsecondary, have the capability of training people to provide needed services: Now, therefore,

Be it resolved by the Senate of the State of Kansas, the House of Representatives concurring therein: That in recognition by the Legislature of the state of Kansas of the need to maintain a high quality of care for residents of adult care homes and in an effort to

begin meaningful planning for a comprehensive recruitment and ~~pre-employment~~ training program for adult care home aides, the Secretary of Aging, the Commissioner of Education, the Secretary of Health and Environment, the Secretary of Human Resources, the State Board of Regents, ***the Secretary of Social and Rehabilitation Services*** and the State Board of Nursing be directed to appoint persons from their respective agencies to form a task force for the purpose of developing, coordinating and recommending a plan to provide for comprehensive recruitment and ***training especially*** pre-employment training of aides for adult care homes. The task force may call upon other agencies of government to provide assistance and shall solicit suggestions and proposals from citizens and groups interested in adult care homes. The plan shall include, but not be limited to: A recommended time-frame for gradually phasing in the proposed ~~program~~ ***plan***; a recommended pre-employment training course; how, where and when the recommended course will be offered; a proposal for recruiting persons to receive training; and a proposed level of compensation to improve job satisfaction and reduce the rate of turnover and absenteeism; ***a comprehensive evaluation of the fiscal impact on adult care home operations of any recommendations or proposals of the task force;*** and

Be it further resolved: That the Secretary of State be directed to deliver enrolled copies of this resolution to the Secretary of Aging, the Commissioner of Education, the Secretary of Health and Environment, the Secretary of Human Resources, the State Board of Regents, ***the Secretary of Social and Rehabilitation Services*** and the State Board of Nursing; and

Be it further resolved: That the task force report its plan for a comprehensive recruitment and pre-employment training program for adult care home aides to the Legislature and to the Governor on or before December 1, 1980.

JOSEPH P. TEASDALE
GOVERNOR

STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF AGING
P.O. Box 570
JEFFERSON CITY 65102

DAVID R. FREEMAN
DIRECTOR

DAVID MONSON
DIRECTOR

SUMMARY OF MISSOURI NEEDS

An examination of the ranking of needs shows clearly that income and health care were held by survey respondents to be the most important needs. Furthermore, these were considerably more important than other ranked needs.

After income and health care, transportation and crime were indicated as the next most important concerns. The respondents indicated these as considerably less important than income and health care; however, they were certainly of greater concern than other ranked needs of isolation, nutrition, housing.

RANKING OF NEEDS AND PERCENTAGE OF RESPONSES INDICATING A PARTICULAR NEED AS "A VERY IMPORTANT PROBLEM" OR "SOMEWHAT OF A PROBLEM" FOR BOTH UNWEIGHTED AND WEIGHTED RESPONSES

	UNWEIGHTED RESPONSES		WEIGHTED RESPONSES	
Need	Very Important Problem	Somewhat of A Problem	Very Important Problem	Somewhat of A Problem
Income (money)	14.4%	25.8%	13.3%	25.7%
Health Care	11.6%	20.7%	11.8%	19.7%
Transportation	6.5%	12.9%	6.2%	12.1%
Crime	4.6%	11.4%	5.1%	11.4%
Isolation	2.9%	10.2%	3.1%	10.2%
Nutrition	2.7%	7.9%	2.9%	7.9%
Housing	2.4%	6.3%	2.4%	6.3%
Activity	2.0%	9.4%	2.0%	9.3%
Employment	1.9%	6.9%	2.2%	6.8%
Age Discrimination	1.2%	5.8%	1.3%	6.2%
Education	.8%	5.4%	.7%	5.3%

Leisure activities, employment, age discrimination and education were reported by the fewest respondents as an important need. While it should be recognized that a problem may affect only a small proportion of the population, to those citizens, the problem is still "very important."

When the respondents were asked to identify among all "very important problems" the most serious problem, the listing was as follows:

Income (Money)	39.2%
Health Care	24.7%
Transportation	11.2%
Crime	11.1%
Housing	4.2%
Isolation	2.5%
Nutrition	2.0%
Activity	1.8%
Employment Opportunities	1.6%
Education	0.9%
Age Discrimination	0.8%

According to the Missouri Needs Assessment, the "Frail Elderly" definition was "a respondent who is unable to perform any of the variables (dressing, bathing, preparing meals"); however, no effort was made to demonstrate the degree of fragility.

Using 350 respondents (identified as frail elderly) the responses were as follows:

	Very Important Problem	Somewhat of A Problem
Income (Money)	21.0%	29.0%
Health Care	24.6%	25.5%
Transportation	12.5%	16.2%
Crime	3.8%	10.2%
Isolation	6.0%	11.4%
Nutrition	4.9%	12.5%
Housing	4.0%	6.1%
Activity	4.8%	12.5%
Employment	2.0%	6.3%
Age Discrimination	1.0%	5.5%
Education	1.6%	5.5%

Proportionately the needs of the fragile elderly are more extensive than the total population of persons age 60 or older.

FINAL PERSPECTIVES ON PROBLEMS AND NEEDS OF THE ELDERLY

The very nature of analyzing a needs assessment survey places emphasis on identification of needs and consideration of factors which might be associated with these needs. As a result, there may be some distortion of what is actually the situation of circumstances of most persons 60 years of age or older.

The questions concerning needs asks a respondent if a particular need was "a very important problem", "somewhat of a problem", or "no problem". Even with the number one ranked need, income, 59.8% of the respondents said income

was no problem. Obviously, as one moves down through the ranked needs, the proportion of respondents replying "no problem" for a particular need increases. Thus, for health care this was 66.8%; for transportation 80.6%; for crime 84.0%; for isolation 86.9%; for activities 88.5%; for nutrition 89.4%; for employment 91.1%; for housing 91.3%; for age discrimination 93.0%; and for education 93.8% of the respondents said this was "no problem."

When respondents were asked, considering everything, how satisfied they were with life, 61.3% replied that they were "very satisfied" and 25.3% said "somewhat satisfied". Only 1% of the respondents said they were "very dissatisfied" with life. When the question was asked how the respondent felt about retiring, 49.6% gave positive responses. Finally, when respondents were asked how often they felt lonely, which is a fairly good indicator of discontentment, 55.9% said "almost never".

It would seem that most older persons manage reasonably well with little or no assistance and are reasonable content with life. This should not be taken as an effort to denigrate the needs of other older persons. To these people who have needs, there can be little comfort in knowing that other older people manage fairly well. It is fortunate that the needs of older people are no more extensive than they are, for should they be, an already burdened system would face even greater difficulties. Furthermore, as the proportion and number of older persons increases in America it may be difficult to meet even the most minimal requirements of older people.

DBM:pds
4/11/80

PREPARED STATEMENT OF ANITA FAVORS

Senators Dole and Danforth, and Congressman Winn, good afternoon. My name is Anita Favors, and I'm the Director for the Wyandotte-Leavenworth Area on Aging.

The Area Agencies on Aging are mandated, thru the Older American's Act, to plan and implement programs for the elderly in designated planning and service areas. This is accomplished by the subcontracting of Older American Act funds to agencies in the community that can provide a needed service, and also by coordination of existing services and pooling of untapped resources.

The testimony I present to you today represents the concerns of elderly consumers as reported to our agency thru public hearings and surveys, and also the concerns of agencies and organizations attempting to provide services to the elderly.

This year health care has moved up on the Area Agency on Aging's priority list from number 4 to number 2. Particular areas of concern are 1, the high cost of health services; 2, transportation or access to health service facilities; and 3, medicare and medicaid coverage and the problems inherent in the rules and guidelines regulating these programs. Seniors in our area are particularly concerned that medicare does not presently allow for the purchase of eyeglasses, dentures and hearing aids. Home health care, health screening and the establishment of local day health care centers for the elderly are also special areas of concern.

Some of the concerns of health care providers are as follows:

1. The current regulation under medicare which limits the number of home health care visits to 100 visits under Part A and requires an additional hospital stay of 3 or more days before further service may be purchased. It is the feeling of several providers in our area that not only does this regulation increase the overall cost of health care for the elderly person, but it also causes unnecessary re-hospitalization of a patient for 3 days in order to renew necessary home care visits.

2. That care of terminally ill patients should be covered by 3d party payors under medicare. Often with a little support, a family is able to care for a dying loved one in an environment the dying person would much prefer and at much less expense than would be incurred by a nursing home or hospital.

Along that same line, medicaid, medicare and other 3d party payors should reimburse for maintenance care of the elderly in their homes. Often, individuals require homemaking assistance in order to remain independent, however if a skilled service such as that service provided by an RN or a physical therapist is not necessary, the other services are not paid for by medicare.

3. Efficiency incentives should be incorporated into medicare and medicaid financial programs. There presently is no incentive to keep costs down and providers are reimbursed at the rate of their costs. As an example, an area average cost might be established for nursing home care (along with standards of care). If the quality of care provided met the standards, and the cost was below the average, then nursing homes should be allowed to retain the difference in costs for capital improvements, expansions, etc.

The issue of cutting the food stamp program from the federal budget is one that is of much concern to the elderly and to agencies providing service to the elderly.

What with the rising rate of inflation, this is a most cruicial issue which could detrimentally effect the lives of many elderly persons in our two county area.

I hope that I've provided you with some helpful information and again, I thank you for the opportunity to testify on behalf of the elderly in our community.

Senator DOLE. Now we'll ask Dr. Biery, the director of health, of Kansas City, Mo., representing Mayor Richard Berkley and Donald Flora, executive director of Mid-America Health Systems Agency to come forward.

STATEMENT OF RICHARD M. BIERY, M.D., ACCOMPANIED BY DONALD FLORA

Dr. BIERY. Thank you for this opportunity.

Up until now medicare costs for the elderly were able to grow without jeopardizing other portions of the economy. The proportion spent per capita for the elderly would normally demand that a portion of the health dollar be shifted to the elderly person. I don't think this will happen. If it did happen, this would mean that other sectors of the population would be displaced. However, if this displacement does not happen, it means fewer per capita dollars for medical services.

I'd like to address one issue, that I consider important and have a growing concern about. I am concerned that the value placed on human life is becoming increasingly blurred. We fight to save a wanted infant, but don't work with our elderly as much. My concern is that we'll have an increasing utilitarian view of human life. That same view could occur at the other end of the spectrum.

I think with socioeconomic pressures growing, we may see that value on human life is being jeopardized. I think that the economic trends are causing problems. To increase the productivity of life should be possible. We've had a concern regarding overlegislation.

I want to plead for as much State and local administration as possible, even if it gives the community or agency the chance to be wrong and botch it. My personal feeling is that we should focus on the problems. There is the problem of jumping and then having to recoordinate.

I believe that the resource in America for the aging will have to be returned to the extended family and would encourage Congress to look in that direction.

Senator DOLE. I think we're about out of time.

Dr. BIERY. I just have two sentences.

Senator DOLE. Go ahead then.

Dr. BIERY. There has just been a long, extensive study completed that is under debate right now on home health versus extended care. I am not prepared, at least, not right now on that.

Thank you.

Senator DOLE. If you could wait, we'll hear Mr. Flora, and then maybe there will be some questions.

STATEMENT OF DONALD FLORA

Mr. FLORA. I represent the Mid-America Health Systems Agency.

My remarks are strictly my interpretation, as the board has not had a chance to comment yet.

More services for the elderly are required. The 10 leading causes of death are due to behavioral lifestyle. The health care cross section points out that over 54 percent of the health care resources are allocated for institutional or reactive health care.

Medicare and medicaid should encourage, rather than prohibit less costly alternatives in basic health care. It should be accomplished without necessarily increasing the total share of the national budget spent toward health care.

There are 200 or more agencies that are part of the health care network. More money should be spent only as necessary even though health care is important.

Senator DANFORTH. The alternatives to inpatient care has become a popular concept. With respect to acute hospital care, are there any appropriate noninstitutional alternatives?

Mr. FLORA. There probably are.

Senator DANFORTH. There probably are?

Mr. FLORA. There probably are. What we're not in a position to do is to offer specific advice. We've just been in a position to identify some of the issues. We may be able to offer some specific advice in the future, but we cannot do that now.

Senator DOLE. Dr. Biery, do you have anything to add?

Dr. BIERY. I trained at the University of Minnesota at the Cancer Institute. We learned that the per patient care costs were substantially lower there than in the primary care centers. It was intended as a terminal institution. People were going home from that institution. There were those benefits.

Senator DOLE. Thank you, gentlemen.

[The prepared statement of Dr. Biery and Mr. Flora follow:]

PREPARED STATEMENT OF RICHARD M. BIERY, M.D., DIRECTOR OF HEALTH, KANSAS CITY, MO.

BROAD ISSUES

Members of the Committee, Senator Danforth, Senator Dole, thank you for this opportunity to appear.

Up until now medical care costs apportioned to the elderly have been able to grow without jeopardizing other sections of the medical economy but now, in the face of increasing constraints on the health industry's share of the gross national product, disproportionate per capita expenditure for older individuals coupled with a growing elderly population would normally demand that an increasing percentage of the health dollar be shifted to the elderly population, i.e., a larger and larger piece of the medical economy. I do not think this will happen. If it were to happen it would mean that other sectors of the medical marketplace or the population would be displaced—spelling certain upheaval. If displacement of other segments, on the other hand, does not happen it means fewer per capita dollars for medical services for the elderly.

What issues are created by these projections, especially in the light of other social and economic signs and trends?

Let's start with an extremely basic one, the value of life. I have a personal concern that the value placed on human life is becoming increasingly blurred and relative. The blurring is currently and primarily, at this time, probably most marked at the late second trimester of life where the same institution (and often the same staff) which disposes of very lightweight, immature, and "unwanted" human life must then fight desperately to save the life of similarly sized infants when they are, on the other hand, wanted. Very recently a neonatalogist here in Kansas City told me that one of his nurses stated in tears she felt "they weren't trying as hard as they used to."

Now, I make the prediction that economic pressure and an increasing utilitarian view toward human life (in the name of humanism) will begin to produce the same pressure toward blurring on the other end of the age spectrum, first by raising questions concerning the "value" of, for example, the elderly, who are mentally incapacitated or severely handicapped and then expanding the definition.

We have seen that question already in a series of Massachusett's court actions surrounding an elderly man with organic brain syndrome who was on renal dialysis. I predict that pressure to move in that direction (euthanasia) will grow—ostensibly for humanistic and economic reasons. All Federal policy must strenuously resist any such temptations and trends.

What other issues are in store on the health side? I think the economic trend and consequent pressures should compel us to put dollars into effective measures to prevent disease and disability and promote health in order to increase the productivity and quality of life—to as late in life as possible. These are high leverage dollars. (Remember, you cannot reduce the incidence of death, per se.) Obviously this also implies social policy which does not sideline the elderly but creates continued room for creativity, productivity, and even leadership.

OTHER GENERAL CONCERNS

Overlegislation/regulation from a paternalistic government; the classic case in aging programs was the imposition of feeding policies (not nutritional policies) which killed a proud voluntary meals on wheels program in Kansas City which was providing meals at a per meal cost of $1.00, fostered a small bureaucracy and promptly raised the cost to $2.50. I have discovered from fellow health officers that that scenario was repeated elsewhere. That case illustrates how to accomplish several things simultaneously, a true test of bureaucratic efficiency; create a bureaucracy, raise costs, eliminate a spontaneous locally-based volunteer effort, organize another one (under Federal guideline), and create years of hard and sad feelings.

I want to plead for as much local discretion as possible in such legislation even if it gives a community or an agency a chance to be wrong and botch it.

SPECIFIC ISSUES

Do not pass laws which foster fragmentation in health. Focus on problems, not age groups per se. Conceptualizing and costing legislative programs based on this principle is easier. (There is a spreading tendency to organize around "aging" apart from any other organizational principle.)

Do pass laws which foster/demand compassionate care and services, nonprofit organizations, hostels, and hostel systems.

Do pass laws which foster integrity of the extended family.

There are some programs for which the jury is still out, e.g. home health services—CF National Center for Health Services report on this subject.

Thank you sincerely for this opportunity to be heard. I am available for any question you may have.

MID-AMERICA HEALTH SYSTEMS AGENCY,
Kansas City, Mo., April 10, 1980.

Senator JOHN C. DANFORTH,
U.S. Courthouse
Kansas City, Mo.

DEAR SENATOR: Thank you for your invitation to testify at the Senate Finance Committee field hearing, Friday, April 11, 1980. We understand the focus will be how best to provide health care services for older Americans given the current economic forecasts and the clear need to reduce federal expenditures.

The Mid-America Health Systems Agency (MAHSA) was created in accordance with Public Law 93-641, The National Health Planning and Resources Development Act of 1974, to develop plans for improving the health of the residents in the eight-county Kansas City metropolitan area. Three health systems plans have been developed by MAHSA since 1976. Complete copies of the 1980-1984 Health Systems Plan (HSP) and 1980 Annual Implementation Plan (AIP) are transmitted to the Committee with this letter. The Committee's attention is especially directed to the HSP's letter of transmittal and the following portions of the HSP: Health Status, pages 3.1.1–3.1.21; Health-Caré Costs, pages 3.2.1–3.2.17; Consumer Health Education, pages 3.3.1–3.3.18; Primary Health Support for the Elderly, pages 3.13.1–3.13.16; Mental Health Services, pages 3.15.1–3.15.50; and Continuing-Care Services, pages 3.16.1–3.16.41.

With the exception of the Health Status and Health-Care Costs sections of the Plan, each of the Plan sections tend to report that more medical and health care services for the elderly are required. The emphasis, however, is on different services—services which are more appropriate to the medical and social needs of the elderly in the area. These services, such as home health services and adult day care centers, should be funded instead of, rather than in addition to, institutional care.

The Health Status section of the Plan points out that the ten leading causes of death are due to behavior and lifestyle. The Health-Care Costs section points out that over fifty-four percent of health care resources are allocated to institutional or reactive medicine. The Mid-America Health Systems Agency is firmly convinced that a reordering of resource allocation priorities is necessary over the long term in order to have any permanent effect on rising health care costs and, more importantly, on the quality of an individual's life.

Medicare, Medicaid and other third-party payment mechanisms should encourage less costly and equally effective alternatives to inpatient care. This could be accomplished without necessarily increasing the total amount of money spent on health care.

There is no real way to adequately summarize the health systems plan and the underlying discussions of hundreds of volunteers about community-wide health care issues, including health care for the elderly. We would welcome the opportunity to meet with representatives of the Committee to discuss these issues at greater length.

On behalf of the Mid-America Health Systems Agency Board of Directors, I extend my thanks to you for the opportunity to present MAHSA's views to the Senate Finance Committee.

Sincerely,

DONALD L. FLORA,
Executive Director.

Senator DOLE. Next, we have a university panel, Dr. Russell Mills and Dr. Richardson Noback.

STATEMENT OF RUSSELL MILLS, PH. D.

Dr. MILLS. I'm pleased to be spending a few minutes talking about my concern for the elderly. We're deeply involved at our center in the things that have been talked about here today. We've talked about the increase in the number of the elderly over 65, with the real health problems beginning to occur at 75. The elderly often react differently to treatment and to isolation.

In Kansas and Missouri the elderly population are already greater than the national average. For instance, in the United States, 4.3 percent of the population is over 75; in Kansas, 5.5 percent is over 75. The numbers over 85 are even more striking.

The elderly are concentrated in the small towns like Chanute, in Neosho County, Kans. In Neosha County only 2.4 percent of those between 65 and 74 are in nursing homes, while 22.4 percnet of those over 85 are in nursing homes. Therefore, nursing homes have been an increasing component of health care costs.

We need something to prevent at least some of this institutionalization of the elderly. Perhaps 20 percent of the current nursing home residents could live independently with only a moderate amount of in-home services.

Appropriate maintenance and rehabilitation programs should be planned for individuals who can benefit from them.

Day care programs, both social and medical, should be available. There are many important factors in maintaining people outside of institutions.

Thank you.

Senator DOLE. Thank you.

[The prepared statement of Dr. Mills follows:]

THE UNIVERSITY OF KANSAS,
LONG-TERM CARE GERONTOLOGY CENTER,
Kansas City, Kans., April 11, 1980.

Senator ROBERT DOLE,
U.S. Senate,
Committee on Finance,
Washington, D.C.

DEAR SENATOR DOLE: I am pleased to have an opportunity to testify at this field hearing of the Senate Finance Committee, concerning provision of health care services for older Americans in these times of fiscal restrictions.

The rapid increases in numbers of the elderly which will occur over the next 50 years are well known; the projections are summarized in the attached table. From the 1980 national estimate of 24,900,000 persons sixty-five or over (11.2 percent of the total population), an increase of 121 percent to 55,100,000 persons (18.3 percent of the population) is projected.

Per capita medical care costs for this segment of the population are 6 times the costs for young people under 19. An increasingly large proportion of these costs is for long-term care; there are now over twice as many long term care beds (about 28,000) in Kansas as there are acute care hospital beds (about 13,000).

The persons needing the most medical care are those over 75 or 80—the old-old, frail elderly, or vulnerable elderly. These people should be our real concern; their problems are often unique, more complex, and of different magnitude than those of younger persons. They often react differently to medication, other treatment, and isolation.

It is estimated that nationally the population 75 years of age and older will increase 2½ fold in the next 50 years, from 9,400,000 (4.2 percent of the population) now to 23,200,000 (7.7 percent of the population) in 2030. This expansion will have a major fiscal impact, in terms of providing necessary health and social services to maintain and improve the quality of life of our elderly citizens.

Kansas, Missouri, and several other midwestern states north and south of us have elderly populations significantly greater than the national average. In Kansas, for instance, 12.8 percent of the population were 65 or older in 1978, and 5.5 percent were 75 or older. In Kansas 1.4 percent of the population were 85 and older, 40 percent over the national average of 1 percent. Within Kansas wide variations exist in proportions of the olderly. Kansas wide variations exist in proportions of the elderly. In 70 of the "rural" counties (without cities over 100,000, or major universities, or major military installations) 17.4 percent of the population were 65 or older, 8.1 percent were over 75, and 2.1 percent were 85 or older! In urban/university counties the numbers of elderly were below the national average (see table). However, the numbers in the urban areas are increasing annually at about 3 times the rate of increase in the rural counties.

In Kansas, therefore, most of the rural counties are facing very severe, present problems of delivery of health care for older persons; the urban areas, with severe problems already in the delivery of health services to the elderly, must prepare for rapid increases in the numbers needing these services.

Major attention must be given immediately to developing the most efficient, while still acceptable and satisfactory, system of services and service delivery.

We have been working with local service providers, the elderly, and state and local offices on Aging, Health and Environment, and Social and Rehabilitation Services in Neosho County in southeastern Kansas to develop voluntarily improved methods of service delivery. As part of our work there we have done a detailed analysis of the numbers and locations of the elderly in that county, using the annual enumeration by name, done by the county assessor's office.

Neosho County, with about 18,000 residents, has 3515 people 65 and over, or 19.7 percent of the population. (A number of Kansas Counties have even higher proportions of elderly.) 8.7 percent are 75 or over, and 2.4 percent are 85 or over. Interestingly, those 75 and older concentrate in the very small towns and the one city; only 11 percent of those 85 and older still live on farms, and only 15 percent of those 75 – 84 do so. Only 2.4 percent of those between 65 – 74 are in nursing homes, but 22.4 percent of those 85 and over are! The number of those at risk increases markedly after age 75; in these towns 10.5 percent of the total population is in this high-risk, vulnerable group.

Costs of health care for those over 75, including nursing home operational and capital expenditures, will continue to increase rapidly, simply because of the

numbers. Nursing home expenditures will become an increasingly large component of these costs. Improvement and expansion of programs which will prevent or delay institutionalization of some of the elderly is therefore of immediate and long-range economic importance.

Various studies indicate that a significant fraction of those presently in nursing homes would not need to be there, if adequate community support systems were available; estimates range from 15 – 40 percent. Data so far do not provide clear evidence of cost effectiveness (or lack of it). However, careful selection of recipients of services as an alternate to institutionalization was not done in most studies. It is quite likely that perhaps 15 – 20 percent of present nursing home residents could live independently with only moderate amounts of community services, and at less cost to society than institutionalization. In other words, definite cost savings to society should accrue if adequate support services were provided to well-selected individuals who could benefit from them, maintaining independent living as long as possible.

Programs and services which should be provided or expanded to implement these concepts include:

Easily accessible comprehensive assessment services, physical, psychological, and social—to allow selection of those who can benefit at reasonable cost from community support services, and to define which services are needed, if the person desires them. Appropriate rehabilitation and maintenance programs could also be planned.

Improved and expanded comprehensive case management services, to assure the acquisition, coordination, and continuity of the services each individual needs, and followup and response to change of condition.

Home-health services, such as by nurses, home health aides, physical therapists, must be much more readily available.

Homemaker services; often home health aides and homemakers serve the same client, funded by different programs. Cost savings and program efficiency could result from one person providing both services.

Day care programs, both social models adn medical models, should be available in most communities. In the smaller communities, such as in Neosho County, the medical models would logically be operated by nursing homes or by hospitals. Rehabilitation programs should be a very important component of such programs, and should be widely available. Reimbursement for such programs is now extremely difficult.

Nutrition programs, both congregate and home-delivered, are vital links in programs to maintain the frail elderly in health. They need to be expanded.

Transportation services, also vital, are often chaotic, unsatisfactory, or just unavailable. Coordination and good management of the multiple transportation services now available should be highly cost-effective and should improve the services.

I mention all these programs because they are all important in maintaining the elderly in an independent status as long as possible. All need to be improved and/or expanded. However, I believe that the most serious efforts should be made in the next few years in the areas of home health services, rehabilitation programs, and in developing assessment and case management resources.

All these programs require training programs, for many different types of workers, to enable them to be sensitive to the special problems of the elderly, from both health and social viewpoints, and to be able to work in and utilize the resources of the complex support systems now existing. Training programs need continued support and expansion, and coordination and imaginative planning.

The Administration on Aging is taking the lead in attempting major improvements in the relatively uncoordinated present support service system. I laud these efforts, and believe strongly that the development of problem-oriented Long-term Care Centers in universities with medical schools, and the new program of Channeling Demonstration programs (joint with the Health Care Financing Administration) will have major long-term payoff in controlling health care cost increases as the old-old population grows.

The availability of "discretionary funds" for such attempts at more rational use of scarce resources is vital, I believe, and should be protected, especially in times of financial stress.

Thanks very much for letting me comment on these issues.

Sincerely,

RUSSELL C. MILLS, PH. D.,
Associate to the Chancellor.

Enclosure.

ELDERLY POPULATION COMPARISONS

	Total population	64 to 74		75 to 84		85 plus		65 plus	
		Number	Percent of total	Number	Percent of total	Number	Percent of total	Number	Precent of total
United States:									
1974	211,390,000	13,537,000	6.4	6,535,000	3.1	1,744,000	0.8	21,816,000	10.3
1980 (estimated)	222,653,000	15,500,000	7.0	7,100,000	3.2	2,300,000	1.0	24,900,000	11.2
2030 (projected)	300,678,000	31,900,000	10.6	17,500,000	5.8	5,700,000	1.9	55,100,000	18.3
Kansas (1978):									
70 rural counties (including Neosho)	933,500	89,000	9.5	54,660	5.9	19,620	2.1	163,280	17.4
10 urban/university counties	1,218,200	67,670	5.6	34,610	2.8	11,700	1.0	113,980	9.4
25 southwestern rural counties	158,900	10,450	6.6	5,480	3.5	1,630	1.0	17,560	11.1
Total	2,310,600	167,120	7.2	94,750	4.1	32,950	1.4	294,820	12.8
Neosho County, Kans. (1978, rural county):									
12 Rural townships	5,158	490	9.5	173	3.4	46	.8	699	14.0
7 towns/cities	12,708	1,482	11.7	951	7.5	383	3.0	2,816	22.2
Total	17,866	1,972	11.0	1,124	6.3	429	2.4	3,515	19.7
Number in nursing homes; percent of that age group		48	2.4	84	7.5	96	2.4	228	6.5

Senator DOLE. Dr. Noback.

STATEMENT OF RICHARDSON K. NOBACK, M.D.

Dr. NOBACK. I am Dr. Noback from the University of Missouri at Kansas City.

My roles there are those of a professor of medicine and the person with responsibility for the geriatric program of our medical school. I consulted colleagues in our university system in preparing my statement. The faults are mine; the good ideas are theirs.

Since you have my prepared testimony, I would like to concentrate now on several comments and three recommendations.

I am sure, from the remarks you have made that you are all aware of the problems. There are insufficient funding sources and funding commitments. There is an insufficient effective demand for services. There is insufficient encouragement and ability to develop alternate possible ways to provide services, and less costly alternatives.

These problems can be regrouped. One, there are insufficient mechanisms to bring our problem-solving capacities to bear on these issues. Two, there are insufficient mechanisms to bring informed public judgments on these issues. Three, there are insufficient mechanisms to reach policy and priority decisions about efforts—efforts which need to include coordination between all those with abilities to contribute by programs, by resources, by ideas, by experience.

It is clear that we are all concerned about a very large problem. A solution to that problem will depend upon very large efforts.

In June of 1979 I took a group of students and faculty to Canada to study their health care system. Of relevance here is the fact that Canada has a strong process of the type included in my first recommendation to you. For those with particular interest in Canada's experience, I refer you to the LaConde and Castonguay reports.

Those of us who have been fortunate enough to travel to other countries know, and must return here with the conviction, that we have an affluent and immensely powerful nation. Yet we devote a large amount of our treasure to entertainment and diversion.

Let me turn now to three specific recommendations.

The first recommendation is that the Federal Government increase efforts to develop strong and durable local, regional, State, and Federal processes to: One, provide information about the needs of the elderly and the frail elderly; two, establish policies and priorities among and between these four levels of action; and three, assign resources to help solve the problems which many of the elderly face on a day-to-day basis.

The second recommendation is that true multidisciplinary and interagency efforts be achieved to assess the problems faced by the elderly and to design the ways by which society can respond to those needs. The context of discussions must be broadened to include those problems which the elderly rank as of greatest importance and to shift from preoccupation with nursing home care to a much broader range of alternatives.

The third recommendation is that those engaged in efforts to help the elderly avoid any conclusion that our society is providing adequately for the elderly or that the provision of more effective services would be beyond the expenditure capacity of our society. Only by

careful examination of alternatives, review of existing experience in this and other countries, and deliberate examination of alternate possible options can any society reach sound decisions about programs, priorities, and funding allocations.

Senator DANFORTH. Let me ask you a question which is unrelated to your testimony, but important. Is there a reasonable possibility that we can develop a better way of preventing stroke? Are we doing as good a job as we should be doing, as a country? If the answer to the first question is yes, are we doing as good a job as we should be doing, as a country?

Dr. NOBACK. I have two answers: One is professional, and the other is based on hope. The professional answer would be that by concentrating on the tremendous importance of hypertension and a certain number of metabolic diseases, we can reduce the liability to stroke.

The second is that basic biomedical research is so important that I hope that in 10 years people will look back and be surprised by how little we know today.

Senator DOLE. Dr. Mills, you mentioned the HEW channeling project. We're already getting pressures to hurry up and pass some legislation. Do you think we're ready for legislation or should we wait and compile some history before we start moving?

Dr. MILLS. I think we should have a chance to get some data first.

Senator DOLE. Do you see any resistance on the part of physicians, as far as home health care? Are they going to drop by your house at night, or are they going to drop into some place where you have 50 people?

Dr. MILLS. I think the physician would rather drop in where there are 50 people. Usually when we're talking about home care, we're talking about nonphysician personnel.

Senator DOLE. Do you agree with that, Dr. Noback?

Dr. NOBACK. One of our jobs as educators is to stress the importance of society's needs. We are doing that. I believe we will see increasing physician participation in long-term care.

Dr. MILLS. Attitudes are changing and I think will change.

Senator DOLE. Do you think there is a change in attitude of physicians toward the use of nonphysician providers such as nurse practitioners in home health care? Will that too change with time?

Dr. NOBACK. I think it certainly will. I think we're seeing progress.

Senator DOLE. You believe the physician's attitude will change with reference to nonphysicians?

Dr. NOBACK. I believe it will, yes.

Senator DOLE. Do you agree with that, Dr. Mills?

Dr. MILLS. Yes.

Senator DOLE. I appreciate very much your testimony.

[The prepared statement of Dr. Noback follows:]

STATEMENT OF RICHARDSON K. NOBACK, M.D., PROFESSOR OF MEDICINE, UNIVERSITY OF MISSOURI-KANSAS CITY SCHOOL OF MEDICINE

This testimony is designed to make three specific recommendations and to provide a base of information adequate to support those recommendations.

RECOMMENDATIONS

The first recommendation is that the Federal Government increase efforts to develop strong and durable local, regional, State, and Federal processes to: one, provide information about the needs of the elderly and the frail elderly:

two, establish policies and priorities among and between these four levels of action; and three, assign resources to help solve the problems which many of the elderly face on a day-to-day basis.

The second recommendation is that true multidisciplinary and interagency efforts be achieved to assess the problems faced by the elderly and to design the ways by which society can respond to those needs. The context of discussions must be broadened to include those problems which the elderly rank as of greatest importance and to shift from preoccupations with nursing home care to a much broader range of alternatives.

The third recommendation is that those engaged in efforts to help the elderly avoid any conclusion that our society is providing adequately for the elderly or that the provision of more effective services would be beyond the expenditure capacity of our society. Only by careful examination of alternatives, review of existing experience in this and other countries, and deliberate examination of alternate possible options can any society reach sound decisions about programs, priorities, and funding allocations.

BACKGROUND INFORMATION

In 1979, the Institute of Medicine of the National Academy of Sciences published a summary of the findings of one of their Committees in Volume 300 of the New England Journal of Medicine. The following three paragraphs from that article state some of the dimensions of the health and social needs of our elderly citizens.

"Improvements in sanitation, housing and nutrition, as well as the conquest of many infectious diseases, have resulted in striking demographic changes during this century. More than 50 percent of those who have ever been over the age of 65 are alive today. The number of Americans 65 and over has risen from 3 million, or 4 percent of the population, in 1900 to more than 23 million, or 11 percent of today's population. On the basis of present trends, this figure will increase to 55 million in 50 years.

"Age 65, although not necessarily demarcating biologic old age, has provided, until recently a convenient bench mark for social and legislative purposes. Despite the relative health and vigor of many over 65, they are more likely to suffer from multiple, chronic diseases. Their personal health-care expenditures in fiscal 1977 were $41.3 billion, about 30 percent of the total for all Americans. Per capita figures for those 65 and over were $1,745 as compared to $661 for those 19 to 64, and $253 for those under 19.

"Public funding of the total health-care bill in fiscal 1977 amounted to 67 percent for those over 65, in contrast to 29 percent for adults 19 to 64. The percentages of government spending for major components financed were as follows: hospital care (88 percent), nursing-home care (57 percent) and physician services (60 percent). The combination of substantial public funding, legislatively fixed expenditures, inflation and a declining economy has resulted in increased scrutiny by governmental policy makers and Congressional committees. The concern is whether our care system, so well equipped to deal with acute problems, is appropriately addressing the task of caring for the elderly. One facet of this review has been directed toward physician education."

In 1978, DHEW published one of the Science Monograph series from the National Institute of Mental Health: "New Views on Older Lives" by Anne H. Rosenfeld. The foreword to this monograph summarizes some basic facts about elderly citizens.

FOREWORD

"Aging is a fact of life which as a Nation, we have tried to ignore. Advertising has been directed toward youth; educational systems have been devoted largely to professional and vocational rather than lifetime learning; and modern housing patterns have, in effect, interrupted for many the intergenerational exchange of ideas and experiences which formerly enhanced family life.

"The demographic facts of life are changing our focus. American elderly are emerging as a social and political and, indeed, economic force. Social scientists and medical researchers are learning more about what the elderly are really like and, in the process, are changing much of the stereotyping of the aging. They point out, for instance, that all old people are not alike and, in fact, probably grow more dissimilar as they grow older; that the slowing of physical and

mental reflexes and diminished hearing and eyesight are usually more than compensated for by greater patience and resourcefulness and by wisdom and strength in meeting crises; and that old age does not necessarily limit sexual activity, intellectual capacity, or interest in meaningful work.

"Balancing the persistence of decline and deterioration of functioning with the optimistic and positive aspects of the aging experience adds interest and urgency to research on the mental health of the aging. The National Institute of Mental Health has supported much significant research, both basic and applied, on the relationship of physiological, psychological, and social factors to the aging process. Probably the most influential of early studies was a 12-year study of normal, healthy, aged men which indicated, among many important findings, that severe deterioration apparently is indicative of disease rather than of aging itself.

"Research activities have extended from the study of organic brain syndrome and depression in the elderly to the improvement of community care, whether the aging persons live in rundown, urban hotels, their own homes, or in housing designed especially for them. Reducing the need for hospitalization and improving institutional care, whether in hospitals, nursing homes, or long-term care facilities, are additional areas of research on the aging in which the Institute takes pride.

"Work continues on all of these and on preventive measures for the healthy aged, not only in housing and information and referral services, but in helping to meet the potential crisis of retirement, adding recreation and rehabilitative training programs to prepare elderly persons for community service activities. Many of these Institute-supported programs in training and research are described in this publication, although a number of them are still underway and final evaluations are yet to come, they are exciting and full of promise. The book is a worthy addition to a growing, and varied, number of publications for and about the aging, designed for both the mental health professional and the concerned citizen of a society that cares."

FRANCIS N. WALDROP, M.D.,
Acting Director,
National Institute of Mental Health.

In the body of "New Views on Older Lives" there are several passages which emphasize clearly the necessity to know what the elderly believe they need. The following short citations are from pages 60, 62, 63, and 64.

"As the preceding studies have revealed, the older residents of a given community differ appreciably among themselves in their expectations, their living arrangements, their financial and social resources, their health, their coping abilities, and their subjective sense of fulfillment. As countless studies have documented, there are many avenues to improving the quality of life for these older people, but they must be carefully addressed to well-identified populations and tailored to the specific needs and wishes of older individuals. In most communities, minimal time and effort have been devoted to carefully assessing the match between available services for the elderly and the needs of those for whom they are intended, and rarely are older people themselves consulted about their own perceptions of how their lives and those of their peers might be improved."

"However, for the elderly, the problem was not so much a lack of health services per se as dissatisfaction with the quality of care and/or lack of home care such as visiting nurse services."

"Beyond these general similarities of perceived need, there were many significant discrepancies among the three groups of informants. For example, for the elderly, the highest-ranked service need was in the area of housing, although this need was given low priority by the other informants. Dr. Kahana believes that this ranking by the elderly may reflect great concern with neighborhood problems, rather than housing per se."

"While good interagency communication is essential to help clients find their way within the helping network, the referral chain is but a means to an end: direct service. In this study, relatively few agencies were found to offer direct services to older community dwellers, and those that did offered counseling primarily (one service ranked quite low by potential users). As Dr. Kahana has put the issue poignantly:

> 'A striking pattern * * * is the preponderance of referral services (53 percent) and those of counseling (38 percent) among actual existing service programs. In contrast, the aged consumers and significant others did not even

report referral service among service priorities. *Based on these data, it appears that one is either referring clients or helping them adjust to their problems. Who, one wonders, then delivers the actual services?* (italic added)'

'Another important problem is posed when one considers the populations served by the various agencies. Although economic eligibility criteria are diverse, it appears that in some situations, those in financial need, and in others, those above a specific income level, are cut off from access to needed services.'

"Such studies, however informative they may be, are but the first step in creating an effective service system; the next step is to develop a working coalition of planners, agency representatives, and elderly consumer representatives to bolster existing informal social support systems, wherever possible, and to direct the efforts of formal service providers to those groups most in need of their help."

Commissioner Robert Benedict of the Department of Health, Education and Welfare at the 1978 Grove Conference on Marriage and Family addressed the importance of the provision of long term care services with the variety, quantity, high quality, and satisfactory service arrangements necessary to be responsive to the problems faced by the chronically ill and impaired older citizens in our country. He stated that this problem was challenged only by the other questions of how to arrange the cost of maintaining income and providing the needed services for the rapidly expanding older population.

Commissioner Benedict has drawn on information from the Urban Institute in the following statement. "Using data provided by the Urban Institute, the Senate Committee on Aging estimated that about one fourth of the older population (about 5 million persons) need some type of long term care. According to the Urban Institute figures, about 2 million of these receive care in institutions or elsewhere, while the other 3 million are not receiving needed care. It is estimated that about 600,000 of these need nursing home care and one and one third million need home health services, and over 1 million need assisted residential living services."

In "Long-Term Care: Handbook for Researchers, Planners, and Providers" author Sylvia Sherwood makes the following statements. "Data from the National Center for Health Statistics (1971) indicate that in 1970 approximately 40 percent of those over 65 living outside of institutions had some limitation of activity because of chronic medical problems." Translating those figures to the present means that between 9.2 and 9.6 million people today among our elderly have faced the same problems.

In the literature of gerontology and geriatrics there is repeated emphasis on the logical necessity to consider the full range of services which may solve the problems of the elderly and elderly ill. There is often concentration on either institutions such as nursing homes or some type of alternate care provisions in the community with the implication that institutional care is either not necessary or a second best choice. The literature makes clear the fact that many older citizens require care in institutions such as nursing homes. Many other citizens could be served better by a wide range of residential options in community settings outside of formal institutions. The imperative is to find the means by which to provide quality services in the mix appropriate to the needs of the older and the chronically ill citizens in this country.

As noted earlier, many thoughtful contributors to the fields of gerontology and geriatrics stress the great importance of putting in place the services and the communication links which are now lacking if we are to achieve the goal stated in the previous paragraph. Experience is repetitive in pointing out that needed services are often non-existant, in short supply, or uncoordinated. The responsibility for such services may lie with the federal government, state government, city government, county government, hospitals, nursing homes, rehabilitation programs, or a wide variety of community agencies.

Two examples are selected to point out the need for an orderly process called for in recommendation number two. In 1975, Medicare long term care expenditures in Missouri for home health services represented only 1.6 percent of total long term care expenditures. Second, in Missouri, the preoccupation has been on nursing home care to the exclusion of the provision for less expensive and sheltered living arrangements. Obviously, the result is that residents remain in Intermediate Care Facilities because they have insufficient funds to pay for other care for themselves.

OBSERVATIONS

There are reasons to be encouraged about the processes by which our society identifies its problems, analyzes alternate response possibilities, and formulates commitments to change. One is the fact of this Hearing today. Another is the recent establishment of the Missouri Division of Aging; this makes clear the importance which our State Government gives to the elderly.

On the Missouri side of State Line, the MARC Council on Aging is a respected and effective body. The University of Missouri has signaled its commitment to the problems of aging in a number of ways including the establishment of Joint Centers for Aging Studies, the Older Missourians Programs, and a variety of School and Departmental actions which involve curriculum emphasis on geriatrics and cooperative efforts with community organizations.

From the Columbia Campus there are significant programs in collaboration with citizens in Callaway County both to strengthen programs of care for the elderly and to provide needed education for students in the health professions.

At the University of Missouri-Kansas City there are new long-term care programs which involve faculty and students from the four health science disciplines of Dentistry, Medicine, Nursing, and Pharmacy. There are investigative efforts to learn more about drug therapy in older individuals with leadership from the School of Pharmacy. The School of Medicine is making a major curriculum commitment to geriatrics. The School of Dentistry is a national leader in providing dental services to the elderly and chronically ill.

The Truman Medical Center Corporation has made major developments at Truman Medical Center-East in care for elderly and chronically ill patients. There is a skilled and dedicated staff at Truman Medical Center-East, excellent facilities, and a multidisciplinary program which have earned many plaudits.

Even with these important facts, my daily experience as a practicing internist brings me face to face with the types of inadequacies and gaps which were cited earlier. Much has been done but much more needs to be done.

CONCLUDING COMMENTS

We are an affluent and powerful nation. We spend immense amount of treasure on luxuries and diversion—cosmetics, tobacco, alcohol, and entertainment.

Many recognize compeling needs for improvements in many areas such as the resources of the penal system, for the strengthening of educational programs, and for the services appropriate for yesterday's leaders when they become today's oldsters—and when we become tomorrow's oldsters.

In June of 1979, I had the privilege of leading a body of faculty and students to Canada where we studied the background, structure, and performance of their health care system. We had the opportunity of extended discussions with Canadian leaders who had studied the experience in many other countries before they made their major changes in financing and provision of health care services in 1969.

In comparison with Canada, we have not yet achieved the type of process which is delineated in the recommendation number one. Our service programs are fragmented as noted earlier. We have not yet developed a sufficiently effective means to interrelate local, regional, state and federal programs.

One possibility is to construct a process that brings together representatives of our several levels of government, the elderly, providers of services, community agencies, and civic leaders to consider the problems of the elderly, to examine alternate ways of responding to these problems, and to formulate recommendations for coordinated action. This process must involve outstanding individuals, adequate and organized data, and sufficient staff. Each component needs to be of recognized and highest quality.

Such a process could be organized within States and then within the Regions of the U.S.P.H.S. to recognize regional differences in problems and in solutions to problems. In turn principles and programs of importance throughout the United States could come to a White House or Congressional plenary body.

I urge that we avoid a tentative conclusion that improving services for the elderly is impossible or impractical. Rather, I urge the acceptance of the three recommendations in the conviction that informed Americans make sound decisions when the issues are clear.

Finally, I would like to thank Senators Danforth and Dole, together with members of their staffs, for the opportunity of presenting these remarks. Many appreciate their continuing and deep interest in the concerns which are so vital to such a large proportion of Americans.

Senator DOLE. Roberta, do you want to go first?
Ms. ROLLER. Let Joe go first.
Senator DOLE. Oh, you want Joe to go first.
I might say that Joe worked in Congressman Winn's office.
Maybe you were going to say that yourself, Joe—as a senior intern.

CONSUMER PANEL

STATEMENT OF JOE LEVERENZ, VICE CHAIRMAN, KANSAS JOINT STATE LEGISLATURE COMMITTEE, AARP-NRTA

Mr. LEVERENZ. Congressman Winn, Senator Dole, Senator Danforth, the three of us up here, I believe, are representing the consumer. You're going to hear a lot more from us for a long time to come because we don't intend to go away. We're in better spirits today than we've ever been.

I came from Washington, D.C., after 23 years as executive vice president of the American Cancer Society, and I couldn't have picked a better place than the Midwest to retire. They're rugged individuals. They're determined to see it through. They don't want anybody to give them something if they can do for themselves.

I work with older people—I'm with them every day. I hear how they feel about things, and I'm glad to know that Barbara Sobal in her needs survey recognized this. They're trying to point up what the older people want and how they evaluate programs. So many times providers, whether you're talking about health, social or economic providers, make up their minds what's good for us. We're at the place now where we want to have part of the action. We want to have part of the planning for our health care. We would like to have part of the delivery if we can assist. When you get ready to evaluate, ask senior citizens whether what is being done is good for us. We haven't been doing enough of that, and I think the surveys that are now being taken are a conscientious attempt to do that.

The other thing I want to say is that we want to remain in our own homes as long as we can. This is going to be good for the community. It's certainly good for us, and it's good for our families to have us in our own homes as long as we can, as independent as we can. We would like to be as involved in the community as possible.

We don't want to be relegated to the role of just being served. We want to serve as well as being served. I have been concerned about the CAT scanners. For those of you who don't know what a CAT scanner is, it is a half-million dollar electronic tool. It is a tremendous tool for diagnosis. We have 18 scanners in the metropolitan Kansas City area. In a couple of years it is going to have to be updated. It's a sad state of affairs when that kind of money is squandered. Only one of the 18 hospitals is using their scanner up to the 2,500 utilizations per year which is considered cost effective.

Health care is costing too much. We did everything we could as far as the Federal legislation re hospital cost containment, but failed.

I talked to Senator Nancy Kassebaum: she said that's the type of legislation which should be handled at the State level. The 1980 Kansas Legislation failed to pass this legislation.

Now on with the show.

I'm Joe Leverenz, vice chairman of the Kansas Joint Legislative Committee of the National Retired Teachers Association and the American Association of Retired Persons.

With me today is Roberta Roller, chairperson of the Missouri Joint State Legislative Committee.

We're here today representing our association, 365,000 members in the States of Kansas and Missouri.

We appreciate this opportunity, and we have a more detailed statement, which the staff person asked whether we would like to give detailed or abbreviated, and we chose the abbreviated.

The association's national legislative council and the board of directors and the general membership have established as their primary goal at the national level to pursue the policy, programs, and legislation that will aid in cotnrolling the rate of inflation.

As you are well aware, the rapidly escalating health care costs continue to impose a relatively greater burden at precisely the same time as this segment of our population is facing high rates of increase in the cost of food, energy, shelter, and other necessities. Left unchecked, such unjustifiable and uncontrolled rates of increase will continue to further erode the real level of medicare and medicaid benefits being received by the elderly and adversely impact the efforts of Congress and the administration.

All right, do you want to take it over.

Representative WINN. Mr. Chairman, I ask unanimous consent that Joe be given an additional 3 minutes.

Mr. LEVERENZ. You really shouldn't miss this.

Senator DOLE. We don't want to miss that, Joe. We don't want to miss the flight either, so you go ahead and take 3 minutes. I won't ask any questions. You can have my time.

STATEMENT OF ROBERTA ROLLER, CHAIRMAN, MISSOURI JOINT STATE LEGISLATURE COMMITTEE, AARP-NRTA

Ms. ROLLER. Senator Danforth, Senator Dole, Congressman Winn, being considerate of our time, I'm going to cut down a great deal more. I'm not going to give you the summary of it. I'm going to give you a summary of the summary. I'm going to cut it out and not waste time, I hope.

I am presenting now again our association's views in NRTA and AARP, and I would like to add a brief, personal comment at the closing.

In the summary of our statement, the basis of national health insurance must be strong cost containment provisions starting with hospital costs containment.

The key to controlling costs in any national health insurance program necessarily lies in Government's ability to negotiate less generous terms of provider payment for the services it purchases than presently exist.

At the same time, our association strongly believes that the only viable way to control the rise of health costs over the long term is to bolster the creation and development of a variety of health care facilities through the urban and rural areas of this Nation, so that the demand on acute care, high-cost inpatient hospital facilities is greatly lessened.

The promotion of health maintenance organizations, intermediate, and long-term care facilities, community health centers, local outpatient clinics, and home health care should lower costs by creating an alternative to treatment in acute care hospitals.

As our record statement indicates in much greater detail, our associations are most supportive of congressional efforts to increase the availability of home health services as a cost-effective means of reducing the needless hospitalization and institutionalization.

It is clear that episodic, incidental, or acute medical care is our present national response to the health needs of the elderly, as well as other segments of our population.

All proposed national health insurance programs, to the extent that they ignore the acute need for national long-term care policy and program, reinforce this inadequate and inappropriate response.

Now, that is a summary of our association's opinion.

Now Roberta Roller—speaking of the elderly, and you can see I am one of them—the rising costs of health care, the runaway inflation has reduced us to the place that health care costs have doubled and tripled, and it has reduced us to the place where in many cases we can no longer live.

The rising funeral costs have brought us to the place where we can no longer die.

There we are out in no man's land, with a barrage of artillery from both sides. We're out there lost: and with the many viable suggestions that you've received today—and we do support those, of course, I do—we're asking you folks to take us out of no man's land. Put us in a place where we can live, really live.

We don't want to wait until we are poor to have health care. Let's get it beforehand. Health maintenance organizations, get them under medicare so that we may have help to keep us from becoming ill, to keep us well as much as possible. So I'm asking you, please, take us out of that no man's land.

Thank you.

STATEMENT OF HATTIE NORMAN, TOPEKA, KANS.

Ms. NORMAN. Senator Dole, Senator Danforth, and Congressman Winn, my name is Hattie Norman, and I am a resident of Topeka, Kans., where I am the chairman of the Topeka Council on Aging, and I am also chairman of the East Topeka Senior Center.

Besides working to support my family when I was younger, I have worked as a volunteer all my life. I am currently volunteering my time to the senior center to take older people to their doctors, hospitals, and grocery shopping.

I'm in contact every day with older, poor people. I am 70 years old, and my only income is from my social security. I am covered by medicare insurance, but I am not eligible for medicaid.

Thank you for the opportunity to share with you my concerns about the increasing costs of health care, particularly for people like me who live on fixed incomes and cannot afford to be sick or go to the hospital.

Medical costs continue to rise, and it seems that no effort is made to control them. I testified before the members of the Insurance Committee of the Kansas Legislature in February about my concern for these rising costs and told them that if these costs for health care continue to rise, I do not know what poor people are going to do. It seems to me that some means must be found to hold the line in these kinds of costs.

I feel that I could not afford to go to the hospital if I were sick even though I have medicare, and I am in contact every day with older people who are in similar circumstances.

Medicare covers only 80 percent of the hospital bills, and I would have to pay the rest from my small social security check. I cannot afford to pay the other 20 percent. So I must do everything I possibly can to stay healthy. I pray that I do not have to be hospitalized.

My neighbor, a 72-year-old woman, subscribes to plan 65, a supplement to her medicare, and she recently found that this does not cover the cost of X-rays, dentures, eyeglasses, and her prescription bill runs $75 a month. She really cannot afford to pay for these medical necessities; but when she needs new glasses or X-rays, she has to use the money she would use to buy food.

My husband recently passed away after a long illness and hospitalization. If he had not been a veteran and received care through the Veterans' Administration, we could not have afforded to pay for his hospitalization.

Those of us that have worked all of our lives, tried to pay all of our bills, and live as good citizens now find that we cannot afford to eat and be sick at the same time. When I say that, I believe I speak not only for myself but for my many friends and generally for all older folks.

Being old and sick and poor and not being able to make ends meet in order to pay our hospital, doctor bills, and still have a little bit of money left to buy groceries with leaves us with few choices.

I am not an expert in health matters, but I have worked with hospitals and with old, sick people. I believe that measures must be taken to slow the inflation that is eating away at our fixed incomes, and I believe that the measures must be taken to contain health care so that folks like me can afford to get the necessary medical attention we need.

While we are doing everything we can to stay healthy, so we do not have to visit a doctor or go to the hospital, I believe there are some things that could be changed to help keep older people in their homes longer and reduce health care costs. My suggestions are:

First, elimination of some of the luxury items that you must pay for when you are hospitalized, like the toothbrush, toothpaste, lotion soap, and washcloth packets you get upon entering the hospital where there are two color TV's in the room.

Second, greater Federal and State support for a public health program that would expand public health nurses and clinics to provide medical checkups, visiting nurse programs, and other home health services so that older people can avoid hospitalization or institutionalization as long as possible.

Third, support a program aimed at teaching families how to give basic health care, like the turning of a bedridden patient or giving them a bath, so that caring for older family members would not be so frightening.

Fourth, support the programs that could assist older people in meeting the costs of their prescriptions. Older people have much higher drug costs than the rest of the population, and we are least able to pay for high-cost drugs.

Fifth and the last, one little item, talk to and listen to older people who will use programs before you start them; and by listening to us, many problems could be avoided.

I know there are many more ways that can be thought of to meet the health needs of older people, but these are a few that I believe would not only help reduce health care costs and to help older people, like me, to be healthy and independent longer.

I do not want to be sick or hospitalized, and I do not want to go to a nursing home if I can help it. I simply cannot afford it.

Thank you for your time and your attention specifically.

Senator DANFORTH. You have all done very well: and in the interest of time, I am not going to ask any questions, except to say that yesterday afternoon it was my pleasure to visit with the Boone County branch of AARP, Ms. Roller, and it was very clear to me from visiting with them that they knew how we got into what you call the no man's land and who got us into it. Their view is that Washington is the culprit, and I think they're absolutely right.

Senator DOLE. Before you leave here, Ms. Roller's comments reminded me of a story our minister told us at the family church. He said this man was taking a survey—somebody mentioned, Barbara mentioned surveys—and he came to this one house, and a man came to the door, and he went down a list of questions, and he got down to No. 4, and the surveyor asked the man, "What do you think is America's most important problem, ignorance or apathy?" and he thought about it a while, and he said, "I don't know and I don't care." I think that probably ties right into some of the problems that you suggest that you may be having. Some people don't know and some people don't care. I hope that does not reflect on those of us in Congress or the representatives from HEW who were kind enough to come today or others in the room, we do understand.

Hattie, do you have any supplemental insurance to take care of that 20 percent, or is it too expensive?

Ms. NORMAN. It's too expensive.

Senator DOLE. That's an area that we are looking at, too, so maybe we might be able to pick up that gap of the 20 percent, but that does get a little costly.

Ms. NORMAN. Yes, it does.

Senator DOLE. Joe, we're happy to have you in Kansas, and I know you are going to stir things up.

Mr. LEVERENZ. While the others are coming up—I went to China last November to see how they handled their older people as well as health care, and I was so surprised—there were doctors who went to the homes. They're called "barefoot doctors."

Senator DOLE. I think Larry has a question, Joe.

Representative WINN. I don't have a question of Joe. I was just going to remark about Ms. Norman's statement, what she wished the Government would ask those of you that are involved in the health care programs and senior citizen programs before we tell you what we think you ought to have. I think you are just exactly 100 percent right on that.

Mr. LEVERENZ. This could be true for all consumers, not only older people. So wherever you are developing programs, for goodness sake, "try it on for size."

Ms. ROLLER. Congressman, may I add a comment to that, also?

Representative WINN. Yes.

Ms. ROLLER. You folks listening to us, and it is our duty to give you our views, and many of us fail to do that, and there is an area there in which there is a problem. You cannot do what we want you to do unless we tell you, and we are a tough people. We weathered the depression. We are very self-sufficient. We don't ask for help unless it's absolutely necessary. So we ask you to help keep us tough.

Senator DOLE. Just one more thing. If you had one more benefit, what would it be, drugs or home health care, or extended physician benefits?

Ms. ROLLER. Home health care.

Mr. LEVERENZ. Home health care.

Senator DOLE. Roberta, we appreciate your comments. I think that you may have a good point. I think a lot of times we do things in Congress thinking that's what we ought to be doing because somebody thought of it. We never consulted with the people that were going to be the victims or the beneficiaries of it.

We need to seek out that consultation.

[The prepared statement of Mr. Leverenz follows:]

STATEMENT OF THE NATIONAL RETIRED TEACHERS ASSOCIATION AND THE AMERICAN ASSOCIATION OF RETIRED PERSONS

HEALTH AND THE ELDERLY—AN OVERVIEW

The Associations' health policy is based on three points. First, our objective is to improve the health of the elderly. Second, although issues relating to the treatment of illness dominate discussions of health policy, the real challenge is how to maintain health and avoid illness. Third, health care cost containment is vital to any realistic formulation of health policy.

Defining "health" in terms of the elderly must take account of the problems that distinguish them from the non-elderly. When applied to the elderly, our definition focuses on the degree of the individual's independence in conducting life activity. Thus we are concerned not only with the elderly's access to treatment for illness but also with their need for those health and health-related services that will help them remain active and in good health. In addition, we are committed to securing sufficient resources for such efforts as nutrition education and biomedical research because these are essential if we are to cope with chronic illness and prevent and cure dread diseases which disproportionately afflict older persons.

The elderly's special health needs are all the more important because the population is aging. The types of special services they need (especially the oldest of them) to maintain health must be increasingly promoted. Geriatric medicine must be given far more emphasis.

OBSTACLES TO PROMOTING THE HEALTH OF THE ELDERLY: THE ACUTE CARE SYNDROME

There are two obstacles to promoting improvements in the elderly's health status. The first is the belief that all needed levels of care can be supplied

through the present medical system. The second is escalating medical care cost and the country's limited resources. Health services presently available to the elderly are most often overlapping, confusing, fragmented and unevenly distributed.

Today's health care system is concerned almost exclusively with the treatment of illness and acute care intervention. Yet health status is affected far more by such factors as education, nutrition, housing, lifestyles and environmental pollution than by medicine. Therefore, the country should not be allocating, almost automatically, an increasing proportion of its scarce resources to medicine for the treatment of illness after the fact.

Real growth in the nation's gross national product (GNP) in 1980 will be negligible at best. Yet, because of the economics of the health care system (and its third-party reimbursement system) minimal or even negative growth rates in the economy will not constrain the proportion of resources allocated to the treatment of illness in acute care, institutional settings. Health care services are in fact taking a larger and larger share of the total "pie," rising from 6.7 percent of GNP in 1967 to 9.1 percent in 1979. If more resources are to be allocated to more health-effective and cost effective measures and less to purely medical care, we must start to restructure the health care industry.

THE HEALTH CARE INDUSTRY: ITS GROWTH, STRUCTURE AND SHORTCOMINGS

The health care industry is one of the nation's largest economic sectors. Since Medicare began, health spending has increased at an average of 12.2 percent per year while the economy as a whole has grown at an annual rate of 9 percent. In 1978, health spending totalled $192 billion.

It is important to understand why this economic sector has been growing so rapidly. This growth is due partly to the expansion of the number of elderly persons who, as a group, need and utilize health services far more than the non-elderly. Adding much more to demand for medical services, however, has been the expansion of the third-party payment system. By 1978, third-party payments accounted for slightly over two-thirds of personal health care expenditures, 91 percent of hospital expenditures, and 65 percent of expenditures for physician services. Generally speaking, this growing demand for medical services has been met through a more than 50 percent expansion of hospital capacity, hospital personnel, and health care professionals since 1960.

Government has subsidized both the demand and supply sides of this growth. On the demand side, the private third-party system's growth has been subsidized through the tax laws. Also, Blue Cross/Blue Shield are tax exempt in most states facilitating the public's purchase of high-option, first dollar health insurance coverage. Moreover, the public Medicare and Medicaid programs were modeled on the private third-party payment system. On the supply side, hospital expansion was stimulated by the Hill-Burton program and by the tax exemption of hospital construction bonds. Federal spending for the training of health professionals alone totalled $5 billion between 1964 and 1976.

Government subsidies to increase the supply of medical facilities and services were expected to moderate costs for health care. However, the third-party payment system makes the patient indifferent to cost, except the part for which he is responsible. Consequently, there is little restraint on the rate of increase in charges of providers or the rate of increase in costs they incur. Third-party payers reimburse hospitals for virtually all costs incurred and cover much of the fees charged by physicians and other professionals. Also, doctors tend to overutilize hospitals, the most expensive component of the medical care system, and this overutilization is promoted by the third party payment system which tends to cover hospital services but not less costly, out-of-hospital services.

As a consequence, medical costs and charges (and therefore total spending) have been growing much faster than prices in general. Since 1969, price increases of medical care providers have accounted for about 63 percent of this growth; quantity and quality (technology) increases account for about 30 percent; and population increases account for about 7 percent. Typically, during 1977, when the Consumer Price Index increased 6.8 percent over the prior year, medical care services rose 9.6 percent, semiprivate room charges 11.5 percent and physicians' fees 9.3 percent.

NEW DIRECTIONS FOR THE ELDERLY

Despite all the money funnelled into health care, major elderly health needs are not being met. As the elderly population grows, the problem of meeting those

needs will also grow. Restructuring the health services industry should not just be a means for controlling costs but also a means for developing a comprehensive, efficient, and rational system to accommodate these unmet needs.

An adequately restructured system should include such components as: (1) adequate, supervised residential facilities for those who lack families, but wish to live in their communities; (2) a range of facilities as alternatives to hospitals and nursing homes, including a comprehensive system of home care; and (3) innovative and compassionate ways of caring for the terminally ill, outside of the hospital and nursing home. However, if needed new services are to be promoted, the rate of expansion of the medically oriented health industry must be checked.

CONTROLLING HEALTH CARE COSTS THROUGH GOVERNMENT REGULATION

Despite government efforts to control costs and spending by regulating the health industry, little success has been achieved. The powerful economic incentives contributing to the growth of health care spending have so far overwhelmed the regulatory effort.

Since the larger part of the industry's billings are fully reimbursed, experiments have been undertaken to pay hospitals on the basis of prospectively approved budgets. Eight states have implemented mandatory rate reviews for hospitals with some success. While all hospitals nationwide were experiencing a 12.8-percent rate of increase in expenditures in 1978, those states with mandatory cost containment programs had only a 9.3-percent rate.

The 1972 Social Security Amendments established Professional Standards Review Organizations (PSRO's) to assure that the services financed by programs like Medicare were medically necessary, professionally acceptable and provided most economically. Unfortunately, this "peer review" method of regulation is itself costly and the results are still inconclusive.

The 1974 National Health Planning and Resources Development Act is supposed to control the expansion of the supply of institutions like hosptials and expensive equipment by requiring, at the state level "certificates of need". The program does appear to have slowed down the creation of new and unneeded hospital beds and the addition of ever more expensive and underused equipment. However, much more needs to be done in these respects.

Because Government regulation has not accomplished much in terms of restraining the rate of increase in costs and spending, increased attention is being given to new and less costly ways of delivering health services. Health Maintenance Organizations (HMOs) for example, have demonstrated significant cost savings potential. Their emphasis on preventive medicine, consumer education and health maintenance techniques drastically reduce costly hospitalization among health plan members. As for Medicare beneficaries, Congress is presently completing action on the 1979 Medicare/HMO Reimbursement Amendments which should encourage greater numbers of Medicare enrollees to join pre-paid health plans. In those many instances where actual costs to the HMO of providing a range of services would be less than the "95% capitation fee", the HMO would be required to return the difference to its Medicare members in reduced cost-sharing and deductibles or in increased preventive services.

COST CONTAINMENT: THE KEY TO PROGRESS

To restrain the rate of increase in conventional health care expenditures the Associations have a four-pronged strategy. First, we would remove the economic incentives that are causing the excessive expansion of conventional medical facilities, particularly hospitals with surplus beds. Second, we would cap hospital expenditures, thus "freeing up" some resources for other, more health-effective uses. Third, we would restructure health care service delivery away from acute care institutional settings to make available needed but less costly services (e.g. home health services). Fourth, we would support government regulatory programs with the potential to yield significant savings.

To date, too little has been done to remove the economic incentives which have caused the explosive expansion of the supply of medical facilities. To constrain this expansion, we recommend the following steps:

(*a*) phase out (depending on need) tax breaks that promote the expansion of hospitals;

(*b*) eliminate blanket tax deductions for medical insurance premiums paid by employers if the insurance fails to cover lower and less costly levels

of care as well as provide (where available) multiple health insurance options (including at least one pre-paid plan or HMO);

(c) stop cost-plus reimbursement under government health programs and cease employing provider-linked intermediaries/carriers in making disbursements;

(d) do not exempt health/medical insurance corporations from anti trust laws and abolish any state or federal anti trust exemptions of medical institutions;

(e) regulate all corporations selling medical/health insurance to eliminate duplication, encourage competition, and do away with fraud and abuse in the sale of supplemental Medicare insurance policies; and

(f) subsidize the training of only those health professionals who agree to work in medically underserved areas.

As stated above, the second thrust of the Associations' strategy calls for a cap on the rate of increase in hospital expenditures and physicians' fees. Hospitals have registered cost increases of about 14 percent annually for the last decade. As for physicians, they have been increasing their fees at double-digit rates far too long. Such caps should be legislated until surplus beds are eliminated, the rate of increase in hospital expenditures is brought into line with average economic growth rates, and until the rate of increase in physicians' income is brought into line with that of non-medical professionals.

In the event the Congress refuses to legislate caps on the rate of increase in hospital expenditures and physician fees, the problem ought to be attacked from a number of different (albeit complimentary) directions. As discussed above, limitations should be placed on the supply side through a restructuring of the Hill-Burton Act hospital financing mechanism. There should also be a closer coordination of this funding mechanism with the certificate-of-need health planning process and the activities of local Professional Standards Review Organizations (PSROs). Moreover, tax incentives should be utilized to promote competition. Exclusion of premium payments from taxable income should be tied to the employer's offering his workers a variety of health plans to choose from—including at least one pre-paid, HMO-type plan (where available) as well as lower option plans covering less costly levels of care. In coordination with these initiatives, the States should be encouraged to implement rate review programs.

The third point of the proposed strategy—restructing health service delivery—should have the effect of expanding the supply of needed services that are less costly alternatives to hospitals and nursing homes. In public and private insurance programs and in the delivery of health care services, there remains an overwhelming bias toward acute care and institutionalization. To partly redress this situation, competing forms of care like HMO's, health care centers, small clinics and ambulatory health care facilities of all kinds ought to be promoted. Greater use should also be made of para-medical personnel, especially in underserved rural and inner-city areas. For the elderly, this kind of health care restructuring would mean better access not only to conventional medical care but also to a variety of needed non-medical, social services like homemaker/chore maintenance services, counseling services, and "linkage" services which connect the elderly with other forms of care.

Of total Medicare program benefit payments in 1978, 73 percent went to pay for acute care in hospitals. On the other hand, funding was almost non-existent for home health care, ambulatory care, preventive care and other outpatient health services based in the community. Less than 3 percent of all nursing home expenditures were covered by Medicare in 1978.

As for the fourth part of the Associations' strategy, we shall continue to support government efforts to control costs by effective regulation. State efforts through mandatory prospective budgeting/rate setting and certificate-of-need programs especially ought to be promoted. Indeed, should the effort to legislate a strong hospital cost containment bill fail, this will be the primary focus of our effort—encouraging state rate review and federal regulation.

A COMPREHENSIVE PROGRAM OF LONG TERM CARE: THE MAJOR DEFICIENCY IN THE EXISTING HEALTH CARE DELIVERY SYSTEM

The lack of a long term care system that encompasses both medical and social services is the greatest deficiency in the present health structure from an elderly viewpoint. The elderly's access to long term care is restricted by the non-

availability of services and qualified personnel and by their financial inability to pay for the services that are available.

The implication of demographic trends for long term care policy is significant since the elderly have the highest incidence of functional disability. Demand for long term care service is going to increase rapidly. Yet, current demand is not even being met. Of 8 million persons estimated to be in need of assistance with daily activities, only 2.3 million receive long term care under government programs.

Nearly half of all nursing home costs in 1978 were paid from private sources; 46 percent of these costs were paid for out-of-pocket. The average annual cost of a nursing home stay in 1977 was $9,614. It is no wonder that nursing home care is the main "catastrophic" health expense of the elderly. They are forced to deplete their resources or "spend down" (impoverish themselves) to become eligible for Medicaid assistance for nursing homes. Perpetuating a long term health care system based on institutional services alone will only continue to consume all available resources and make it very difficult to initiate or expend an integrated and community-based service system.

It is clear that episodic, incidental or acute medical care is our present national response to the health needs of the elderly. All proposed national health insurance programs, to the extent that they ignore the pressing need for a national long term care policy and program, reinforce this inadequate and inappropriate response. In particular, present catastrophic health insurance proposals would only provide medical care in acute care hospitals in spite of the fact that catastrophic health expenses for older people are for the most part a direct result of nursing home expenditures.

While further delay in providing, coordinating and financing a comprehensive long term care program ought not to be tolerated, the financial difficulties of Medicare and Medicaid prevent any significant expansion of services under either of these programs at this time. Meanwhile, costs are being driven up by high inflation, demographic trends, and increased utilization of services.

Current government programs are clearly biased against home-based services. If an adequate supply of sheltered living arrangements, congregate housing, homemaker/home health care and other community-based services were available, an estimated 20 to 40 percent of the present nursing home population could be cared for in less intensive and less expensive ways. The ultimate goal in this area is a long term care program providing a complete continuum of care, creating in the process a network of community-based long term care centers that would function as providers, payers, certifiers and evaluators of services. In the interim, however, a pre-admission screening program for nursing homes could be established that could provide comprehensive needs assessment for nursing home applicants; assistance in planning for and securing available services in the community; case management and periodic reassessment and controls over costs and utilization of public programs.

A number of amendments to the Medicare and Medicaid programs ought to be enacted to expand benefits in the area of home health services. The Part A Medicare prior hospitalization requirement the Part A and B 100-visit limit and the "homebound" and "skilled" requirements under Medicare home health services ought to be eliminated. Also, homemaker and periodic chore services ought to be included in the benefits package.

In addition, Medicare beneficiaries ought to be encouraged to enroll in Health Maintenance Organizations (HMOs) and other alternative health delivery systems. While such enrollment should be voluntary, increasing the number of elderly participants in HMOs will most likely lead to a meaningful (short-term) expansion of benefits (through a more comprehensive level of services) as well as generate significant cost savings. The latter would be the result of reduced hospitalization and increased emphasis upon preventive health care and health maintenance.

NATIONAL HEALTH INSURANCE

The Associations strongly advocate the enactment of a comprehensive national health insurance program. The magnitude and number of problems in the health area and the need for complete restructuring of the means of delivery and paying for services justifies this position.

Medicare was designed to pay 80 percent of the elderly's hospital and physician costs. In 1977 it covered only 78 percent of the former and only 55 percent of the

latter. The result of this, plus escalating costs for other needed services such as nursing home care, drugs, dental care and eyeglasses (which are uncovered or inadequately covered) is that older Americans are spending more out-of-pocket for health care today than they did before the inception of Medicare.

The per capita health bill for persons 65 and over in 1979 will be $2259 or nearly 3½ times the amount for citizens under 65. While Medicare picks up approximately 38 percent of the bill (when beneficiary deductibles and cost sharing are considered), the elderly are in a relatively worse position because of the extraordinary rise in health care costs not covered by Medicare. A full 35 percent of the average health bill is paid for out-of-pocket by the elderly. Private health insurance covers only 6 percent of the total per capita expenditures. In 1977, older Americans were personally responsible for 98 percent of their total expenditures for eyeglasses, 94.5 percent of their dentists' fees, 86 percent of their drugs, 51 percent of their nursing home costs, plus other professional and health services. Clearly, increases in health costs and diminishing benefits are financially constricting the elderly's access to needed health services.

Because of the deteriorating situation, these Associations regard a national health insurance (NHI) program as an important need for the country. The NHI program we seek should contain these essential elements:

(*a*) more primary health care providers with a shift in emphasis and resources away from institutionalization and acute care services to preventive medicine, and health maintenance and home health care;

(*b*) standards for increasing quality and efficiency of health care;

(*c*) competition among providers with profit incentives to lower costs;

(*d*) comprehensive benefits with universal and mandatory coverage;

(*e*) immediate system reforms and prospective rate (or fee) setting for institutional care and physicians' services;

(*f*) financing by combination of progressive employer-employee payroll taxes and general revenues;

(*g*) a patient-oriented health care system with majority representation of consumers on policy-making and administrative boards; and

(*h*) Maximum concentration of program administration at the local level with federal and state public authorities limited in size and scope to providing budgets and guidelines.

The Health Care for all Americans Act proposal (S. 1720 and H.R. 5191) comes closest to fulfilling these immediate objectives. The Act would establish short and long term controls to restrain the rate of increase in health care costs. On the benefit side, the Act would retain the Medicare program but upgrade its benefits to provide full coverage of inpatient hospital services, physician services, X-rays and lab tests. There would be no arbitrary, non-medical limits on the number of hospital days or physician visits. Physicians would not longer bill Medicare patients but would be paid directly by one of four insurance consortia, thus reducing the paperwork that has become so burdensome for the elderly. Finally, some prescription drugs for chronic conditions would be added to the list of Medicare's covered services.

Only with a NHI program that improves quality while containing the rapid increase in costs in the entire health system can we provide adequate health care for all Americans based on need rather than ability to pay and at a price the nation can afford.

With inflation constraining spending on private and public health programs to the limit; only through the substantial savings that can be generated from eliminating waste, duplication and inefficiency in the current system of medical care and from stringent cost containment features such as the proposed program would entail can we expect to be able to improve the health and quality of life with no greater real share of the federal dollar than we are now spending.

"MEDIGAP", MENTAL HEALTH AND OTHER HEALTH POLICY ISSUES

Fraud and abuse in the sale of insurance policies ("Medigap") to supplement Medicare are widespread and well documented. In the absence of effective state enforcement of already implemented statutes and guidelines and out of the realization that it is because of the gaps in Medicare that the market for this type of insurance exists, minimum federal standards ought to be enacted to govern the sale of "Medigap" policies. These standards should include: information disclosure; limitations on exclusions for pre-existing conditions; no-loss cancellation;

minimum-loss ratios; and strong penalties for criminal misrepresentation and mail fraud.

Strong information disclosure provisions also need to be legislated as federal and state governments develop and initiate multi-media programs of consumer education. Clear and easy-to-read summaries of benefits, limitations and exclusions ought to be part of any salesman's presentation of a policy. Misrepresentation, fraud and the sale of duplicative policies must also be policed. These goals can best be realized through a comprehensive program of federal certification of all health insurance policies sold to supplement Medicare. As a first step, such a certification program could be strictly voluntary but should be accompanied by studies of the advisability of policy standardization; appropriate minimum loss ratios for these policies; the sale of dread disease and indemnity policies; and the success (or lack thereof) of the National Association of Insurance Commissioners' (NAIC) "model state law" approach * * * and the possible need for mandatory certification of "Medigap" policies by the federal government.

Another area where health care policy has responded inadequately to existing and growing need among the elderly is the area of mental health. The National Institute of Mental Health has estimated that during 1980 approximately 80 percent of the elderly who need assistance for emotional disturbance will never be served. Moreover, as many as 30 percent of those older Americans described as "senile" actually have reversible psychiatric conditions which, if treated, would allow them to become better functioning members of society while saving a substantial amount of Medicare dollars.

With respect to mental health services there should be two goals: access to services—especially community-based services—and avoiding inapproprate institutionalization. To achieve these goals, two things ought to be done. First, comprehensive mental/physical geriatric assessment units should be established to prevent needless institutionalization and facilitate appropriate placement of the mentally infirm. This should yield savings for Medicare by reducing present levels of inpatient hospitalization. Second, changes must be made in Medicare so that community mental health centers (CMHCs) will begin to serve the needs of the elderly. Such changes should include extending Medicare provider status to CMHCs, increasing the present $250 Part B annual ceiling on outpatient mental health services to $1,000, eliminating the 190-day lifetime limit on inpatient psychiatric care under (Part A), and incorporating periodic reassessment requirements for Medicare patients and stiff utilization review requirements for CMHC providers.

In response to demographic trends and an aging population, and explicit strategy for the delivery of geriatric medical care and health services to senior citizens should be adopted. To help facilitate this objective, manpower appropriations legislation should make grants available for the establishment and operation of educational programs in geriatrics at schools of medicine.

Finally, in the health policy area, the matter of public disclosure of information by PSROs, should be raised. In authorizing the PSRO program in 1972, the Congress established certain principles of operation that were to serve as the basis for regulations governing the disclosure and confidentiality of the information PSROs acquire in the course of their activities. The question has subsequently arisen as to what extent PSRO data on the relative performance of hospital and doctors should be subject to disclosure and with what safeguards. The Associations believe that this information should be disclosed and disseminated to carry out the purpose of the PSRO program, to assist with the identification of fraud and abuse, and to assist in the conduct of health planning activities. It is our belief that there is a pressing need for a greater degree of patient information and education concerning the relative performance of health care providers, especially if we are to attempt to bring greater competition to the health care marketplace and ths hold down health care costs.

Senator DOLE. The next panel will be the noninstitutional providers: Jerry Hess, Thomas Scott—Jerry is the director of medical personnel pool in Kansas City, Kans.; accompanied by Karen Foster, director of nursing; and Tom Scott, executive director of Visiting Nurses Association, Home Health Services of Greater Kansas City, Kansas City, Mo., accompanied by Marilyn Dymer, director of nursing.

Do you want to be first?

Mr. HESS. Senator, we had one change in our program. Catherine Tillson with Kelly Health Care is sitting in for Karen Foster, if that change could be made.

Senator DOLE. Yes.

NONINSTITUTIONAL PROVIDERS

STATEMENT OF JERRY HESS, DIRECTOR OF MEDICAL POOL, ACCOMPANIED BY CATHERINE TILLSON, DIRECTOR OF NURSING

Mr. HESS, Senator Dole, Senator Danforth, Congressman Winn, I thank you for the opportunity to appear before you as a representative of the home health care community. I appreciate your allowing me to serve on this panel of health care providers and to discuss the needs of the elderly.

As a health care provider, both in Kansas and Missouri, I'm proud to say that our center is not only recognized in health care problems of the elderly, but are actively working to improve these conditions.

I know you have introduced legislation to expand the home health care services, and I assure you this legislation is needed.

Every member of this panel is concerned about our elderly. Ten percent of our population falls into that area, and the estimates are that within the next several years, this percentage will increase significantly; and if we cannot adequately serve them now, how will we serve them in the future?

We noticed three basic problems in delivery of the health care services to the elderly:

No. 1, the health care for the elderly is primarily institutional-based. Most elderly patients are cared for in hospitals or nursing homes because this is the primary source of care available. There's certain sections of Kansas and Missouri that don't even have access to home care.

In addition, where home care is available, home services are limited; and in most cases, they are nonreimbursable. Therefore, the patient has no alternative but to go into an institution.

The present reimbursement system, No. 2 in the problem area, the present reimbursement system, medicare and medicaid supports and reinforces institutional care only. Most elderly people cannot pay for their health care. They do not have the private funds, nor can they afford to carry some of the private-pay insurances. Most home care services under present insurance coverage are nonreimbursable anyway. Therefore, elderly patients in most cases need some sort of Federal reimbursement to handle their health care.

Hospitals receive between 80 to 100 percent of the medicare requirement, depending on whether they have supplemental tie-ins, nursing homes in the same area. The home care reimbursement is restricted because of existing laws which only allow patients 100 visits per illness and require 3 days of prior hospitalization; and we know Senator Dole has been working on legislation in this area to correct that particular situation.

In some cases, institutional care is inappropriate and more costly. We feel that all patients should be assessed to determine the particu-

lar kind of care needed. Patients requiring acute care should be hospitalized. Those requiring long-term care should be in nursing homes. However, the patients requiring part-time or intermittent care could and should be cared for in their homes. In most cases, elderly people prefer to be at home if at all possible; and in many cases this is less costly to the taxpayer.

The average cost of a patient stay in a hospital is between $175 and $200 a day; and in Kansas I think it is $187. The average cost of a patient stay in a nursing home is between $7,000 and $10,000 a year; and the average cost of home care is approximately $2,000 a year.

Quite frequently, and I'm speaking of daily in our particular business, medicare elderly patients contact our office seeking help; and because we cannot provide the service under the present law, they are forced into institutional settings, and this may occur even if they only need at-home care.

It appears that the task that is facing all of us health care providers of service to the elderly is to work together to assume the best quality care at the least possible cost.

Thank you.

Senator DOLE. Catherine, did you have anything to add to that?

Ms. TILLSON. I think that he has pretty much said it all as far as we are very much handicapped by existing situations, and I think that the older folks that you've heard from have touched on it exactly, in that many of them do prefer to maintain their independence and their home setting as long as possible, and they are not allowed to at this point in time because of their finances, because the medicare-medicaid, even with a supplemental Blue Cross-Blue Shield tie-in. That's not going to cover anything unless the medicare does it in the first place. So if they have an expense, a medication or eyeglasses or hearing aids that they want to purchase, and medicare is not going to cover it first, then Blue Cross is not going to consider it either. So in many cases, if they can afford the supplemental policy, then it's practically worthless to them anyway because they are spending money for something that may not give them anything in return.

We're handicapped in that we cannot provide service to many people at home because it is considered maintenance, and there are many, many folks, as Jerry has indicated, that will call us on a daily basis that maybe need maintenance care in their home in order to stay out of hospitals and nursing homes. Those institutions have their place, and it's for the acutely ill or the long-term patients that cannot be cared for in a home setting. There are many, many folks that can't.

Senator DOLE. Thank you. Tom.

STATEMENT OF THOMAS V. SCOTT, EXECUTIVE DIRECTOR OF VISITING NURSES ASSOCIATION, HOME HEALTH SERVICES OF GREATER KANSAS CITY, ACCOMPANIED BY MARILYN DYMER, DIRECTOR OF NURSING

Mr. SCOTT. Thank you, Senator Danforth, Senator Dole, and Representative Winn.

On behalf of myself, Mrs. Dymer and the board of trustees and the staff of the Visiting Nurses Association of Home Health Services of

Greater Kansas City, may I express to you my appreciation for the opportunity to provide testimony to you relative to home health services to the elderly.

I did have some material to present; but I will have to admit that the information that has been presented so far far outshines anything I could say, especially the last group—and I think some of those folks are gone.

So, in the interest of time, I'm going to defer my comments, my time, to Mrs. Dymer who does have some comments, and I would like to set the stage a little bit about our agency so you know where we are coming from.

We currently provide home health services in five counties in Missouri and one county in Kansas, and we currently have a caseload of over 1,500 persons who are 65 years of age or older, and we are also in our 89th year of service as a home care organization, to kind of set the stage. So with that, I would like to defer my time to Mrs. Dymer.

Senator DOLE. Mrs. Dymer.

Mrs. DYMER. I'm director of nursing services for Visiting Nurses Association of Greater Kansas City.

My educational background includes a master's degree from the University of Pittsburgh, having majored in nursing administration.

I am a strong supporter of home health care.

I was asked to testify today on the needs of the elderly and how from my point of view, that of a nurse employed in home health care, I saw those needs best being met in light of our current economy and evident need to curb Federal expenditure.

First, let me emphasize that my experience is not one-sided. Although I have spent over 7 years in community home nursing, and most of that time as a field nurse, my last position was that of a clinical director in a 1,500-bed geriatric hospital in Pittsburgh, PA. I feel that having worked in both settings, home care and the nursing home, I am able to compare the alternatives and make a very valuable observation.

Home care services and nursing home placement are not interchangeable solutions to the person who can no longer care for himself or herself independently. Each offers something different based on the unique needs of the patient. Unfortunately, this fact has gone unrecognized time after time.

In my experience, I have known that a number of elderly residing in nursing homes have been truly misplaced; that had home care been available to them, their needs could have been met not only in a more economical fashion, but also in a way which would have enhanced the quality of their lives.

Further, if home health care services were expanded to include such apparent luxuries as sitter, homemaker, food and chore service, an even larger portion of those confined to nursing homes could consider home health care services as opposed to where they are now.

Picture yourself, if you will, several years from now. Suppose you are chronically ill and just cannot manage alone. Suppose your income is at or below the poverty level. Would you prefer to remain at home, a place where you felt secure, surrounded by your belongings, a place where you could eat and sleep when you wanted, watch the television programs you chose to watch, derive companionship from

your own pet dog or cat, or would you prefer to live in an institutionalized setting?

If you think you might prefer to stay at home you might check with a nurse in home health care. She is trained in assessment and knows the support systems available in the community; and if it is found that home care is the alternative for you, you might just save the government over half of what it would cost should you be placed in a nursing home.

I assume that you know about home health care, the services which it offers, the regulations which govern it, and how we are reimbursed.

I would like, however, in the time I have remaining to focus upon the role of the home health nurse and let you know a little about our qualifications and what we can provide.

For one thing, we are all registered nurses, and we function under the direction of the patient's physician. We are educated to assess the patient's physical and emotional needs and construct a corresponding care plan involving the patient and his or her family in the goals we hope to attain. This assessment function is ongoing throughout involvement with the patient.

When the assessment indicates significant change in the patient's condition, the patient's doctor is notified and new orders are obtained.

We carry out the plan of care with the help of the patient or the family and at times delegate tasks to an L.P.N. or home health aide who is under our supervision.

Sometimes it is necessary for us to call in related home health service personnel, such as a physical therapist, the nutritionist, or the medical social worker. It is all a team effort.

It is impossible to list all the treatments the home health care nurse can provide to the patient in the home. Some of the most common are colostomy and catheter care, dressing changes and injections, blood drawing for lab tests, and tracheotomy care, even the more involved treatments such as I.V. therapy, chemotherapy, and renal dialysis can be provided by a nurse in the home setting; but I must emphasize we are not treatment oriented. Instead we are oriented toward teaching the patient to arrive at his or her maximum level of independence.

We teach the patient or his or her family how medications are to be taken and what side effects to look for, how to transfer from the bed to the wheelchair and back again, how to change a dressing or administer insulin or regulate the flow of the oxygen tank.

Patient and family education is stressed beyond anything else, because for home health care to work, the responsibilties must be shared, the result of which being the patient can stay in his or her home.

Senator DOLE. I don't have any questions, just an observation. I really appreciate the testimony, but I was just asking Sheila, a nurse on our staff, how many patients you could handle, and, of course, I guess it would depend on the severity of the illness, but I was trying to add up the cost, how cost-effective it would be, and I assume there are some average figures available—maybe in your statements, but do you have any comments on that?

Mrs. DYMER. Go ahead, sir.

Mr. SCOTT. We look at it from a home health agency point of view in terms of providing intermittent visits to the home. We look at it in terms of numbers of visits a day. It varies from home health agency

to home health agency. Ours, at our agency, it's somewhere between six and seven patients a day. But that's a little high.

Ms. TILLSON. In a proprietary agency, we have a large staff of temporary personnel. We do not have a permanent staff that we send out to visit so many patients a day, and with a temporary staff, it ranges anywhere between 100 and 300 nurses who are interested in maybe doing part-time work, 1 day a week, whatever their interest may be. You can cover a large number of persons in their home and keep them there on a continuing basis, providing not intermittent care as far as coming in and visiting for one-half hour, an hour, or even up to 2 hours, in order to do some treatments or instruct as far as how to do shots. You go in for an extended period of time, from 2 hours to 4 hours, whatever is required to help keep those folks in their home; and with a temporary staff, we're not talking of any kind of a cost to the public unless they are out there helping those folks in their home. So with less staff of that nature, you can cover a large number of folks.

Representative WINN. I would like to ask Jerry and Tom both, just for a quick answer, but from a congressional viewpoint, what do you see as the top priorities that should be addressed with regard to health care for the elderly?

Mr. SCOTT. I guess I would comment in terms of taking off some limitations in terms of the available number of visits a medicare beneficiary, for example, could have; and second to that is to focus the reimbursement financing mechanism more from an institutional perspective to a home care perspective.

Representative WINN. Jerry?

Mr. HESS. I think those things are being considered right now. Senator Dole has introduced that sort of thing.

One think as a proprietary provider, we would like to have considerations to compete in the industry for the home health work, and I think private industry has repeatedly exhibited their skills in being able to compete at a fair price for this type of work, and I think that is one area that needs to have some consideration given to the private sector to see if they can work with the Government too, in some cases, I think probably help save a little bit in the cost of the home health care.

Representative WINN. I know we are short of time, but maybe I didn't make it clear. That's your top priority. From a congressional viewpoint, what should our top priorities be?

Mr. HESS. I personally see them one and the same. I don't see that there's a distinguishing difference.

Representative WINN. Thank you.

Senator DOLE. Thank you very much.

[The prepared statements of the preceding panel follow:]

TESTIMONY OF THOMAS V. SCOTT, EXECUTIVE DIRECTOR, THE VISITING NURSE ASSOCIATION, HOME HEALTH SERVICES OF GREATER KANSAS CITY

HOME HEALTH SERVICES FOR THE ELDERLY

On behalf of the Board and staff of the Visiting Nurse Association Home Health Services of Greater Kansas City, may I extend to you my appreciation for the opportunity to present testimony to you on providing home health services to the elderly. The VNA stands in a unique position in this community to provide this information to you, partly because we serve both urban and rural areas, and partly because we have provided home health care for eighty-nine years. We

consider ourselves as "experts" in community-based home care with the knowledge that comes from serving the community for so many years.

The social security amendments of 1965 affected us as it did other VNAs and home health programs. The effects were in the terms of financing home care and in the way in which we provided services. It did not change what we did however. A useful theme to carry through my presentation is that while we have changed how services are provided, the services are still the same—health services in the home.

Like most home health agencies, a significant portion of our caseload are persons sixty-five years of age and older. Currently this age group represents approximately 1,550 persons, or 60 percent of a total caseload of 2,600. These persons are served by the full range of home health services and by a very active homemaker program. Although homemaker services are new by our agency's standards because we initiated the program in our agency seven years ago, it is a different way of doing the same thing. We are providing a service to persons in their home.

Our experience tells us that the elderly person prefers to remain at home where his dignity is preserved and his independence maintained. These are real goals for the elderly person. Part of what we do best is to help this person achieve these goals. Our stated mission finds its basis in the independent character of the people we serve. Federal regulations and reimbursement mechanisms require that we do differently what we have done in the past and will continue to do in the future—provide health and supportive services to persons in their homes.

We recognize that the family is the major "provider" of services to the elderly. The family is a major part of our approach to caring for the elderly person. The family provides the supporting mechanism which allows our services to be fully maximized. The isolated elderly person represents a special problem for us. Often, we become the only real and continuing link to the resources that are available to him. But that link may be the deciding factor that allows him to remain independent and functioning. The elderly tell us in no uncertain terms that they want to remain in their homes and in their community.

One good way of providing health care to the elderly while facing up to economic and fiscal realities is to promote and encourage the coordinated expansion of in-home health and supportive services. In-home health care services are less costly than institutional care and they well should be. In-home health care services are cost-effective and again, they well should be. Costs are incurred for a one-to-one encounter of patient and provider. This is truly cost-effective.

The coordinated expansion of in-home health and supportive services would be best realized through a Title XXI concept. Senator Dole hit the mark in his address to the National Association of Home Health Agencies in Washington, D.C., when he stated that we must not only look at health services but at other services necessary to keep people at home. Examples are home-delivered meals, homemaker services, and perhaps housing arrangements. Respite care services which permit family respite from the caregiver role on a temporary basis to have a break or take a vacation is another example. We see a tremendous need for this service in our present caseload.

Hospice care is an old idea getting new attention. We have been caring for terminally ill persons in their homes for many years and are encouraged to see this focus. We will participate in some form of hospice hoping that the expansion of in-home services will realize the importance of this concept of care. On the other hand, any expanded program must recognize and deal with those elderly who are healthy and need assistance to stay that way. We assist many healthy elderly through our homemaker program.

In summary, in-home health and supportive services are good ways to provide health care to the elderly when those services are expanded to include a range of services as I have mentioned and are coordinated in their financing and delivery. Such a program would go far in meeting the health needs of the elderly while operating in economic and fiscal realities.

M. Dymer, RN, Visiting Nurse Association of Greater Kansas City

I am Marilyn Dymer, Director of Nursing Services for the Visiting Nurse Association of Greater Kansas City. My educational background includes a masters degree from the University of Pittsburgh having majored in nursing administration. I am a strong supporter of home health care.

I was asked to testify today on the needs of the elderly and how, from my point of view—that of a nurse employed in home health care, I saw those needs best being met in light of our current economy and evident need to curb federal expenditures.

First, let me emphasize that my experience is not one-sided. Although I have spent over 7 years in community health nursing, and most of that time as a field nurse, my last position was that of a Clinical Director in a 1,500 bed geriatric hospital in Pittsburgh, Pennsylvania. I feel that having worked in both settings, home care and the nursing home, I am able to compare the alternatives and make a very valid observation: Home care services and nursing home placement are not interchangeable solutions for the person who can no longer care for him or herself independently. Each offers something different based on the unique needs of the patient.

Unfortunately, this fact has gone unrecognized time after time. In my experience, I have noted that a number of elderly residing in nursing homes have been truly misplaced; that had home care been available to them, their needs could have been met not only in a more economical fashion, but also in a way which would have enhanced the quality of their lives. Further, if home health care services were expanded to include such apparent luxuries as sitter, homemaker, food and chore service, an even larger portion of those confined to nursing homes could consider home health care services as opposed to where they are now.

Picture yourselves, if you will, several years from now. Suppose you are chronically ill and just cannot manage alone. Suppose your income is at or below the poverty level. Would you prefer to remain at home—a place where you felt secure surrounded by your belongings, a place where you could eat and sleep when you wanted, watch the television programs you choose to watch, derive companionship from your own pet dog or cat; or would you prefer to live in an institutionalized setting? If you think you would rather stay at home, you might check with a nurse in home health care. She is trained in assessment and knows the support systems available in the community, and if it is found that home health care is the alternative for you, you might just save the government over half of what it would cost should you be placed in a nursing home.

I assume that you know about home health care, the services which it offers, the regulations which govern it and how we are reimbursed. I would like, however, in the time I have remaining, to focus upon the role of the home health nurse and let you know a little about our qualifications and what we can provide.

For one thing, we are all registered nurses and we function under the direction of the patient's physician. We are educated to assess the patient's physical and emotional needs, and construct a corresponding care plan involving the patient and his/her family in the goals we hope to attain. This assessment function is ongoing throughout our involvement with the patient. When the assessment indicates a significant change in the patient's condition, the patient's doctor is notified and new orders are obtained.

We carry out the plan of care with the help of the patient or family and at times delegate tasks to an LPN or home health aide who is under our supervision. Sometimes it is necessary for us to call in related home health service personnel such as the physical therapist, the nutritionist, or the medical social worker. It is all a team effort.

It is impossible to list all the treatments the home health care nurse can provide to the patient in the home. Some of the most common are colostomy and catheter care, dressing changes and injections, blood drawing for lab tests, and tracheostomy care. Even the more involved treatments such as I.V. therapy, chemotherapy, and renal dialysis can be provided by a nurse in the home setting.

But I must emphasize that we are not treatment oriented. Instead we are oriented towards teaching the patient to arrive at his/her maximum level of independence. We each the patient or his/her family how medications are to be taken and what side effects to look for, how to transfer from the bed to the wheelchair and back again, how to change a dressing or administer insulin or regulate the flow of the oxygen tank. Patient and family education is stressed beyond anything else, because for home health to work the responsibilities must be shared. The result of which being—the patient can stay in his or her home.

Senator DANFORTH. The next panel is a panel of institutional providers: Melvyn Weissman, Howard Funston, Ronald Schaumburg, and Jim Redding.

Let me say, as this group is coming up, I am going to have to leave at 3:45, and it's not out of lack of interest at all but only out of the requirements of TWA.

Mr. Weissman?

Would you like to begin?

INSTITUTIONAL PROVIDERS

STATEMENT OF MELVYN WEISSMAN, EXECUTIVE DIRECTOR, JEWISH GERIATRIC AND CONVALESCENT CENTER, KANSAS CITY, MO.

Mr. WEISSMAN. Senator Dole, Senator Danforth, and Congressman Winn, I appreciate the opportunity to participate in the testimony today.

My name is Melvyn Weissman. I'm executive director of the Jewish Geriatric Center, which is a 182-bed skilled nursing facility in Kansas City, Mo., and also executive director of the Shalom Plaza Apartments, which is a Department of Housing and Urban Development 125-unit apartment project with 100 percent section 8 subsidy for the elderly.

Cicero, speaking before the Senate around 50 B.C. stated,

"Old age has no fixed term, and one may simply live in it so long as he can observe and discharge the duties of his station."

In the April 1980, issue of "Psychology Today," Bernice Newgarden, one of the leading geri-sociologists, talks about a term of age irrelevancy. Two thousand years ago, we are affirming Cicero's statement back in 50 B.C.

I would like to first share with you my thoughts and insights on the impact of current policies and programs and the ability of the long-term care facility to serve the elderly.

On reimbursement policies, there is a continued problem with the inadequate reimbursement under the medicaid program. Emphasis should be placed on States providing realistic cost-related reimbursement. Quoting David Munson who spoke earlier, he stated, "Funding of programs for the elderly without reductions."

A second issue now confronting the nonprofit facility, which we are, and that is concerning charitable contributions. They are being adversely affected as some States, such as Missouri included, have placed restrictions on community efforts.

If the dollars from community supporters are going to be discounted against reimbursement under medicaid, there is no incentive for homes to seek community investments in the quality of care; and what this means is if a facility is receiving a certain rate under medicaid, as an example let's say $30 a day for a bed or medicaid program, and they are receiving contributions from the community of, say, the equivalent or $2 or $3 a day, $3, $4, whatever it might be, the way the law reads now, the facility will be reimbursed at a maximum of the difference between the $30 and the amount received from the community.

A third area that I would like to talk to, and that's the return on equity. The cost of capital for nonprofit facilities is not reimbursed.

It is increasingly difficult for the nonprofit to extend services due to reduced contributions, tighter mortgage markets, and a high mortgage market.

A return on the investment for the nonprofit sector should be considered, either a growth allowance or a return similar to that permitted for the proprietaries.

The fourth area, the quality of care standards, the Government continues to make it difficult because of the attendant cost of paper compliance. Too much emphasis is still placed on the physical plan and paperwork rules rather than activities and services to assist the residents in leading fuller lives.

Another area, problems of developing a continuing care approach, and I think we've heard about that all afternoon. There's a lack of reimbursement for a number of services.

People who deal in housing know little about long-term care and vice versa. There's a great need for commitment to housing. It can help to stall off institutionalization, particularly if congregate services are provided.

Another area and probably one of the most critical is manpower; and if you have heard other speakers testify, you have heard about numbers of professional personnel that are serving each of these agencies. We have run out of personnel. The shortages are critical and is continuous and is adversely affecting quality of care in our long-term facility both at the professional and nonprofessional level.

On the professional levels, we need more PR in the nursing schools, occupational therapy, all therapy, et cetera. The situation of the doctors today I would say generally has been pretty hopeless, and I'm sorry that I cannot agree with the doctor that spoke earlier, that they see a light on the horizon. We have not seen any indication of any light on the horizon with the younger generation of medical students or doctors showing any additional interest in long-term term. In fact, it has been just as negative or even more so.

In the area of nonprofessional personnel, we're dealing generally, at least in Kansas City, with a socioeconomic element of personnel who, because of educational levels and background, find it very difficult to operate and give the kind of care that is required to maintain the dignity of the elderly. Until we're able to do something and upgrade these individuals and not just training them in nursing, but training them in dignity and human life and helping them economically and educationally to be that person and to run themselves first and identify themselves as being important, it's very difficult for them to go to another minority group, the elderly, and expect them to come on the bus, spend the bus fare, and then smile all day and then go home to a situation which is possibly not the best.

We believe in holistic health care which is defined as a system with respect to total living, embracing concepts of health promotion and disease prevention. The individual becomes a primary health care resource, taking into consideration all aspects of living, including pscho-, physio-, socio-, cultural-, spiritual-like forces of the universe that focus on a therapeutic potential of the total environment favorably affecting the person of those in our care.

In summarizing again, and in the interest of time, I believe very strongly and firmly—I've been in the field 17 years—that I don't be-

lieve alternatives, I think we have parallel services of care rather than alternative. I think this was addressed this afternoon.

I think when somebody needs a long-term care facility, they need a long-term care facility. I believe very strongly in home health care. I do know, too, of many long-term care facilities that could avail themselves of home health care if it was available. I also know and have heard from Dr. Carl Isedorfer, one of the leading psychiatrists in the country in geriatrics, that there are at all times between 10 and 15 percent of the elderly that are not able to avail themselves of long-term care for one reason or another, particularly minority groups, that there are not enough facilities available through various kinds of restrictions that affect them.

I feel a long-term care facility has a responsibility in the community to get into athlete programs, go beyond their four walls. We have a day care program for the frail elderly which is now being used as a model both in Kansas City and nationally, serving those who can remain in the community during the day, during the evening, come to our facility 1 to 5 days a week and participate in programs, where they can espouse during the day and giving them an opportunity to share in the good things that still remain in life.

Lastly, reiterating again the Federal programs of medicare and medicaid, the limitations under medicare in terms of eligibility, both financial eligibility and eligible lack of drug coverage, lack of the dietary, the most important losses that an elderly suffers are essentially losses, and these losses are not covered by medicare. So you have the eyeglasses, the hearing aids, the teeth, very, very expensive types of services needed by the elderly most important are not covered.

Under medicaid, unfortunately, we relieve the families of all responsibility, which is a terrible thing. There is no moral obligation on the part of the family, and legally there certainly isn't any.

Our facility, and in most States there are caps—there are medicaid caps, so that we do not receive full reimbursement under the medicaid program. We are not allowed to ask families for contributions because that's against the law. The number on medicaid continue to increase as people's money run out. If this continues much longer, we will be in the situation of not being able to handle a medicaid case.

In summary, I would say that I would hope that the long-term care would receive a little more prominence in terms of being part of continuing of care systems, and, also, that we might also see on the front page when one elderly person is helped one step along the road to recovery.

Thank you.

Senator DOLE. Thank you.

[The prepared statement of Mr. Weissman follows:]

PREPARED STATEMENT OF MELVYN L. WEISSMAN, EXECUTIVE DIRECTOR, JEWISH GERIATRIC AND CONVALESCENT CENTER AND SHALOM PLAZA RETIREMENT APARTMENTS

Senator John C. Danforth, Senator Robert Dole and Congressman Larry Winn, I appreciate the opportunity to testify at this hearing and provide input to better serve our elderly population. Cicero, speaking before the senate around 50 B.C. stated: "Old age has no fixed term and one may fitly live in it so long as he can observe and discharge the duties of his station."

In the April, 1980 issue of Psychology Today, Bernice Neugarten, a leading sociologist talks about "Age Irrelevancy", 2,000 years later, reaffirming Cicero's comments.

I would like to first share with you my thoughts and insights on the impact of current policies and programs and how they affect the ability of the long-term care facility to serve the elderly.

A. *Reimbursement policies.*—There is a continued problem with inadequate reimbursement under the Medicaid program. Emphasis should be placed on States providing realistic cost-related reimbursement.

B. *Charitable contributions.*—These are being adversely affected as some states, Missouri included, have placed restrictions on community efforts. If the dollars from community supporters are going to be discounted against reimbursement under Medicaid there is no incentive for homes to seek community investments in the quality of care.

C. *Return on equity.*—The cost of capital for non-profit facilities is not reimbursed. It is increasingly difficult for the non-profit facility to extend services due to reduced contributions, a harder mortgage market, etc. A return on the investment for the non-profit sector through either a growth allowance or return similar to that permitted for proprietaries should be considered.

D. *Quality of care standards.*—Government continues to make it difficult because of the attempt to force paper compliance. Too much emphasis is placed on physical plant and paper work rules, rather than activities and human services to assist the residents in leading fuller lives.

E. *Problems of developing a continuum of care approach.*—There is a lack of reimbursement for some services. People who deal in housing know little about long-term care and vice versa. There is a great need for commitment to housing. It can help forestall premature institutionalization particularly if congregate services are provided.

F. *Manpower.*—Personnel shortages are a continuous, critical problem adversely affecting quality of care besides being very costly both at the professional and non-professional levels.

I will dwell more on some of these issues later in my statement.

The long-term care facility plays a significant role in the continuum of care for the elderly. A holistic approach to health care should be its primary goal. This is defined as a system and a perspective of total living embracing concepts of health promotion and disease prevention. The individual becomes a primary health care resource taking into consideration all aspects of living, including the psycho-physio-socio-cultural-spiritual life forces of the universe. The focus is on the therapeutic potential of the total environment in favorably affecting the "person" of those in our care.

In order to carry out this philosophy, it is desirable and essential for the long-term care facility to provide a rehabilitative and restorative care program to meet the individual needs of each of their residents. This can and should be done through the team approach consisting of administration, nursing, medical staff, dietary, social services and various therapies that are included in the patient's plan of care such as, Physical Therapy, Occupational Therapy, Speech Therapy, Art Therapy, Music Therapy and Recreation Therapy. The goal of the team is to assist each resident to function at his optimum level both physically and emotionally.

Another role of the long-term care facility is to serve as a training site through arrangements with local colleges and hospitals for students going into the health care professions. At the Jewish Geriatric & Convalescent Center we have developed excellent training programs in all areas of health care with the exception of the medical profession. We will continue to be handicapped in trying to improve quality of care until the medical profession, i.e., students, faculty and practicing physicians willingly and actively become more a part of the "team" in a long-term care facility.

The Jewish Geriatric & Convalescent Center, which is a 182-bed skilled nursing facility and certified under the Medicare and Medicaid programs, extends its services into the community through the delivery of homebound meals, a day care program for the frail elderly, and out-patient therapy services.

I would like to now share briefly with you some specific problems with the current system. Medicare reimbursement is very limited. Very few elderly qualify under Part A because of the stringent eligibility requirements and even though most elderly in long-term care facilities have Part B Medicare coverage, reim-

bursement is limited in two ways: First, it does not cover prescription drugs, foot care, eyeglasses, hearing aids and dentures, items which are very costly and essential for the well-being of the elderly. Second, the majority of the therapeutic services that we give our elderly in order to reduce pain and make their lives more meaningful, are not considered covered services. I seriously question the Federal interpretation of rehabilitation.

Another problem area is the Medicaid program. This is basically a public assistance program with a combination of Federal and State dollars. Specifically, as I mentioned in my opening comments, the States are not providing true cost-related reimbursement. Therefore, the Jewish Geriatric & Convalescent Center and other homes certified under the Medicaid program, suffer significant losses each time a Medicaid recipient is accepted. The percentage of Medicaid recipients in our facility keeps growing each year for the following reasons: more of the elderly are running out of their own assets, a number of Medicaid homes have been closed down by the State, and others either refuse to be certified under the program, or use a quota system because costs exceed the Medicaid reimbursement rate. To add insult to injury, since families are not legally responsible for the care of their elderly, Federal regulations prohibit us from obligating families of those on Medicaid to make up the differences between our Medicaid rate and our full-cost rate. There is a serious question how much longer long-term care facilities can continue to accommodate the Medicaid recipient under these most trying circumstances.

Another area of great concern is the rising rate of inflation, which has hit the health care institutions more deeply than other segments of the population. The shortage of personnel which I alluded to earlier as affecting quality of care, also cuts deeply into our budgets. With the demand for professional personnel much greater than the supply, we are forced to pay bonus dollars in order to hire and retain professional personnel. Much to our regret, we are forced to hire personnel from agencies at an expense 40% higher than our normal costs. Unfortunately, most agency personnel have little or no feeling for the elderly they are serving. It is strictly a temporary job for them.

The last problem I would like to cover briefly, concerns the negative publicity given the long-term care facility throughout the media. When a nursing home is closed down by the State, it makes the front page of the paper or is the highlight on the television or radio news of that day. And yet, very little, if any, publicity is carried by the media on therapeutic programs, services and activities that make life more meaningful for our residents; and when this information is picked up, it is hardly noticeable to the public because of its hidden location in the paper or minimal coverage on radio and television.

I would like to make the following recommendations: Realizing that funds are very limited, I would suggest that funds be made available for grants and demonstration projects in the following areas: Transportation by vans with wheelchair lifts to take residents living in long-term care facilities shopping, to the doctor and to various activities; training for professional and non-professional personnel; expansion of day care programs in long-term care facilities thereby allowing elderly to remain in the community longer, forestalling premature institutionalization, yet giving the frail elderly an opportunity to spend anywhere from one to five days a week with their peer group in a heathy, therapeutic setting; and lastly. I would like to see an expansion of homebound meals programs so that the isolated elderly might have an opportunity for a meaningful life again.

In conclusion, I feel that there is no alternative to long-term care. When an elderly individual needs a long-term care facility, there is no substitute for that setting. I look at long-term care as one of a variety of very important programs and services for the elderly along a continuum of care that also includes the hospital, home-health, homebound meals, etc. If more socially intense settings such as our own Shalom Plaza Retirement Apartments can be established in which congregate dining and multi-activity senior center operate for elderly in the community, we will have gone a long way to meet the critical needs of so many of our elderly.

Thank you.

Senator DOLE. I might say to those in the audience who may want to submit statements, we certainly would be very glad to have your statements or letters. I've had about three or four letters handed to me.

They will be made a part of the record; or if you have thought of something while listening to some of the witnesses, that you would like to have included in the record or would like to comment on or rebut or refute or agree with, we would be very happy to have your written statement on that, and that can be sent to me in my office in Washington. Just address it to Senator Bob Dole, Dirksen Building, Washington, D.C. So if there is anything you don't agree with or do agree with or want to raise another point that hasn't been raised, we need all the information we can get.

Mr. Funston?

STATEMENT OF HOWARD FUNSTON, CHIEF EXECUTIVE OFFICER, VALLEY VIEW PROFESSIONAL CARE CENTER, JUNCTION CITY, KANS.

Mr. FUNSTON. Thank you, Senator Dole and Congressman Winn.

I'm Howard Funston, the executive director of the Valley View Professional Care Center, Junction City, a 125-bed skilled nursing home.

Most of my opening statements have been touched on to some degree by the former panelists, therefore, I will read my statement hurriedly in order to emphasize some of the specific points.

Dramatic changes have occurred in long-term health care in the past 20 years, particularly so in the past 10 years.

First has been the explosive in our elderly population. In 1978, there were over 23 million people in the United States over the age of 65.

Second is the increasing need for nursing home care due to increase in longevity. There has been a greater need for nursing home care. In 1978, there were over 23,000 nursing homes in the United States with 1,300,000 beds.

Third, there has been a tremendous change in the type and quality of care. Skilled nursing facilities now provide around-the-clock nursing care, highly specialized geriatric care to include inhalation therapy, oxygen, intravenous and gastrostomy feeding, and even in some cases blood transfusions.

In nearly all nursing homes now, there is a broad spectrum of adjunct services such as physical therapy, diversional therapy, recreational therapy, occupational and speech therapy, with an array of consultants and pharmacy, medical records, audiology, nutrition, and even music therapy. These are all geared toward providing quality of life as well as quality of care.

Fourth is the image. Most nursing homes have now become full service institutions run by professional administrators and a professional staff. This is in contrast to the mom-and-pop operation of the early facilities, which were referred to many times as the old folks home or rest home or the county poor farm. We are no longer considered second-class citizens.

These services have now become accepted by the majority of the residents in the nursing homes and their families. The Bureau of Census report released in September of 1978 shows that almost 90 percent of the residents and their families are satisfied with their care.

The most important fact is yet to come. With all of the growth and

changes, I think we have only scratched the surface from what is to come in continued growth and continued improvement. By 1985, it is estimated that we will need 2,300,000 nursing home beds, more nursing homes and more nursing home beds than we have hospitals and hospital beds.

The resident patient in the future will demand a far different style of care. There must be a far greater continuing of care from residential care to the extended skilled nursing home care. There will be a greater need for skilled, professional care, a requirement for more specialized care, and a greater involvement in community support.

There will be alternative services such as day care, home health care, meals-on-wheels, congregate nutrition programs, and hospice care for the terminally ill.

How can it be provided?

All of these programs are now being provided to some degree, primarily dependent upon the philosophy of the individual providers. However, there are two major concerns: Cost and availability of resources.

The first and foremost concern is inflation. The majority of residents in nursing homes are on a fixed income or living on their lifetime savings, and they are not receiving increases for the cost of living.

The second is the availability of professional resources. It will be necessary to make better use of the availability of professional resources. There must be more consolidation of programs. Currently, most specialized programs such as day care, home health care, residential care, hospice programs are separate programs with separate overhead and separate professional staff. This is costly and inefficient.

The Massachusetts study of 1978 shows that a free-standing day care costs 30 percent more per patient per day than round-the-clock nursing home care.

A recent study just released by the National Center for Health, a 1980 study for day care, shows that it costs $51.94 per day for day care.

I would like to have half of that reimbursement for 24 hours a day.

Volunteer home hospice program in Topeka, Kans., is allocated considerably more for their director than most nursing homes have for their total hospice budget.

The answer? There must be greater effort to consolidate programs and the use of a staffing program. There must be more community planning for total care, and long-term care administration must be included as a central focus on all long-term care. No one knows more about the care of the elderly than qualified, professional, long-term care administrators. There must be a greater effort by the Government to simplify reporting and participation, particularly in the medicare program.

To date, there are only 13 nursing homes in the State of Kansas still participating in the medicare program, and most of it because of the complicated procedures. I withdrew about 3 years ago.

There must be an equal opportunity for proprietary facilities to receive grants and participate in Government programs. Grants for research and new programs are available only to the nonprofit and the

Government agencies. An example is the energy conservation discriminates against the proprietary facility.

There must be a greater effort to incentives to develop and maintain total care in contrast to penalties for poor care.

The home health care program could be economical if properly coordinated. However, just staying in their own home as long as they can may be penny wise and pound foolish.

For example, I have tried to establish a day care center in my own facility for the last 2 years but have been unable to obtain any support from the State.

I'm also unable to understand why nursing homes can't combine services for home health care. I think the nursing home can provide excellent home health care.

I'd be glad to answer any questions.

Thank you.

Senator DOLE. Thank you. Ron.

STATEMENT OF RONALD SCHAUMBURG, ADMINISTRATOR, MEMORIAL HOSPITAL, McPHERSON, KANS.

Mr. SCHAUMBURG. Thank you, Senator and Congressmen.

I am Ronald Schaumburg, administrator of Memorial Hospital in McPherson, Kans. Memorial Hospital is a 122-bed facility consisting of 70 beds and an attached 52-bed skilled nursing facility.

Appearing before you is a real pleasure. And you have the thanks of all hospitals with long-term care units for taking the time to learn more about the problems we face. These problems are causing many hospitals to either close their long-term care units or to drastically cut back on the number of beds offered for use, and to also discontinue some of the community services offered by these hospitals.

I might also mention that our hospital has neither a CAT-scanner nor cobalt therapy nor plans to do so.

I would like to discuss just a few of the problems of Memorial Hospital and its long-term care facility experience. In 1963, the hospital constructed a 52-bed unit primarily to serve as a residence for those patients who could take care of themselves but who wanted to live somewhere other than their home and yet be close to medical care if and when needed. Over the years though the type of person using this facility has changed dramatically from the self-care type of client to the complete skilled nursing care.

Consequently because of an exhibited need and the fact there were no other skilled nursing facilities in the immediate area—we happened to be the only one in our county—the unit changed to a skilled nursing facility.

This unit usually has 100-percent occupancy with a waiting list of several patients. Most of these patients require considerable amounts of care involving time and skill. The benefit of being connected to the hospital in times of critical need should be self-evident.

However, the reasons for continuing this establishment are seriously threatened by the reimbursement policies of the title 18 and 19 programs. What should be an ideal situation of providing care and comfort for the older generation by sharing the services of an acute hos-

pital with a long-term care facility has actually degenerated to the point of continued operation of the long-term care unit being placed in jeopardy because of insufficient reimbursement for actual costs by the title 18 and 19 programs.

The title 18 medicare reimbursement system is complex and cumbersome, but I will try to briefly explain more specifically the problem. In my hospital's case, the medicare cost formula system for the fiscal year ending June 30, 1978, shifted $106,000 more in costs from the hospital side to the long-term care units we feel is both justified and reasonable.

We arrived at this $106,000 figure by using realistic management analysis and accounting methods. This $106,000 shifting the cost results in actual cash flow loss to the hospital of $50,000 in the medicare program alone. In addition, because the title 19 welfare program utilizes the medicare cost segment formula, an additional cash loss of $10,000 occurred with a total cash loss to the hospital of $60,000.

The long-term care unit serves a most important need in our area, one which would be sorely missed if it were not available. But the medicare program does not participate in its fair share of the hospital costs. Consequently, the long-term care unit patient is paying more than he should. The long-term care unit, in attempting to keep its charges as low as possible, is absorbing more of the losses than it should.

The insurance companies and private care patients are paying more hospital charges than they should and the medicare program is not paying its fair share of the hospital costs.

These costs cannot be adequately reimbursed to the hospital, as I said earlier. Very serious consideration will be given to the future existence of the long-term care unit.

I would like to bring up another item. Several years ago, the hospital entered into a program called meals-on-wheels. The hospital board was convinced that this was a service very much needed by hometown individuals and that by limiting the number of recipients to 24 per day, the meals could be prepared without additional staff. The only additional cost would be the raw food and disposable supplies. if any. Once again, the noble idea of a caring institution is being subjected to undue financial pressure because of the medicare reimbursement system.

Basically, the same situation exists with the meals-on-wheels programs as with the long-term care unit.

Senator DOLE. I want to just say there for the record that I have sent a letter to Secretary Harris asking for some clarification of current policy on that issue.

Mr. SCHAUMBURG. That is very good and I am glad to hear it.

Senator DOLE. This was last week, last Thursday. Go ahead.

Mr. SCHAUMBURG. To continue, this results in a further reduction of the hospital cost title 18 and 19 should be paying.

There are absolutely no other costs involved than raw food costs yet we are forced to increase the cost to the recipient because of overloading the meal-on-wheels cost side with cost from the hospital's side.

I am going to quit there except to say that last year we were paid $8,244 less because of the meals-on-wheels program than we should have been. This caused $1.75 meals that we were changing the recipient

to increase to $3.20 because of the highly inflated meal which is unreasonable.

I would like to just briefly mention something one of the other testifiers talked about and that was the Spellman illness and that needs to be worked on. That is a ridiculous situation.

Senator DOLE. We have a provision in a bill we are working on on that problem too.

Mr. SCHAUMBURG. I realize that you have tried to work to correct some of these things.

Just to close, we offer services to the community which we feel we are being penalized on. However, I believe that the title 18 program is unjustifiably shirking its responsibility by not reimbursing the participating hospitals for its fair share of the hospital's operating costs. I am not asking that medicare pay Memorial Hospital more than its fair share. I am though asking that medicare pay its fair share. To do less not only places an excessive burden on other third party payers and private pay patients, but it results in a negative cash flow to the hospital. We just cannot afford to absorb any more of this loss.

Consequently again, we just give serious consideration to the feasibility of continued operation of the programs as the net cash loss to us of $60,000 cannot be handled any longer. I thank you for your attention to this.

[The prepared statement of Mr. Schaumburg follows:]

PREPARED STATEMENT OF RONALD SCHAUMBURG

I am Ronald Schaumburg, administrator of Memorial Hospital, McPherson, Kansas. Memorial Hospital is a 122 bed facility, consisting of 70 acute beds and an attached 52 bed skilled nursing facility.

Appearing before you is a real pleasure and you have the thanks of all hospitals with long term care units for taking the time and effort to learn more about the real problems we face. These problems, in fact, are causing many hospitals to either close their long term care units or to drastically cut back on the number of beds offered for use, and to also discontinue some of the community services now offered by the hospitals.

I would like to discuss a few of these problems Memorial Hospital and its long term care facility experience.

1. In 1963 Memorial Hospital constructed a 52 bed unit primarily to serve as a residence for those persons who could take care of themselves but wanted to live somewhere other than their home and, yet, be close to medical care if and when needed. Over the years, though, the type of person using this facility has changed dramatically from the self care to the type requiring complete skilled nursing care. Consequently, because of an exhibited need and the fact there were no other skilled nursing facilities in the immediate area, the unit changed to a skilled nursing facility. This unit usually has almost 100% occupancy rate with a waiting list of several patients. Most of these patients require a considerable amount of care involving time and skill. The benefit of being connected to the hospital in times of critical need should be self evident. Other benefits of this arrangement include the use of dietary, laundry, maintenance and housekeeping services which can be utilized in a more efficient manner than if the Long Term Care Unit were a non-attached facility.

However, the magnanimous ideas and reasons for establishing and continuing this facility are seriously threatened by the reimbursement policies of the Title XVIII and XIX Programs. What should be an ideal situation of providing care and comfort to the older generation by sharing the services of an acute hospital with a long term care facility has actually degenerated to the point of the continued operation of the long term care unit being placed in jeopardy because of insufficient reimbursement for actual costs by the Title XVIII and XIX Programs.

The Title XVIII (Medicare) Reimbursement system is complex and cumbersome, but I'll try to briefly explain more specifically the problem. In my hospital's

case, the Medicare Cost Formula Allocation System for the fiscal year ended June 30, 1978 shifted $106,000 more in costs from the hospital side to the long term care unit than we feel is both justified and reasonable. We arrived at the $106,000 figure by using realistic management analysis and accounting methods. This $106,000 shifting of costs results in an actual cash flow loss to the hospital of $50,000 in the Medicare Program alone. In addition, because the Title XIX (Welfare) Program utilizes the Medicare Cost Statement Formula, an additional cash loss of $10,000 occurs, or a total cash loss to the hospital of $60,000. Our problem is not the necessity of separating costs between the hospital and the long term care facility, but rather, the methodology used in the Medicare Reimbursement Cost Report. This methodology involves a system of stepping down costs in each department, so that a supposedly appropriate share of overhead costs are allocated to the various revenue producing departments which really does create an overloading situation in most cases. A simple example may help to clarify. The Dietary Department prepares meals for primarily the hospital patients and employees. With just a few additional dietary employees, the meals for the long term care unit can also be prepared.

Because of the step down allocation system and because more long term care patients meals are prepared than the hospital (due to the lower hospital occupancy), a great number of payroll costs and fringe benefit costs are allocated to the long term care unit than justifiable. The Medicare Program does not recognize that, should the long term care unit be closed, only a few employees would be unnecessary, rather than over half because of the current methodology. This situation exists elsewhere in the hospital and it is a frustrating and costly situation for the hospital. The long term care unit serves a most important need in our area, one which would be sorely missed if it were not available. But, the Medicare Program is not participating in its fair share of the hospital costs. Consequently, the long term care unit patient is paying more than he should; the long term care unit, in attempting to keep its charges as low as possible, is absorbing more of a loss than it should; the insurance companies and private pay patients are paying more hospital charges than they should; and the Medicare Program is not paying its fair share of the hospital costs.

I respectfully suggest that consideration be given to a system of independent analysis and management accounting methods, so as to remove those costs applicable to the long term care unit before the step down process is begun for the hospital. Thereby, only actual hospital costs remain and are involved in the step down method. Consequently, no undue overloading of costs occur on the long term care unit side; thereby, resulting in a more adequate and fair reimbursement by the Title XVIII and XIX Programs, which in turn remove an excess cost burden from the other third party payors and private pay patients.

If these costs cannot be adequately reimbursed to the hospital, very serious consideration will be given to the future existence of the long term care unit.

2. Several years ago the hospital entered into a program called Meals on Wheels. The hospital board was convinced that this was a service very needed by homebound individuals and that by limiting the number of recipients to 24 per day, the meals could be prepared without additional staff. The only additional cost would be the raw food and disposable supplies, if any. Once again, the noble idea of a caring institution is being subjected to undue financial pressure because of the Medicare Reimbursement System. Basically, the same situation exists for the Meals on Wheels Program as the long term care unit, in that excessive and inaccurate costs are transferred from the hospital side to the non-reimbursable cost center of Meals on Wheels, which results in a further reduction of hospital costs Title XVIII and XIX should be paying. There are absolutely no other costs involved than raw food costs and yet, we are forced to increase the cost to the recipient because of overloading the Meals on Wheels cost side with costs from the hospital side. I might add that non paid volunteers transport the meals by their personal car to the recipient's home. What should be a beneficial community service by the hospital is being threatened because the hospital cannot continue to absorb those losses created by inadequate reimbursement by federal programs.

The Medicare Program paid the hospital $8,244 less than was due for the cost report in the year ended June 30, 1978. This simply means that a meal for which the recipient was paying $1.75 to cover the cost of raw food and supplies is now

costing more than $3.20 to the recipient. Yet, this $3.20 is a highly inflated figure because of the allocation system of the Title XVIII Program.

3. As a sidelight to the hospitals' continuing frustrations, we were just notified by letter from our Medicare Intermediary that in the future we must treat guest meals as a separate cost center. Guest meals are prepared at no additional payroll expense, and only raw food cost. Yet, we are faced with the same dilemma as the Meals on Wheels Program. Most of our guest meals are for Board Members, Physicians and relatives of patients.

The examples cited hopefully reflect the inadequacies of the Medicare Reimbursement Formulas. The system is causing hospitals attempting to be of the utmost service to their communities to cut back on very beneficial services. The reason is simple—money. They just cannot continue to absorb the losses caused by inadequate reimburesment by the Medicare Program not paying its fair share. The Department of Health, Edcation and Welfare, in its quest to control federal expenditures, is seriously threatening the very existence of the smaller institutions serving their communities. It is a most exasperating experience to try and keep up with the various changes and restrictions the Department of Health, Education and Welfare instigates to reduce the federal expenditure but not taking into account the serious consequences caused to hospitals. The Department of Health, Education and Welfare's goal seems to be to increase the services by hospitals to the patient, but reduce the expenditure to the hospital for that patient; consequently, causing the hospital to absorb more and more loss.

4. My last area of concern is not one of such direct financial implication to the hospital but, rather, a concern by me for the persons who may utilize both the hospital and a nursing facility. This problem refers to the "spell of illness." Briefly, as explanation, some nursing facilities are considered to break a spell of illness and some do not. In fact, it is my understanding this can be a changing situation as a facility for one period of time may break a spell of illness and then, its status may change to one which does not break a spell of illness. I assume this probably occurs due to interpretation by different surveyors. As an example, a Medicare beneficiary has as coverage 60 full days, 30 days of co-insurance and 60 lifetime reserve days. Let's assume that this patient is admitted to Memorial Hospital from our long term care facility and stays 30 days. From the original 150 days maximum coverage, this person now has remaining 120 days. Because our long term care facility is not deemed to break a spell of illness, even if the patient remains out of the hospital for the required minimum 60 day period of time, this patient when readmitted to the hospital, does not start with a new spell of illness maximum coverage of 150 days, but rather, the 120 days. By contrast, however, had the patient been discharged to their home or a nursing facility in our city deemed to break a spell of illness, the same patient in the previous example would be admitted to the hospital with a maximum coverage of 150 days. Our facility and one other facility in the city are not considered to break a spell of illness.

This can be very harmful to the patient and I feel is very discriminatory to anyone using our long term care unit. The Medicare Program and Memorial Hospital wishes the patient to be discharged from the hospital as soon as possible, and yet, Medicare does not allow the person full benefits the next time he is admitted to the hospital. This can be a very serious financial situation for a patient who has several long term illnesses and whose residence is one that is deemed to not break the spell of illness.

Senator Dole and Senator Danforth, I have enjoyed this experience and appreciate you taking the time from your busy schedule to inquire into problems faced by the nation's smaller hospitals. These problems are not imaginary; they are very real and are the cause of much concern to hospital administrators and Boards of Trustees. Regardless of what some politicians and bureaucrats would have the nation believe, hospital leadership is vitally concerned with patient care and the attendant costs. It is this concern that causes me to address you today. I wish to provide the citizens within the service area of my hospital with the best hospital medical care at the most reasonable cost possible. I also wish to utilize the facility's capabilities to the fullest extent possible without adding further cost to the hospital patients. To this end, we have served those who need less than hospital care, but do require special care, by operating a skilled nursing facility; we prepare a hot meal daily for 24 homebound people through the Meals on Wheels Program; we furnish meals for visitors of our patients, so

that during a time of emotional stress, they will not be further inconvenienced by having to go elsewhere for their meal.

In summary, these programs are offered as an extension of already existing services. They provide a community service which is most beneficial to the recipient. However, I believe that the Title XVIII Program is unjustifiably shirking its responsibility by not reimbursing its participating hospitals for its fair share of the hosptals' operating costs. I am not asking that Medicare pay Memorial Hospital more than its fair share. I am, though, asking that Medicare *pay* its Fair Share. To do less not only places an excessive burden on other third party payors and private pay patients, but it results in a negative cash flow to the hospital. Memorial Hospital just cannot afford to absorb any more of this loss; consequently, we must give serious consideration to the feasibility of the continued operation of these programs as a net cash loss for one year of $68,000 just cannot be further tolerated.

I hope that this rather long presentation will enable you to have a better understanding of these problems. I hope that you can help us to improve the reimbursement system to one of fairer participation, so that these needed programs can continue.

Thanks very much for your interest.

Senator DOLE. Let me say again we have had the company all afternoon of six representatives from the Kansas City HEW regional office and I know they have been listening to the testimony. We had hoped we would have time at the conclusion of the hearing for their comments, but that is not going to be possible.

I hope that having listened to some of these statements that if you have any comments that we should know about, we would be happy to have those. Jim.

STATEMENT OF JIM REDDING, ADMINISTRATOR OF NEVADA CITY HOSPITAL, NEVADA, MO.

Mr. REDDING. Senator Dole and Congressman Winn, my name is Jim Redding from Nevada, Mo. I am the chief executive officer of several health facilities owned and operated by the city of Nevada, Mo.

It is my unique privilege, I feel to be directly associated in management by our city hospital of 100 beds. We have an adjoining separately operated nursing home that is qualified under title 18 and 19 as a skilled nursing facility. We also operate a hospital-based home health agency. I have also been involved in the meals-on-wheels program.

We have also had great difficulty in trying to combine services between a hospital facility and a nursing home facility to reduce overall costs that have been penalized by certain medicare regulations and cost reimbursement both in combined services and the meals-on-wheels program.

Our health facilities serve a significant portion of the elderly population of our service area. Approximately 22 percent of the population of our service area is 55 or older. And virtually 100 percent of all our nursing home patients and our home health patients are elderly individuals.

Approximately 55 percent of the inpatient census of our acute hospital is 65 or older. So a very significant part of our total medical services are provided to the elderly and typical in many rural areas.

I gave you these figures to make a point that with the common ownership and the management and a common base of expense with these services, these costs, based on the last fiscal year, the average

patient cost of inpatient at the hospital is $133. The average cost in our skilled nursing facility was $23 and the average cost of the home health care was $29.

Patients are usually followed from one of these services to another or one facility to another by the same attending physician. And it is very common that patients are transferred between any two of these facilities or services.

I agree that hospital care and nursing homecare and especially home health care are each individual and distinct services and not necessarily one as an alternative to another.

I agree that it is my experience that the average, elderly patient does prefer to remain home and receive medical services there rather than seek care in an institutional setting. Therefore, I agree also that it would appear that expanding the role of care and home environment is preferable to the patient and can in some instances, reduce health care. I think natural consequences of increasing home health services would perhaps decrease the total institutional phase of care and cost.

In closing, I would like to make these points. I would like to see more emphasis and funds allocated to initiate startup and expansion programs in the home health field. We need, definitely need to expand the public awareness of the home health care program. And even more importantly, we need to in some way give our physicians incentives to choose home health care programs. We don't seem to have been very successful at it in the past.

Operating both a long-term care facility and a hospital adjoining, we have a tremendous problem with the Spellman illness problem. Our average length of stay in a long-term health care facility is in excess of 2 years and the frequency of hospitalization of that individual over that period of time is far beyond the current medicare regulation benefits for hospital inpatient stay.

And also, we have had an extremely difficult time in certifying patients in our long-term care facility for title 18 medicare benefits. We maintain six beds in distinct part and at no time have we been able to certify in excess of one patient at any one time and it is not because the demand is not there.

I thank you.

Senator DOLE. I thank you.

I have some additional questions. But I am sorry that I do not have time to ask them. I have to speak in Wichita and the Air Midwest leaves at 4:30.

Is there anyone in the audience who has a statement that they want to make part of the record that we do not have? We do not have time to give it orally, we just have time to file it, so if you have it, we will be glad to accept it.

Are there any others who would like to file statements? Thank you very much. We appreciate it.

The hearing is closed.

[Whereupon, at 4 p.m., the subcommittee recessed, subject to the call of the Chair.]

[By direction of the chairman the following communications were made a part of the hearing record:]

KANSAS HOUSE OF REPRESENTATIVES,
Topeka, Kans., April 4, 1980.

Hon. BOB DOLE,
U.S. Senator,
Washington, D.C.

DEAR SENATOR DOLE: Thank you very much for your letter informing me of the Finance Committee Health Subcommittee hearing in Kansas City, Kansas on April 11, 1980.

I am very concerned with health care and particularly with health care for the older Americans.

One of the important issues is to promote home health care and improving this concept. The hospice program is a new type of program wherein the patient can be taken care of in a way which will decrease medical costs and give the support to the patient of those in his family.

Transportation needs for the older Kansans, especially in Western Kansas is crucial. "Meals on Wheels" has been a big help, but there is still a need for providing transportation for the older Kansans.

Another area of need is for some type of insurance to be available to help with the payment of those staying in nursing homes. There is a need to develop something in the insurance line which would help in cutting the cost of nursing home care.

I appreciate the opportunity to share these comments and suggestions for issues of critical importance to older Kansans.

Sincerely,

ROY M. EHRLICH,
Representative, 112th District.

CONCERNED GIRLS AND WOMEN OF KANSAS CITY, KANS.,
Kansas City, Kans., April 10, 1980.

Hon. BOB DOLE,
Committee on Finance and Health Subcommittee,
U.S. Senate, Washington, D.C.

DEAR SENATOR DOLE:-Your letter of April 2, 1980 received. Special thank you to the Finance Committee and the Health Subcommittee for the hearing at the city of Kansas City Commissioner's Chamber concerning providing needed health service to older Americans in Kansas.

May we address the issue of providing health care of the elderly in the home and paying some fee to competent registered nurses for care as they pay in nursing homes?

A case study of a 93 year old patient who was kept in her home environment and cared for around the clock with an R.N. was allowed $175.00 per month. The same patient, cared for part time by the same R.N was allowed $495.00 per month to the nursing home.

The second issue is the need for a well staffed home or a unit in a nursing home for emergency care to the elderly who have strayed away from nursing home and/or their homes.

Federal guidelines are so rigid that in many cases the only place for these elderly is the jail.

The two issues need careful study and Action.

Sincerely,

ETTA LEE OWENS,
President.
ROZELLA K. CALDWELL SWISHER,
Founder.

LEAVENWORTH, KANS., *April 9, 1980.*

Senator ROBERT DOLE,
U.S. Senate, Committee on Finance,
Washington, D.C.

DEAR SENATOR DOLE: Thank you for your letter of March 31, advising me of the hearing on programs for the elderly with you and Senator Danforth in Kansas City, Kansas, on April 11.

I am sorry I will be unable to attend, but I am very interested in these programs having served for several years on the Advisory and Policy Board of the Wyandotte-Leavenworth County Area Agency for Aging.

I would hate to see any of these programs reduced to any great extent as we senior citizens have worked so hard to get them organized to the degree they are now helpful to those in need.

I especially would hate to see the Home Care Services cut in any way. From personal experience, their services were invaluable to my sister when she was forced to remove her invalid husband from the hospital. He had suffered a severe heart attack and stroke which left him paralyzed, and unable to speak. When confronted with this seemingly impossible task at age 73, it was the expert services of our local dedicated nurses and therapists from our Leavenworth County Public Health Services who made the task possible. We feel this service should be expanded instead of limited in any way.

Community service Program offered by our local Immaculata High School has been most helpful. Twice weekly a student in the program exercises her paralyzed husband and he is now able to walk a short distance with help of a brace and assistance of therapist. This is great progress in two years after doctors had predicted he would never walk again.

Services from our local Area on Aging Office have been most helpful especially since they have secured a van equipped to handle wheelchair patients. Our local Nutrition Program is outstanding.

I am most concerned with the skyrocketing cost of care for our elderly who have to rely on Nursing Homes for their services.

As a ranking Republican member of the Finance Committee, I am sure you will do all that is possible (as you have in the past) to expand these programs in lieu of their being cut.

Thanking you for the opportunity of expressing my feelings on a few of these beneficial programs.

Sincerely,

Mrs. Eleanor Matthews.

Statement by Harold D. McMurray Before the Health Subcommittee of the Senate

Thank you for inviting us to appear before you for the purpose of study of needed Health Services to Older Americans.

I am Harold D. McMurray, and I represent a group of the Elderly of the Elderly, The World War Veterans and Widows of the U.S.A. Inc. I am a member of the National Legislative Committee.

I became an Older American 20 years ago when I retired in 1960 and believe I have the experience to speak for our group.

While having my annual medical check-up last Tuesday, I told my Doctor that I was attending this hearing and asked him if he had any suggestions. His studied reply was that he probably would be the worst person to give advice, but said what came to his mind was "early detection." I believe this is more profound than most of us realize.

There seems to be degrees of old age and those in the early brackets, say 60 to 80, this seems to be the best advice. However, when we reach the 80s we are past the experience of most Doctors, who seem to be as much at a loss for answers as we are, but, they can still give better educated guesses than we ourselves.

My wife was hospitalized last year for very intensive study for her dizziness and nausea. After intensive study by many experts, the conclusion was that at her age (over 80) she would just have to live with it for the rest of her life and to take 4 dramamine a day. There was no cure, just reconciliation to the facts of life.

In desperation, we went back to our family Doctor, who seriously sought answers and in a few weeks she was very much better. Her dizziness and nausea became much less frequent and less severe.

I believe early detection is important along with a personal Doctor who knows the patient personally and has special interest in the patient and keeps their records.

You cannot set a definite age between the new elderly and the older elderly but for the latter group, I find the greatest need, although not medical, is for some place that is affordable to this financially deprived group, where either

one or both members of the family needing physical assistance can be cared for. Just try to picture yourself in this predicament.

One of our members age 86, whose wife has been mentally incompetent for years, has a daughter who has been taking care of them, living in their own home. Last year she had a stroke, from which she only partially recovered and now this 86 year old veteran is trying to take care of both of them.

Do you realize that in this area it costs more than $1,000, per month to keep only one person of a family in a suitable institution where the person is mentally alert and sensitive to comfortable living? This cost is prohibitive for the Older elderly people living on a fixed retired income based on the 1960 period.

While the Government can perform miracles in most modern needs, I don't believe our Government is prepared to care for the needs of the citizens who are trying to finish their life cycle in comfort.

Testimony Submitted by the Adult Restorative Services, the E. S. Edgerton Medical Research Foundation, Wichita, Kans.

Introduction

The Adult Restorative Services Project wishes to take this opportunity to comment on public financing of health services for the aged. The Adult Restorative Services is a model project supported by Grant No. 90-A-1620(01) awarded by the Administration On Aging, U.S. Dept. of Health, Education and Welfare.

Methodology of Adult Restorative Services

Individually prescribed and group activities will be offered to chronically ill or disabled adults who are present at licensed nursing homes in rural communities for day treatment, but continue to live in the community. Data will be examined for evidence of improvement, stabilization, or deterioration of ability to accomplish activities of daily living with a degree of independence which allows the individual to live alone or with family in the familiar community, retaining established ties and social roles. Restorative services will be offered in cooperation with other social and health services.

Issues

Implementation of The Adult Restorative Services program has been seriously hampered by the Washington Bureaucracy which has proven so time-consuming. We, therefore, strongly urge the combining of agencies to eliminate this "logger heading" or at least some communication between the bureaus.

Issue identification: Health services for the aged too often are equated with nursing home care. The services should include the full continuum of care. Adult Restorative Services is an effort to provide restorative and maintenance health programs that are lacking for the rural elderly. Efforts to establish this demonstration program within nursing home facilities however have been met with the following problems:

1. *Inadequate financial base.*—Medicare does not pay in an Intermediate Care Facility (ICF). This project supports Senator Pepper's (Oregon) proposal to combine Title XVIII, XIX and XX to further relax regulations for Medicare to pay in an ICF facility, thus eliminating the costly three day hospital stay and the Skilled Nursing Home (SNF) requirement.

Current programs do not adequately reimburse organizational costs, especially in rural areas, for transportation and time spent in travel.

State laws should require private insurance to cover home health, day care and hospice services.

Financial assistance, when proven necessary, should be available to families who wish to and will keep their aged at home.

2. *Lack of alternatives to nursing homes.*—Home health, day care and homemaker services should be available to all aged. Every county should be required to provide these services.

3. *Lack of an adequate assessment tool and case management program.*—The overall purpose of case management programs is to enable the client to receive the full range of services from which he or she might benefit.[1]

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[1] Andrus Gerontology Center, "Three Working Papers An Exploration of Case Manager Roles: Coordinator, Advocate and Counselor," Univ. of Southern California, Los Angeles, Calif., March 1979.

The number of resources in a community serving an older person may be extensive and the full knowledge of this range of services is not easily available to the potential consumer; therefore, a well planned assessment and case management program would fulfill this need.

Area Agencies on Aging are mandated to have Information and Referral systems. Not all of them, however, have a case management and assessment program. Persons seeking advice for the first time should be referred to case management for complete assessment.[2]

When the solution to a problem being considered is placement in an institution the case should be referred to a case manager.[3]

A formal system of "case management" should be developed, staffed, and used so individuals needing services in the long-term care continuum could look to a single source for entry into the system, needs assessment, an individualized program plan, and financial arrangements.[4]

4. *Inadequate nutritional programs.*—The nucleus of the aging program was the nutrition program. However, the revision of the Older Americans Act (1978) has severely crippled the nutrition program. Under the guise of consolidation, the bureaucracy program was buried under the layers of regulations and limitations until presently the very life of the nutrition program is in danger of being extinguished. This is indeed a sad situation when one considers that this was the program that dealt directly with the older people and fulfilled many of their needs of nutrition, social interaction and services.

The effectiveness of aging programs will turn upward when the nutrition program is restored to its structured, independent former state.

5. *Transportation.*—This remains one of the top priorities of the rural aged, as identified, for example, in five public hearings held in March of this year (1980) in the Northwest Kansas Area Agency on Aging to gather pre-planning data.

Relative to Adult Restorative Services, when we identify potential clients, transportation to and from the nursing home is almost always a key issue. Nursing homes are often pressed into using private cars to transport clients. Senior citizen buses and vans, if present in counties, are not available for on-call trips. Even for those clients who have cars, the cost of gas makes it prohibitive. (For one elderly couple, living 9 miles from the nursing home, the cost of gas for her 3 times per week therapy would represent 9 percent of their total income. They do not have available discretionary dollars to pay that.)

With a little cooperation and planning, school buses could be used for multiple transportation needs of all in a given constituency; other municipal vehicles could be made available. However it's done, transportation experts need to get with rural planners and gerontologists to design a solution.

6. *Lack of an adequate communication system to share experiences.*—Much federal money from various agencies is put into grants for the elderly, however, at present there is not an adequate system to inform grantees of what is going on. Therefore, there is duplication of effort, time and money.

7. *Inadequate home health services.*—Home services are mandated as a responsibility of the Area Agencies on Aging. The intent and money is there. However, if the Area Agency gives this money to the Social Rehabilitation Services (SRS) and SRS "contracts out" the home health services, a means test is given and many "border-line" recipients are left out. The Area Agency has no control if this is done.

This program is failing to meet its original purpose.

8. *Homemaker services.*—Many older Americans could remain in their homes both those needing restorative services and those not needing them, if sufficient homemaker services were available.

In rural communities, the nursing home could assist with this program especially in the training. Persons providing these services should be required to have the same training as nursing home housekeepers.

Community colleges and vocational schools offer a variety of training programs in these areas. Also, many commercial companies will provide this training.

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[2] Jensen, T. A., Bourcy, D. S., Moshier, D. A., and Ureugdenhel, H. "The Devils Lake Human Services Center, final report." Human Services Center 1975.

[3] MacBride S. M., Feldman, C., Gottesman, L., and Ishizaki, B. "A Service Management Manual: A guide to the development of a client oriented approach to coordinated service delivery." Unpublished manuscript.

[4] "The Health of Kansans," Statewide Health Coordinating Council and Department of Health and Environment. The 1979/80 Plan.

At present, in many areas no training is provided for these workers.

Ideally, these workers should have some training in how to work with the elderly.

9. *Mental health.*—Professional mental health services should reimburse for those services performed in nursing homes.

The present program should be restructured to prevent disincentives for independent living. At present, the anxieties, stress, and tensions of trying to cope with the bureaucratic maze of agencies is beyond the capability of many of the elderly. It is therefore simpler for them to enter an institution.

There should be a better method of screening the elderly so that people are not diagnosed as senile when in fact they are suffering from clinical depressions. There is real danger of inappropriate medication which leads to even more depression and despair.

Attention should be given to the mental health of the entire family structure that is affected by the necessity of providing care for an aged member. For example, an aged person may have his "principal" support coming from a child, usually a daughter, who may be experiencing problems with her own aging process. These concerns may force her to withdraw both instrumental and emotional support from an aged parent." (*Social Casework*, Oct. 1973, pg. 448.)

Testimony Submitted by Health Planning Association of Western Kansas, Inc.

INTRODUCTION

In response to Senator Dole's request for input, the Health Planning Asociation of Western Kansas, Inc. (HAWK) takes this opportunity to comment on public financing of health services for the aged.

MISSION

HAWK is a health systems agency responsible for planning and recommending programs to improve the health of the people living in the fifty-four County area of western Kansas. The area encompasses 46,076 square miles and has a population of approximately 432,000 people.

In addition to encouraging the people in western Kansas to take a personal responsibility for their health, HAWK provides a forum for improving the accessibility, continuity, and quality of health services needed in the area, and restraining inappropriate increases in the cost of these health services. The development and use of a Health Systems Plan (HSP) and an Annual Implementation Plan (AIP) is fundamental to the mission of the Agency.

METHODOLOGY

Portions of the Health Systems Plan and the Annual Implementation Plan adopted March 5, 1980 are extracted to highlight the concerns of western Kansas. On March 27, 1980 the HAWK Board of Directors corresponded with the Kansas Congressional Delegation to inform them that the Health Systems Plan supports the concept of H.R. 6194, "Medicaid Community Care Act of 1980," and to request their support.

I. HEALTH CARE FINANCE 1980 HEALTH SYSTEMS PLAN

Alternatives to inpatient nursing home care

Issue identification.—Health Services for the aged have been, in the past, too often equated with nursing home care. The desired services for the aged should include the full spectrum of care; however, maintenance services are of primary importance to the aged. Maintenance services should be provided in four settings: (1) the home; (2) ambulatory centers; (3) short-stay inpatient facilities; and (4) long-stay inpatient facilities.

Maintenance services provided in a home setting are home health services.

Maintenance services provided in an ambulatory setting are adult day care services.

Maintenance services provided in a short-stay or long-stay inpatient setting include services provided in personal care homes, intermediate care homes, skilled nursing homes, and long-term nursing care units of hospitals (or as group nursing homes).

The lack of alternatives to nursing homes such as home health and adult day care services persists as an issue in western Kansas. There continues to be an absence of day care centers in western Kansas. Efforts to establish demonstration programs within nursing home facilities have experienced initial problems in assuring a financial base for these services. Nearly half of the counties in western Kansas still lack minimal home health or home care.

Issue analysis.—It is frequently asserted, and perhaps not incorrectly that the current system of health services for the aged, with its disproportionately large allocation of resources to nursing home care, is more a response to government reimbursement mechanisms than any other factor. A much larger proportion of the total spending for the elderly is paid through public funds with 68 percent of the national total for the elderly in 1976 compared to 30 percent for the age group 19–64 years and 26 percent for the age group under 19 years.

Nationally and in western Kansas there is some evidence that the more expensive care in nursing homes is being substituted for more appropriate levels of care in the ambulatory settings and the home:

"Experts now agree that what is needed is more than marginal improvements in nursing home care quality. Indeed long-term care must be viewed as a continuum which ranges between home care and ambulatory visits at the least intensive extreme to institutional care at the opposite extreme. The point at which a patient enters the care-giving system along this continuum ought to be dictated by his or her care needs. Reimbursement policies should be adopted to enhance this matching of needs and services, and a measure of quality should be appropriateness of care."

Although nursing homes are predominately for the elderly, they also serve terminally ill individuals requiring intensive nursing care, recuperating patients needing briefer convalescence, and developmentally disabled individuals that require both nursing care and training in social skills. Service needs of the elderly range between extensive nursing care and care for the less ill but infirm individuals who lack the socioeconomic resources sufficient to manage in the community. To varying degrees, inpatient nursing home care has been substituted for maintaining the individual in their home with homemaker, home health, day care or hospice services. It also must be expected that there are individuals currently living at home that need these services and would use them, if they were available and accessible. Additionally, the continuum of long-term care services must address both medical and social needs of the individual. The distinction between services is carried over to sources and methods of financing—primarily the public programs of Medicare, Medicaid, and Comprehensive Social Services under Title XX of the Social Security Act. Improved coordination and integration of these financing programs is essential for the provision of a continuum of health and social services. HAWK supports efforts to improve the coordination and integration of these sources of financing.

The extended debate concerning the provision of alternatives to nursing home care, both nationally and in Kansas, has focused almost exclusively on the relative costs of care rather than improved health and social independance. While there is evidence total expenditures would probably increase, it is strongly indicated that both cost savings and health/social benefits are possible through alternative services such as homemaker, home health, day care and hospice services. Continued financial barriers are:

Start-up funds are not adequate and existing facilities (nursing homes or hospitals) are prohibited from receiving reimbusement for some of these services;

Current programs do not adequately reimburse organizational costs (especially in rural areas) for transportation, time spent in travel, and administration of the program;

The net price of these services are high, often making them inaccessible until the elderly or disabled have exhausted their personal resources and are eligible for Medicaid or Comprehensive Social Servces; and

Private insurers do not offer these services as covered benefits.

Finally, the lack of continuity of care provided to the elderly and disabled may be due in part to financing. Although Medicare and Medicaid allow reimbursement for physician services, the care of the elderly and disabled has not been well coordinated with direction to appropriate levels of care. This has been attributed to the declining interest of physicians in geriatric care, together with the emphasis on both medical and social services, with the greatest emphasis on the social. Alternatives for assuring continuity of care with a single point of entry.

case management, movement to the least restrictive environment, ongoing health assessment, etc., range between reimbursement of geriatric nurse practitioner to creating and funding "Long-Term Care Gerontology Center.

Recommended action 1.—HAWK recommends changes in federal and state policy to assure the availability of these services.

1. Either increased direct public support should be provided to cover start-up organizational and capital costs for homemaker, home health, day care, and hospice services; or current reimbursement legislation and policies under Medicare and Medicaid should support shared use of existing resources (i.e., nursing homes and hospitals).

2. Medicare, Medicaid and Comprehensive Social Services should reimburse at levels to meet organizational costs of these needed services in rural areas.

3. State financing should assure the financial accessibility of these services to the elderly and disabled prior to totally exhausting their personal resources.

4. State law should require home health, day care, and hospice services as covered benefits by private insurers.

Recommended action 2.—HAWK supports changes in state and national policy with financial incentives to assure single access and continuity of care provided to the elderly and disabled.

II. CORRESPONDENCE FROM HAWK TO THE KANSAS CONGRESSIONAL DELEGATION, MARCH 27, 1980

The Governing Board of the Health Planning Association of Western Kansas voted to support the concept of H.R. 6194, "Medicaid Community Care Act of 1980." This bill, introduced by Representative Waxman (D-CA) and Representative Claude Pepper (D-FL), is designed to offer state incentives to develop more appropriate and available community programs for the elderly and disabled who would otherwise be forced into institutionalization. Current Medicaid reimbursement policies encourage institutional placement by providing full coverage for such care. On the other hand, Representative Waxman stated community based care coverage is "often capricious, fragmented and inadequate". In 1978, less than 2 percent of the Federal share of Medicaid expenditures went to community care, when 40 percent went to nursing home care. "Yet", Representative Waxman, reports, "only 6 percent of our elderly reside in institutions; the rest, many with chronic medical conditions, reside in their communities, half with their families".

Therefore, we request that you support this legislation which increases the Federal contribution for community based services by 25 percent (to a maximum of 90 percent) as long as the state provides a medical/social assessment of prospective nursing home resident and expand the range of home and community based services.

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TESTIMONY OF PATRICIA COWAN-SCAGGS, CHAIRMAN, MARC COMMISSION ON AGING

For the past seven years, the Mid-America Regional Council has served as the Area Agency on Aging for the five Missouri counties—Jackson, Clay, Platte, Cass and Ray. The total elderly population in this urban/rural planning and service area is 126,000 citizens over age 60.

Since its designation, the MARC area agency through its Commission on Aging has emphasized the need for increased quality health care to elderly residents. The perception of access to the health care delivery system is limited and inadequate when evaluated by those persons it should serve—recently, the MARC area agency participated in a study by the University of Southern California Andrus Gerontology Center in which access to the traditional services system was studied. Interestingly, of the six sites studied, the elderly residents of the Kansas City area had the least favorable impression of both the adequacy and quality of health services. The low score indicated real anxiety about being victimized by a system that does not give attention or concern to chronic conditions plaguing older persons.

Through the Health Services Committee of the MARC Commission on Aging, several attempts have been made to translate documented needs into defined services at several levels of the health continuum. The membership of this Committee is chosen from all levels of community health professionals including physicians, nurses, nursing home administrators, and social workers. Each year the committee makes recommendations to the Commission regarding funding levels for home health services and health diagnostic screening service in congregate settings. During the past six years, these two important areas have together cornered 25% of the total Commission revenues. Although at first glance

this may seem inadequate, it should be noted that these two program areas have not only increased in dollars each year, but have also become more refined through quality control monitoring. More persons are served annually with expanded offerings and reduced unit costs. During our last fiscal year 550 persons received home health care under a total budget of $61,804 at a cost per unit of $3.70; 9,301 persons received health screening services under a total budget of $41,700 at $2.73 per unit. Our experiences with these two service areas have led to some important conclusions. In summary:

(1) Although the importance of skilled nursing care in the home cannot be denied, the levels of unskilled care that can be offered on the home health continuum are more important in long range planning for chronic needs, i.e. chore workers, companion sitter, homemaker, etc.; (2) Any evaluation of home health care must provide monitoring opportunities for rehabilitation of older persons back into the traditional congregate services continuum—ongoing home health care is only an option in the most severe chronic cases and should not risk permanent social isolation simply because it is easiest not to have to encourage linkages to alternative services; (3) Hertofore, funding for home health care has been restricted to Title III of the Older Americans Act because of the inadequacies of Medicare financing in this service area—the need is not being adequately addressed through Title III—alternative revenues, both public and private, have to become available in order to ensure the priority of this service as an alternative to institutionalization; (4) There is a need for expanded health diagnostic screening beyond the traditional blood pressure/basic lab tests/counselling model to a more advanced and sophisticated clinical approach—the MARC Health Services Committee is beginning to study provision of this expanded service by hospitals as an outpatient service linked to community supply of beds; (5) Evaluation of the traditional health screening model has indicated the need to see more different clients regularly and for more qualitative follow up to occur.

The comments offered above are representative of one small segment of the work of the MARC Commission on Aging. We anticipate expansion of our efforts in promoting quality health care in the years ahead. If we can be of additional assistance, with the Committee's work, please call upon us.

CLINICARE FAMILY HEALTH SERVICES, INC.,
Kansas City, Kans.

One more point about Adult Day Care. We've heard today that medicare and medicaid encourage institutionalization with skilled and intermediate nursing home reimbursement. If Medicare and Medicaid could reimburse for Day Care services, this would fill a very big gap between Home Health and Nursing Homes. Many of our patients need more supervision and care than a nursing or therapy visit. If they can't afford to pay for full-time or 8-hr. nursing care, their only alternative is currently a Nursing Home. Day Care would give such care on an 8-hr./day basis, enabling the family to continue working or get relief from home and keep "Mom" or "Dad" at home.

I feel reimbursement for Adult Day Care (Social Service and Medical Models) should be a top priority for Congress to consider for Health Care for the elderly.

Clinicare is a certified Home Health Agency. We are currently exploring funding for a Medical Model Adult Day Care Center for Kansas City, Kansas. Mrs. Dole saw this proposed facility at Cross-lines Towers.

CATHY MATLACK,
Associate Director.

TOPEKA-SHAWNEE COUNTY HEALTH DEPARTMENT,
Topeka, Kans., April 15, 1980.

Senator BOB DOLE,
U.S. Senate, Committee on Finance,
Washington, D.C.

DEAR SENATOR DOLE: Your notice of a Health Subcommittee hearing arrived too late for me to attend, but I do have some pertinent comments to make and hope you will consider them as legislation and funding for health programs are considered.

Health services provided for older citizens through the Topeka-Shawnee County Health Department include both clinic services and in-home services. A major problem for our home care patient is the division of homemaker and home health aide services because one is reimbursable under Medicare-Medicaid and the other under Title XX. This repartment strongly supports a redefinition of home health aide as homemaker—home health aide under Medicare. We also have many requests for necessary Occupational Therapy services where no other health professional is needed and, therefore, support the addition of Occupational Therapy as a qualifying Medicare service. Reimbursement for nutritional services and an initial evaluation visit would allow us to provide more comprehensive home care. Certification of need legislation for home health agencies is essential as a measure to avoid duplication of services and increased costs.

Adult Health Clinics staffed by specially trained Public Health Nurses provide a health care option to non-homebound patient with chronic illness problems. Initial health screening as an on-going nursing supervision in these clinics provides a much needed service, which keeps many of these patients out of institutional care and lengthens the interval between doctor visits. At present there is no third party payment for this type of care.

Thank you for the opportunity to reply.

Sincerely,

RAY D. BAKER, M.D.,
Health Officer.

KANSAS CITY REGIONAL HOME HEALTH ASSOCIATION,
Kansas City, Kans., April 21, 1980.

Re our response to the hearing on health services on April 11, 1980 in Kansas City, Kans.

Hon. ROBERT DOLE,
2227 Dirksen Senate Office Building,
Washington, D.C.
(Attention of Michael Stern.)

DEAR SENATOR DOLE: We are representatives of twelve Medicare Certified Home Health Agencies who provide professional home health services to elderly patients throughout Northwest Missouri and Eastern Kansas. These agencies made approximately 250,000 visits to the patients last year.

The services provided by these agencies are as follows:

1. Skilled Nursing;
2. Physical Therapy;
3. Speech Therapy;
4. Occupational Therapy;
5. Medical Social Service;
6. Home Health Aide.

We believe the elderly population needs additional services available such as adult day care centers, transportation, and in-home meals. As health providers who provide services through a great deal of traveling, we believe home health should be included in any energy exclusion legislation in order to provide the above services.

We realize there are many legislative bills which cover many changes in home health services, but we feel the present limitations regarding visits under the Post Hospital and Medical Plan portions of Medicare probably does not pose a great problem for our industry. In light of pending legislation regarding this area, we would like any funds saved by not changing these regulations to be applied to homemaker services in order to make such services coverable under Medicare. These homemaker services should be provided without affecting a patient's Post Hospital or Medical Plan total visits. We feel it is necessary that Occupational Therapy become a primary service. In order to serve the elderly, we feel to eliminate the requirements of a three day hospital stay and the homebound status should remain as stated in the proposed House Bill 3990.

We feel more pre-nursing home assessment is needed especially when there are many other viable alternatives to such care.

As health providers, we feel the families of our patients should be more involved in the care of our patients. We also feel more health promotion and preventive health services should be a vital component of any health services.

We deeply appreciate the opportunity to provide the above information to concerned Senators and a Member of House of Representatives. We encourage your colleagues and yourself to continue providing the opportunity to provide information in a public hearing format. Thank you.

Respectfully,

KANSAS CITY REGIONAL HOME HEALTH ASSOCIATION.

CLOUD COUNTY CHIROPRACTIC ASSOCIATION,
Concordia, Kans., April 7, 1980.

Senators BOB DOLE and JACK DANFORTH,
Municipal Building, 1 Civic Plaza, Commissioner's Chambers, Lobby Level, Kansas City, Kans.

DEAR SENATORS DOLE AND DANFORTH: Thank you for notifying us of the Finance Committee Health Subcommittee hearing in Kansas City, Kansas, on April 11, 1980.

At this late notice, our attendance is doubtful, however, we would like to express our opinion for your records. Our combined record for weekly patient visits is in excess of 400 patients per week. An estimated 35 to 40 percent of patients are above 50 years of age. These people comment that:

1. They are unhappy that Medicare doesn't pay more on chiropractic health care i.e. x-rays, lab services, supports, physical exam, and office calls.
2. They are unhappy that chiropractic care is not available in hospitals by licensed chiropractic physicians.
3. They are alarmed at the sometimes excessive use of drugs and surgery on older Americans in nursing homes. Many times extensive and expensive surgery is performed on an elderly dying patient. Why?

These comments are those we feel would be most helpful to you.

Sincerely,

ROBIN P. HOOD, D.C.
DEAN J. BLACKWOOD, D.C.
MARK E. BREAULT, D.C.

THE MENNINGER FOUNDATION,
Topeka, Kans., April 17, 1980.

Senator ROBERT DOLE,
U.S. Senate,
Committee on Finance, Washington, D.C.

DEAR SENATOR DOLE: We wish to respond to your March 27, 1980 letter regarding the public meeting to discuss care for the elderly. Sadly, prior commitments prevented us from attending that April 11 forum in Kansas City. We want to support your strong desire to maintain and improve service for the elderly even in the face of financial restraints. It takes great courage to speak out in favor of services for non-vocal minorities in times such as these.

We are Board Certified psychiatrists who work at the Menninger Foundation. One of us (R.G.P.) is a psychoanalyst and works in the Adult Hospital; while the other (D.I.B.) is a Board Certified child psychiatrist and works in the Children's Division. We have been working with and writing about the elderly since 1974. During these past six years, our expertise has focused increasingly upon the changes that the elderly experience. These changes are both psychological and environmental. The elderly respond to the changes in ways which reflect their particular stage of development. How others respond to the elderly during this time of change may help or hinder their continued development and growth.

We believe others' response to the elderly may be critical for their continued well-being. It is with this idea in mind, that we like to offer our help to you in your planning for the continued services for the elderly. We would be happy to consult with you or aid you in any way you might find helpful in your work maintaining and improving services for the elderly.

Thank you for your time and consideration.

Sincerely,

DAVID I. BERLAND, M.D.
RAYMOND G. POGGI, M.D.

STATEMENT SUBMITTED BY ELIZABETH I. KALAU, PH. D., COORDINATOR OF ELDERLY SERVICES, NEJO MENTAL HEALTH CENTER

The World Health Organization defines health as "a state of complete physical, mental and social well-being not merely the absence of illness or infirmity." This definition signifies that physical health cannot be independent of mental health; nor can the person be separated from his or her social environment. This must be recognized for proper care of elderly persons.

Advancing age is characterized by a delicate balance between body and mind. If something goes wrong in bodily functioning such as a common urinary tract infection, the mental functioning may be affected. Confusion and disorientation is a frequent concomitant of such an infection which pass with appropriate treatment. Examples abound where mental/emotional functioning goes astray when physical illness occurs.

Similarly, body functions are disturbed with mental disorders. Depression is a good example. A depressed person may suffer from sleep disturbance, loss of appetite, constipation, weight loss, aches and pains in their bodies. If depression is not treated in older persons, symptoms of what is popularly understood as "senility" may appear because of social withdrawal.

In a cultural/societal milieu which erroneously assumes that old persons become "senile" symptoms such as impaired memory which signal physical and/or mental disease are often ignored and neglected because they are not recognized as treatable diseases.

Old persons use more medications because of multiple symptoms and undue belief in cure. Slowed down physiological functioning of an elderly person can cause drug toxicity and many drugs interacting can increase this even to lethality. Too many drugs in doses which are too big and taken too long are considered by geriatricians to be more harmful than beneficial. This also results in wasted funds which are needed for other areas of medical care. Medicaid lists of approved drugs should be carefully evaluated for efficacy by experts.

Nursing homes need to be brought into the mainstream of the health care delivery system. Although there are more nursing home beds for elderly persons than there are hospital beds the medicare care given to persons occupying the former is not up to hospital standards. Nursing homes are closely monitored by several state and federal agencies; these procedures, however, have not brought the desired results: good care.

Elderly persons are sent to nursing homes because of disabilities brought on by multi-system diseases; in most cases the elderly suffer from more than one of these chronic diseases. Because of these complicated medical conditions, the action variances of medications and the behavioral disorders of disturbed brain functioning, more highly trained physicians and nurses are needed in long term care facilities, not less as is the case.

It is well-documented that nursing home care is an expensive, though inadequate way of caring for the ill-elderly. Day Care Centers, a relatively new concept in this country, deserve the support of government agencies. The goal of the program is to maintain old persons at home, where most desire to be. Institutional living is not desirous to an independent generation, who has much-proven survival skills. Though frailty and illness diminish these skills, home health care personnel together with Day Care Centers can do much to provide the services so old persons can live at home.

For the above reasons the following recommendations are presented:

(1) It becomes imperative then that mental health services and their financial remuneration, Home Health Care, Day Centers as well as nursing homes become an integral part of the health care delivery system for the elderly.

(2) Funds for the education of medical and nursing students in gerontology have to be made available; as a matter of fact gerontology needs to be included in the instruction of all health care providers.

(3) In addition funds for the continuing education of the health care professionals are necessary:

(a) Geriatrics for practicing physicians because components of geriatric medicine have not been part of their curriculum as students. Currently people 65 years and older constitute 30 percent of medical practice and will increase to 75 percent by the turn of the century.

(b) Registered nurses and practical nurses are not trained to assess the mental or physical health needs of elderly persons; but should be.

(4) Nutrition site managers need training to differentiate between mentally healthy and mentally ill elderly.

(5) Meals-on-wheels volunteers are in need of similar training as mentioned in 4.

LENEXA, KANS., *April 11, 1980.*

Re skyrocketing health care cost in U.S. and its effect on older Americans.

Hon. JOHN C. DANFORTH,
U.S. Senator from Missouri, Committee on Finance, Subcommittee on Health, Senate Office Building, Washington, D.C.

DEAR SENATOR DANFORTH: A new concept in health care needs to be introduced. Our present methods of treatment and health care delivery are ineffective, costly, and are not aimed at correcting the specific underlying cause. There is a most significant body of investigative evidence which shows primarily the degenerative diseases of aging are due to unchecked viral disease. These diseases affect the human arterial system, key organ systems, such as the heart, brain, liver, kidneys, and joints. These diseases appear to be amenable to anti-viral drug therapy in a most impressive way. It would appear that in animals and apparently humans, deceleration of aging can occur in an impressive manner with anti-viral therapeutics.

Surgical treatment of viral induced arterial disease is heroic, palliative, and very costly, especially when medical anti-viral therapy is far more effective, specific, much less costly. An illustration is approximately 70,000 coronary artery by-pass surgical operations were done in the U.S. last year, at a cost of 15,000 dollars each. Probably with proper anti-viral therapy over 50,000 of these operations did not have to be done at all. This represents a saving of some 750,000,000 dollars. Anti-viral therapy would significantly reduce morbidity and suffering for ishemic heart disease by reducing the number of by-pass operations. Think of the number of Americans troubled with arterial diseases undergoing palliative repeated hospitalizations due to brain, heart, and key organ involvement. These arterial diseases are amenable to medical anti-viral therapy. We are not talking about three-fourths of a Billion Dollars but many Billions of Dollars being wasted. Do you think we should look at such a solution? Do you think we should just keep doing what we have been doing?

Viral diseases in the U.S. especially of the unborn, the young, and older Americans involving the Brain and Central Nervous System appear to be just as significantly treatable as viral diseases of the human arterial system. Here again the cost for ineffective, symptomatic, palliative health care, such as multiple sclerosis and similar diseases runs into Billions of dollars. There is an effective anti-viral therapy with possible cure and possible arrest of multiple sclerosis and similar diseases. Would not this sharply reduce our health care costs? Do we treat the specific cause? Do we reduce human loss of dear ones and human suffering? Do we still keep doing what we are doing? The attached testimony documents the new way to go. Testimony is in Washington, now.

Sincerely,

JAMES B. MERCER, M.D.

TESTIMONY OF JAMES B. MERCER, M.D.

Senator Dole, and Senator Danforth, Distinguished Witnesses and Guests of this U.S. Health Subcommittee of U.S. Senate's Committee on Finance.

I am James B. Mercer, M.D., a Kansas Physician, who is Certified by the American Board of Family Practice, and an innovator in Medical Research and Health Care Delivery.

I am most grateful to present my views on the health care needs of older Americans to such a distinguished gathering. A new concept in how to deal with health care needs must be introduced. Old ways do not solve old problems. We can not continue to use the same old ineffective methods of medical treatment and health care delivery. What is this new concept? Treat the cause of the diseases of aging and stop the ineffective, symptomatic, costly, palliative care now being rendered to older Americans. The solution to the problem of aging Americans is to know the basic cause of the costly ineffective care. The degenerative diseases of aging are primarily viral in etiology, or cause. The only proper way to treat viral disease is with a potent broad spectrum agent with anti-viral properties. Such a potent broad spectrum anti-viral agent has been utilized in

the United States since the early 1960's. This anti-viral agent was widely used apparently in United States for at least three years in very high daily dosage ranges of 750 to 2500 mg in at least 625 patients, probably in U.S. Veterans Administration Hospitals, given by authorization of the Federal Drug Agency and the George D. Seale Company, Skokie, Ill.

Also in the early 1960's, the anti-viral agent in question was given to alcoholic patients in large numbers for prolonged periods of time at high daily dosages. One of these programs was being carried on at Creighton University Medical School, Omaha, Nebraska as late as the middle 70's by the Dept. of Psychiatry. It seems everything became very quiet when the Epperly Cancer Institute, Omaha, Nebraska, published a study done on U.S. Research Grant from the U.S. Public Health Service. The medical researchers were Mario Rustia and Philippe Shubik, who were doing work for the National Cancer Institute. Their first medical paper was titled, "Induction of Lung Tumors and Malignant Lymphomas in Mice by Metronidazole." Journal of the National Cancer Institute, Vol. 48, No. 3, March, 1972, pp. 721–726.

I first became aware of the spector of carcinogenicity being raised especially by Ralph Nader and his medical advisor, Sidney Wolff, M.D. in late 1975. I could not believe there was any truth in their accusations, based on the work of Rustia and Shubik, in the allegations made in the Medical News Letter of June 20, 1975, "Is Metronidazole Carcinogenic:" similar allegations by inference in the work of Rosenkranz, H.S., Speck, W.T. titled, "Mutagenicity of metronidazole activation by mammalian liver microsomes." Biochem. Biophy. Res Commun. 66:520–525, 1975; and lastly the allegations of Legator, M. S., and Connor, T. H. et al, titled, "Detection of mutagenic activity of metronidazole and niridazole in body fluids of humans and mice." Science 188:1118–1119, 1975. I will now explain candidly, Rustia and Shubik had fatally flawed their research project from two points of view, they used cancer prone Swiss Mice (inbred), which are unpredictably sensitive to viral disease of which cancer presents a group of viral types, and other non-cancerous malignant viral diseases such as arterio-atherosclerosis, degenerative diseases of the heart, kidney, brain, liver, and other key organs.

They used tumor counting as the true index of carcinogenicity rather than the lifetime survival of the control and test series of Swiss Mice. Any agent which is carcinogenic must fulfill this criteria. The test animals, who are fed the carcinogenic agent, must die much sooner of cancerous disease and in much larger numbers, than the control series which had no exposure to the carcinogenic agent, as in this case metronidazole. Crude Statistical Analysis revealed all the treated groups of animals fed 0.5%, 0.3%, 0.15%, and 0.06%, metronidazole in a lifetime diet, showed trends though hardly perceptible to other than the trained scientific eye, of increase in lifespan over the control animals, which received no metronidazole. This indeed was most surprising, for this was the first time in medical history there was an inference of a new dimension in determining length of lifespan. It appears another unknown factor in the aging process had been unveiled. The inference was the experimental animals outlived the control animals, but since they lived longer, they developed more malignant disease from cancer then died. I asked Gary M. Clark, Ph.D., now Assoc. Prof. of Biometry at the University of Kansas Medical School to do a statistical analysis using Rustia and Shubik's original data on a life time survival basis, to determine carcinogenicty. On Dec. 30, 1975, I received his report. "In conclusion, the levels of metronidazole investigated in this study do not appear to reduce the survival time of these mice." Therefore, there was no evidence of metronidozole being truly carcinogenic as Rustia and Shubik alleged in their fatally flawed study, JNCI, 48:3:721–726. 1972.

Rustia and Shubik apparently were stung by the criticism of other learned scientists for using cancer prone (inbred) Swiss Mice in their metronidazole carcinogenicity testing, decided to use in their next lifetime study, Noninbred Sas:MRC(WI)BR Rats. Their next article was titled, "Experimental Induction of Hepatomas, Mammary Tumors, and Other Tumors With Metronidazole In Noninbred Sas:MRC(WI)BR Rats, JNCI Vol. 63, No. 3, Sept. 1979, pp 863–867.

Rustia and Shubik returned to their flawed concept of tumor counting rather and use lifetime survival of both sets animals, control and test groups, as basis of true carcinogenicity. Again, it must be stated, if an agent is truly carcinogenci in animals over a life time test, it must dramatically shorten life span and show the animals died much sooner of malignant disease. In my letter to John Ballor, M.D., Ph.D., Exec. Editor of the Journal of the National Cancer Institute, dated

June 25, 1976, Certified Mail Return Receipt Requested, I suggested he print a retraction of Rustia and Shubik's 1972 article which had been fatally flawed in two ways. Dr. Ballor rejected the idea that lifetime survival of animals in such a study in 1972 be used as the prime criteria in the determination of carcinogenicity, rather than tumor counting. Dr. Ballor was quite incensed when I mentioned the idea, metronidazole was probably extending the lifespan of the test animals over the control animals. He so stated this in his letter by return mail.

Rustia and Shubik's work published on pages, 863-867, JNCI, Vol. 63, No. 3, Sept. 1979, was an amazing reaffirmation of the scientific truth I had stated to Dr. Ballor, III, M.D., Ph.D., Exec. Editor, Journal of National Cancer Institute. Rustia and Shubik had corrected one fatal flaw in their work, selecting to use Noninbred Rats, the true state of whether metronidazole is carcinogenic in rats, and possibly in man. These researchers were so caught up in their tumor counting, they failed to realize a very salient fact was emerging from the data. The rats fed metronidazole in varying concentrations in their lifetime diet were significantly outliving the control animals. Since the hall mark of an aging immune system, is a definite increase in neoplasia whether benign or malignant, it so supports this assumption. The older an animal becomes, the increasing incidence of neoplasis will occur. This is true, both, for man and other mammals. The male rats fed the lowest concentration of metronidazole, 0.06% for a lifetime, show at the median point in the animal group's life, ie, the point where half of the rats are dead, it is between 120 and 125 weeks of life. Now in contrast to this, the control series rats, the median point of where half of the rats are dead, is between 85 and 90 weeks of life. One must remember these rats, never received metronidazole in their diet whatsoever. The female rats fed the lowest concentration of metronidazole, 0.06% for a lifetime, show at the median point in the animals life, ie, the point where half of the rats are dead, it is between 125-130 weeks. Now in contrast to this, the control series rats, the median point of where half of the rats are dead, is between 105 and 110 weeks of life. One must remember these rats, never received metronidazole in their diet whatsoever. The male rats fed metronidazole, 0.06% in their regular diet, had a increase in their life span of approximately 35 weeks. This increase in life span in male rats fed metronidazole over the control series rats, is an average of 35 weeks approximately.

The female rats fed 0.06% metronidazole in their lifetime diet, had an increase in their lifespan of approximately 20 weeks over the control series female rats. Thus, the relative increase in the life span average of the treated male rat over control series rat is approximately 38%. While in the treated female rat, the average increase in lifespan is 22%, contrasted to the average control series rat. Yes, this is truly amazing, for this type of medical experiment with significant increase in a life span has never been done before in medical history. Could Rustia and Shukib inadvertently found a chemical foundation for the prolongation of mammalian life? I believe the true significance of this phenomena in rats is directly translatable in terms of extension of human life span. Before this is done, I must show absurdity of the prior mentioned allegations against metronidazole. The Medical News Letter cites the initial fatally flawed article by Rustia and Shukib done in 1972 as proving carcinogensis, yet the evidence I have presented totally refutes the contention, metronidazole is carcinogenic. I am buttressed by the second Rustia and Shubik article using noninbred rats which shows a marked increase in lifespan over the control series. This evidence most strongly supports the lack of carcinogenicity in mammals. Human beings in general are noted for their lack of inbreeding. Evidence is cited "C. E. Voogd et al, reported that metronidazole increases mutation rate in some strains of bacteria (Mutat Res. 26:483, 1974). Furthermore, the urine of patients taking 750 mg of metronidazole per day also causes genetic changes in bacteria (M Legator et al, Science 188:1118 to 1119, 1975. This is the first report of a drug not used for cancer chemo therapy having mutagenic activity in concentrations found in the body fluids of patients taking recommended doses. A metabolite of metronidazole appears to be much more mutagenic than the drug itself."

"Conclusion—Metronidazole is carcinogenic in rodents, mutagenic in bacteria, and should thus be regarded as potentially dangerous in humans." The body of evidence cited above can be explained very easily, note it just makes inferences, may or might. Now let us look at what really happens, metronidazole is derived from Azomycin, an antibiotic found in a strain of Streptomycis mold, just like Clindamycin. Azomycin destroys bacteria by causing mutagensis.

just like other antibiotics, BJVenDis 1978, 54, 69–71, also anti-viral activity noted in a most uniform manner against infectious mononucleosis, a DNA viral disease, Sven A. Hedstrom et al, Scand J Infect Dis 10:7–9. Authors did not recognize such a uniform rate of cure in 3–5 days would not occur against a multitude of different secondary bacteria infections. Ursing and Kramme cured viral caused Crohn's disease using viracidal doses of metronidazole over extended periods of time, Lancet, 4 5 75, pp775–777. This investigator has used metronidazole as an anti-viral agent against serologically proven measles virus infection, an RNA virus, as well as against Crohn's Disease in 1969 as viral arrest therapy, some six years before Ursing and Kramme used the same drug against same disease with same result. They did not know they were treating viral disease, I postulated this in 1969. G. L. Gitnick, proved Crohn's Disease is caused by a picornavirus, an RNA virus. This investigator through documentation in manuscripts presented to the FDA in 1974, therapeutic control and eradication of herpes Zoster as well as amelioration of the degenerative diseases of aging using long term low dose metronidazole. A. M. Schmidt, M.D., Comm. F.D.A. letter to Congressman Bill Roy of Kansas dated March 11, 1974. Reference, G. L. Gitnick, Lancet 7 31 76, pp215–218. The apparent anti-viral properties of metronidazole also in body fluids be identical to agents used in fections) metronidazole was effective in increasing the survival time of Superatentorial Glioblastomas, NEJM 294:25:1364–66, the most malignant of brain tumors. Metronidazole if carcinogenic should have shortened the average survival of the treated patients, rather than increasing life span as in the Rustia and Shubik noninbred rats, JNCI, 63: No. 3, pp863–867. Could the anti-viral properties of metronidazole also in body fluids be identical to agents used in cancer chemotherapy? The article by Rosenkranz H.S., Speck W. T., Mutagenicity of metronidazole activation by mamalian liver microsomes. Biochem Biophys Res Commun, 66:520–525, 1975 are theoretical speculations which can be explained by my prior comments, above.

C. Mary Beard et al, in the article titled, Lack of Evidence for Cancer Due to Use of Metronidazole, N.E.J.M. Vol. 301, No. 10, pp519–522. They are intrigued by all the smoke being generated by various experts using speculative ideas to support the twice fatally flawed scientific study done by Rustia and Shubik. JNCI, 48:3:721–726. The second article by Rustia and Shubik, JNCI, 63:3:863–867 citing the statistical data of the metronidazole treated noninbred rats of increased lifespan despite a low incidence of malignant disease and benign neoplastic disease, while the control series had less malignant disease but died much earlier. What is the most important factor to die early of non malignant disease or live much longer and die with a malignant neoplasm or die with a benign neoplasm of another cause. This was the thought I tried to get across to John Bailor, III, M.D., Ph.D., Exec. Editor, JNCI, just this simple truth, "When you are dead, you are dead." The greatest sin is to die early in one life rather than to die late in life from a neoplasm (malignant). Now what does all this mean. It means President Carter should recommend to the Federal Drug Agency and the George D. Searle Co. to turn over to the Epidemiologists of the Mayo Clinic and other equally interested astute groups with the scientific expertise, all case files showing those patients treated with metronidazole for protracted periods of time, especially those treated by Dr. Jo Ann T. Taylor, Searles primary investigator, and all the alcoholic long term studies using metronidazole, and other long term studies. This study should be done immediately to remove the unjustified onus placed on metronidazole by a timid group of speculative American Scientists. Just remember, in the approximate 20-year history of metronidazole, there has not been a single death reported as a result of using this agent, let alone, the death being caused by cancer. It would appear something really smells in the old wood pile. Let us air it, and find what really caused the smoke, but no fire.

Now, we will go back and inspect in all probability just what happened in the noninbred rats treated with metronidazole, whose increase in lifespan, contrasted to the control series noninbred rats, was spectacular. There indeed must be a reason for the increased lifespan from taking metronidazole. In 1969 I postulated continuing viral infections in animals and humans would shorten lifespan by causing viral induced arterio-atherosclerosis and atherosclerosis of the brain, heart, kidneys, and key organ systems as well as continuing viral infections of organs parenchymal. Of course we should not overlook viral disease of the central nervous system, muscles, and joints. We should not forget the high incidence of spon-

taneous abortions, congenital malformations, and mental retardation caused by in utero, treatable viral disease. It appears metronidazole has never produced any tetragenicity despite the warning it should not be used in the first trimester of pregnancy. It also appears metronidazole should be used in active diseases of the central nervous system and in the first trimester of pregnancy because of high incidence of congenitally transmitted viral disease which appears curable, such as cytomegalic viral infections. For years metronidazole has been attacked as possibly causing blood dycrasias, yet, no evidence of this fear has ever surfaced. A recent article by R. Anderson et al., titled "Effects of Metronidazole on Certain Functions of Human Blood Neutrophils and Lymphocytes," South African Medical Journal, April 7, 1979, pp593–596, reinforces the comment I made at least ten years ago. Metronidazole does not damage the reticuloendothelial system or hematopoietic system of human patients.

Now it is time to state just why the sudden increase in lifespan in the rats treated by Rustia and Shubik with metronidazole in the 1979 report. There is strong evidence of the emergence of a prior undiscovered factor determining lifespan in animals is present. This factor is known as continuing viral infections, which continually cause an acceleration of the aging process. This factor prior to this time has been unchecked to any significant degree, until the Rustia and Shubik 1979 article. The 1972 article using inbred Swiss mice showed to the discerning eye this was a strong possibility. In 1969 I became aware of viral infections of a continuing nature such as Crohn's disease, herpes simplex infections, herpes Zoster infections, and multiple sclerosis being of a continuing nature. These diseases when brought under viral arrest allowed the patients to lead relatively normal life, using low dose metronidazole therapy, 250mg to 500mg daily. It has been noted that pregnancy, especially a spontaneous abortion, extensive trauma, either operative or accidental, another viral infection such as viral influenza, who trigger the recurrence of a continuing viral infection which had continued to smoulder without the patients knowledge. Some of these patients especially the ones troubled with herpes infections were noted after being treated for several months to a year, their metronidazole was stopped and they remained in good health for years. This indicated in all probability the viral infection had been killed by the anti-viral agent metronidazole. A number of these patients prior to treatment with metronidazole, had been miserable for years. These patients usually women always complained about fatigue unrelieved by adequate rest, frequently accompanied by severe headaches, depression, made worse at the time of an eruption of herpes.

Frequently a bout of the "flu", the birth of another child, or a surgical operation caused the above symptoms to intensify, and herpes virus infection to worsen. Yet, you could treat these patients with low dose metronidazole daily for some time, stop the drug, and the patient would feel as well as before she was ever ill. Sometimes there would be cardiovascular system involvement besides just central nervous system, with frequent bouts of tachycardia with breathless, and unbelievable labored breathing when attempting to do hard work. Or the patient might have viral renal involvement with marked swelling of the feet and hands in the morning, as well as the other symptoms. Yet, treatment with the anti-viral agent metronidazole would cure them of their symptoms after extended treatment. These patients would state at that time they frequently felt as well as prior to the onset of their illness several years prior. The average physician will label these patients as psychosomatic, and they frequently are being treated with anti-depressants and sleeping pills as these patients frequently have insomnia. These are the simple continuing viral infections. Many of them are curable. The continuing viral infection such as herpes Virus One on a recurrent basis is not a simple problem. Many of these patients have developed arterioatherosclerosis involving the brain, heart, great vessels, producing warty viral tumors, which slowly occlude key arteries to key organs. These viral tumors, such as afflicted Arthur Ashe, the tennis champion, are regressible under anti-viral metronidazole therapy. Evidence of this regression of viral tumors is shown dramatically and with spectacular results in the large case series by Jo Ann T. Taylor in probably U.S. Veterans Hospitals in 1962 to 1965. Jo Ann T. Taylor published these eye opening results of metronidazole therapy in the Proceedings of the Western Pharmocological Society of Washington University, 1966, pp37–39.

Dr. Taylor titled her article, "Pharmocodynamic Observations on Metronidazole Therapy. Side Effects in Endocrine, Metabolic, and Auto-Immune Disorders. III—Anti-Ischemic and Anti-inflammatory Action in Peripheral Vascular Disorders.

Dr. Taylor did not realize she had found a potent safe virus killer, effective against both DNA and RNA viral infections, which have plagued man since the beginning of time. She did not realize in this same article she was treating other types of viral diseases of a continuing nature. She did not realize she had uncovered a discovery comparable or of even greater magnitude than the discovery of Penicillin. She did not realize she had truly found the "Penicillin for Viral Infections." She did not realize, she had found an answer to the controlling of "continuing viral infections," which shorten human and animal life span. Evidence of even more spectacular cases treated by metronidazole in dying patients, whose lives have been saved are on file with June K. Dunnick, Ph.D., Anti-viral Program Officer, National Institute of Allergy and Infectious Disease, Room 750, Westwood Bldg., Bethesda, Maryland.

A new concept in health care needs to be introduced at this time. We can not continue to use the same old ineffective methods of treatment and health care delivery. What is this new concept which needs to be introduced? One that viral diseases accelerate the aging process in all humans. Until recently no significant gains were made against viral diseases. In most medical schools, a virus is just something one must live with the rest of one's life. It now appears viral disease of the great arteries of humans is but one of the factors in the acceleration of the degenerative diseases of aging. These viral diseases appear to be treatable, arrestible, and even curable. It now appears multiple sclerosis, a viral disease, is curable and arrestible with metronidazole therapy.

It appears by inference that the viral diseases contribute in large part to the aging process. It would appear these viral diseases are continuous, have been present for many years, and gradually take their toll as degenerative diseases. It also appears these diseases are treatable and regressible with a safe potent anti-viral agent. Evidence is now presented viral infections activate "inactive viral disease," so cause exacerbations of latent viral disease. These viral diseases though latent have already gained a foot hold in the human immune system, such as multiple sclerosis and Crohn's Disease. Reference see Medical Trib une 11 15 1978, page two.

It appears that the apparent anti-viral agent, metronidazole has been mislabeled as possibly carcinogenic by the F.D.A. without any significant evidence of truth. This agent has never caused a single death in over 20 years of world wide use, let alone of causing cancer. The root of the evil is an unscientific work done by Rustia and Shubik for the National Cancer Institute, titled, "Induction of Lung Tumors and Malignant Lymphomas in (Swiss) Mice, Vol. 48, No. 3, March 1972, pp721–726. Then we have the later study done by Rustia and Shubik, utilizing noninbred rats. In this study the rats fed the drug far outlived the rats that did not take metronidazole. This is an unheard of event in medical history. What this experiment shows is the acceleration of the aging process in animals due to continuing viral infections in the life time of these animals. When these diseases are controlled and arrested, the animals live longer. I feel the same is true of humans taking metronidazole for viral infections, such as ischemic heart disease, arterio-atherosclerosis and atherosclerosis of the human arterial system, Crohn's Disease, chronic viral hepatitis, acute viral hepatitis, multiple sclerosis, viral diseases of the kidney, bladder, prostate, cervix, viral sarcoidosis, viral arthritis and other degenerative diseases of aging.

For the young, metronidazole therapy is best for Still's disease in children, viral myocarditis, such as fibro-elastosis of the myocardium, Schonlein-Henoch purpura, Raynaud's disease due to viral cytomegalic virus as well as ulcerative colitis, scleraderma, disseminated lupus erthymatous, sclerosing panencephalitis due to central nervous system viral diseases, active herpetic infections of the central nervous system, probably Reye's syndrome, viral induced juvenile diabetes due to Cox Sackie B–4 viruses, progressive mental retardation in the young due to continuing viral infections of the central nervous systems noted at birth, viral pneumonia of the young and old. Of course infectious mononucleosis should do extremely well with high dose metronidazole therapy, usually cureable in less than a week. Gillian-Barre syndrome caused by Epstein-Barr virus which causes infectious mononucleosis, should do well on high dose metronidazole therapy. The latter viral disease plagued the Swine flu program. I had repeatedly suggested to C.D.C. in Atlanta, the use of metronidazole to stop viral influenza epidemics, but this fell on deaf ears. Had that been done we would not have wasted 35 million dollars, and had all those patients damaged by the Gillian-Barre Syndrome from the Swine flu vaccine.

I believe probably less than one-fifth of the coronary bypass operations, total some 70,000 operations for 1978, were really necessary had the patients been placed on metronidazole to reverse their viral caused heart disease. Certainly those patients who had by-pass surgery for ischemic heart disease should be placed on metronidazole, for this is a palliative operation for the viral disease is unchecked. Just think of the cost of a coronary by-pass operation, 15,000 dollars each, times 50,000 operations, which would not have had to be done. They would not have had to have been done as they would have responded to medical treatment with metronidazole. Total cost for all this hero work, 750 million dollars plus the Billions of dollars spent on the palliative symptomatic care of arteriosclerosis of the human arterial system. Much of this cost is preventable according to the spectacular case studies on file under my name, with June K. Dunnick, Ph.D., Anti-viral program Officer with Nat. Inst. of Allergy and Infectious Diseases, Room 750, Westwood Bldg., Bethesda, Md., 20014. In retrospect now is the very large three year plus study, by Jo Ann T. Taylor, done for the George D. Searle Co. and with the full knowledge of the F.D.A. This study was probably done in U.S. Veterans Administration Hospital, probably Seattle, or west coast hospitals using high dose metronidazole therapy with spectacular results in the treatment of most severe peripheral arterial disease. Yet, this study was completely forgotten about, yet it would have saved millions of lives and many billions of dollars. This study was apparently done in 1962 through 1965.

In Sunday's Kansas City Star, April 6, 1980, page 6A, is an article titled Eagleton aids firm's battle to keep drug on the market. This story concerns the drug, Pavabid manufactured by Marion Laboratories. The F.D.A. contends Pavabid is non-effective. The original research on Pavabid was done by the University of Kansas Medical School. How do I remember this so well. I asked Marvin Dunn, M.D., Professor of Medicine in 1969 to use metronidazole for the treatment of human arterial diseases including the heart. He said, "I do not have the time, I am working on Pavabid." Marvin Dunn, M.D., and his associate, David M. Pugh, M.D. have seen spectacular cases of viral induced heart and brain diseases which significantly improved with metronidazole therapy, yet these same cases when seen or similar cases seen by the University of Kansas Medical School or the U.S. Veterans Administration Hospital, were considered as untreatable. Yet they are seen later in much better health, leading nearly to normal lives as a result of low dose, daily metronidazole therapy. Some of these cases are on file with June K. Dunnick, Ph.D. Senator Eagleton, Senator Danforth, Rep. Ray Roberts, Chairman of House Committee Veterans Affairs, and eleven members of the Black Caucus want to have the best for the American people. I would like to suggest to these gentleman and to the F.D.A., dual side by side studies be carried out using Pavabid versus metronidazole. Let the chips fall where they may. The places where these studies should be carried out.

The first, Meharry Medical College, Nashville, Tennesse, a black medical school. Blacks have more viral infections, thus, have more arterial diseases. The University of St. Louis Medical School, for they have an interest in metronidazole for the treatment of viral diseases of the central nervous system. The University of Kansas Medical School for they have seen the spectacular metronidazole case studies in so-called untreatable patients. They participated in the original Pavabid study. The Oral Roberts University Medical School for they have dedication to treating the whole man, Tulsa, Oklahoma. Creighton University Medical School, because of their interest in metronidazole for many years. The Mayo Clinic and Medical School, Rochester, MN for their interest in metronidazole as a primere chemotherapeutic agent possessing efficacy and safety. The University of Texas's Southwestern Medical School at Dallas, for Charles Pak's interest in trying to find innovative means of treating circulatory related diseases. I know within four months of studies in human patients the question of the most efficacious drug for treating diseases of the human arterial system will be settled in a most affirmative way. The results of this series of studies will have the U.S. Taxpayer many Billions of dollars very quickly.

A good safe broad spectrum anti-viral agent can restore good health to millions and sharply reduce our current health care costs. One must remove the unfair onus imposed by Rustia and Shubik's scientifically flawed 1972 study of JNCI. Remove the concern about mutagensis posed by the Medical News Letter and related studies. These studies are not related to carcinogensis, but simply

the destruction of bacteria by the antibiotic properties of metronidazole. It is this same potency which kill virus diseases in many cases normal dosage levels. What has been seen has been exaggerated. Certainly, the modern European nations in their large medical centers have no qualms about using high dose prolonged metronidazole therapy against viral diseases and disease involving the central nervous system. Just think not one single death attributed to this agent in 20 years of world use. Now you can see why the Mayo Clinic is asking very searching questions about the cancer phobia placed on this marvelous life saving, life changing drug.

I believe the above mentioned schools would be delighted to treat multiple sclerosis with metronidazole. Treat them in the same way a small pilot study demonstrated 100% efficacy, using high dose metronidazole therapy over a month to several months time depending on the tolerance of the patients. Just think, 100 percent efficacy, against a disease which has never responded to any other agent in such a dramatic way. Four small patients (women), with University proven multiple sclerosis, appear to be cured over four years later following high dose metronidazole therapy. One large, very large patient, a female, became intolerant to metronidazole therapy, 1500 mg per day. After six weeks the agent was stopped, the patient remained free of her disease for many months, while on lower dose therapy she would relapse within two weeks. Strange, once her viricidal level was reached she did fine, while she showed no significant effect on a daily dose of 1250 mg daily. One very huge male patient, was diagnosed at the University of Kansas Medical School by Dr. Dewey K. Ziegler, Chairman of the Dept. of Neurology, as having untreatable multiple sclerosis. Several months later he started low dose metronidazole therapy for his multiple sclerosis. He continued to improve for five years with nearly doubling in his hand strength, having improved general strength and balance. Then, of his own free will he stopped metronidazole against medical advise and suffered a very serious relapse one year later. Yes, he is slowly improving but what a lesson he has learned. I told him I thought he was too large to knock out the disease after four months of 2000 mg daily metronidazole. Unfortunately, I was right. These two had University proven multiple sclerosis, but they were too large to knock out the disease with high dose therapy, as was accomplished in the four smaller patients.

High dose metronidazole therapy is much better treatment than the snake venom therapy proposed by Drew Phillips, producer of CBS News, "Sixty Minutes." Drew Phillips attack the National Foundation for Multiple Sclerosis for their lack of positive research in multiple sclerosis. Drew Phillips did not know the Exec. Director of the National Foundation for Multiple Sclerosis, James Q. Simmons, M.D. was advised by a patient in 1973 of value of metronidazole to her. I so advised him in November, 1973 James Q. Simmons, M.D. was advised by Certified letter, return receipt requested, dated July 3, 1976. He was advised of the six patients treated with high dose metronidazole therapy. He was informed they were asymptomatic and that he should come and evaluate them from time to time to ascertain their status. Dr. Simmons never replied to my certified letter. He was not interested. I believe Drew Phillips will agree with my thinking as well as patients with multiple sclerosis. Multiple sclerosis patients the country over should be informed something in a positive manner can now be done for their disease. It is their inalienable right, their right to life, that metronidazole is on their pharmacies shelves. These patients should be informed it is their right to be treated by a physician. Then, after signing an informed consent, to accept the risks of metronidazole high or low dose therapy, rather than accept the risks to life, to sanity, to being "one of the living dead," from multiple sclerosis. They and their physicians can be informed on how to properly administer high dose therapy to reduce the chance of developing a peripheral neuropathy from high dose metronidazole therapy. Proper supervised care can by in large remove this problem. These six cases of patients treated with high dose metronidazole therapy for the University trained neuologist confirmed multiple sclerosis is on file with June K. Dunnick, Ph.D., Anti-viral Program Officer, Nat. Inst. Of Allergy and Inefectious Disease, Room 750, Westwood Bldg., Bethesda, Maryland, 20014.

Perhaps, the most saddening thought of all, is thousands yearly in the U.S., are going blind. Who, I don't feel have to become blind. Why, is this? Probably most of the cases of blindness result from undetected cerebral arteriosclerosis, which is greatly accelerated by diabetes mellitus. It should be noted in Jo Ann T. Taylor's epic article, on untreatably severe peripheral artery disease, published in the Proceedings of the Western Pharmocological Society of Washing-

ton University, 1966, pages 37–39. Of the 61 indolent uclers which did not heal prior to metronidazole therapy, in a total of 43 patients. Eight (8) patients with Diabetic vasculitis with or without occlusive disease, had 20 indolent ulcers of the total of 61 ulcers in the 43 patients. Yet, with metronidazole therapy, 16 of these ulcers healed and the remaining four (4) ulcers were improving. These ulcers had been present from six months to 15 years without healing, now all the ulcers were in a state of healing or had been healed. The implication of this study is all patients, who are diabetic, should be on metronidazole therapy. At least low dose daily metronidazole therapy to prevent the arterial complications that usually accompany diabetic disease. This would prevent the most common cause of blindness. That caused by diabetes mellitus, due to cerebral arteriosclerosis.

Now, why am I an authority on cerebral arteriosclerosis, while academicians from medical schools are not? How many cases of cerebral arteriosclerosis, manifest as bilateral macular degeneration have they reversed after a patient was legally blind with meaningful therapy? I know of none reported in the medical literature utilizing drug therapy. How many cases have I reversed, not by my own hand, but by the help of the Great Physician, three. These patients were Alma Howard, J. H. Hartenbauer, and Irene Kolman. Two of the three patients had diebetes. In 1969 I reported in a manuscript to the A.M.A. Journal, to Senior Editor, Samuel Vaisrub, M.D. on the successful treatment of two patients who had bilateral macular degeneration and were legally blind, confirmed by skilled board certified Opthalmologists. These physicians could offer these patients nothing. The patients objective improvement was confirmed after metronidazole therapy. Yet, Samuel Vaisrub, M.D. rejected my manuscript, denying suffering patients with cerebral arteriosclerosis a chance to have restoration of their vision. Yet some five years later, the A.M.A. Journal states on page 1323, Dec. 2, 1974, Vol. 230, No. 9, "No Medication Known to be helpful for Macular Degeneration." It would seem Samuel Vaisrub, M.D., should have had the curosity and the compassion as an editor to truly seek the truth. Seek the Truth, I had placed in that manuscript, titled, "Metronidazole for Blateral Macular Degeneration." Then, the helpless might be helped. I feel truly sorry for this man. I also, mentioned in this very manuscript, the danger of doing "Strobe light fundograms" in patients with bilateral macular degenerative disease, as a significant cause of further damaging the maculate from the intense heat. The Strobe light fundogram is of no value therapeutically in the treatment of bilateral macular degeneration. Alma Howard, a diabetic patient with bilateral macular degeneration had lost both her macular and peripheral fields of vision. These were restored by metronidazole therapy. I had been told by Dr. Jo Ann T. Taylor, that metronidazole was ineffective against bilateral macular degeneration. I found out this was not true. Dr. Taylor routinely ordered Strobe light fundograms prior to metronidazole therapy in patients with bilateral macular degeneration as well as those with diabetic retinopathy.

Naturally, she found no improvement with patients with bilateral macular degeneration after metronidazole therapy. The intense heat from the Strobe light fundograms had burned out the disease fragile nerve filaments to the maculae of each patient? Was it impossible for the dead tissue to come back? It is possible for anoxic disease tissue to return to functional viability if given the opportunity. This is why I told J. H. Hartenbauer, never to allow anyone for any reason to do Strobe light fundograms on his eyes for any reason. This is why I am an authority on cerebral arteriosclerosis and bilateral macular degeneration of the retinae. The Great Physician gave me a tool, metronidazole, and the curiosity to know and learn. When Alma Howard lost her macular vision from the Strobe Light Fundogram done by the University of Kansas Medical School. It had great meaning for me. It also had great meaning of despair for Mrs. Alma Howard, who lost her macular vision from a Strobe Light Fundogram done by the Dept. of Ophthalmology of the University of Kansas Medical School. This had great meaning for me to stop this unnecessary damaging practice. All these experts in Disease of the Human Eye were like airplane pilots. Airplane pilots, with all their technical scientific background, but had never flown an airplane, figuratively. Yet, I had flown. I knew the truths about bilateral macular degeneration and cerebral arteriosclerosis they could not know. I can speak with authority of having done things and noted phenomena, which they did not have the capability. Should I have any special accollades? No, I was only doing my job as a scientist in medicine. The Great Physician guided my mind, my hands, and my heart as I looked for the Truth, to help the helpless, the sick, and the aged. To Him goes all the

credit for what I have done. The Truth I have discovered in many fields with metronidazole can come from only running the course. "To go and see, to weigh and to ponder, then, to resolve and to act." The rest is history. The primary cause of cerebral arteriosclerosis, made worse by diabetes mellitus, is apparently caused by viral injury to the cerebral arteries.

Now, we can understand how with the regression of the viral tumors, obstructing the arterial blood flow to this sensitive neural tissue of the retinae, with metronidazole therapy. The still viable, but anoxic macular neural filaments to the maculae improved in their efficiency to more effectively transmit neural impulses to the brain. Transmit the neural impulses to the brain so the patient was not blind anymore. See the explanation is very simple. One must have the tool, metronidazole. Claude Bernard said this truth to me long ago. "I had the tool, knew how to use it, others did not."

Five of the seven cases on file with June K. Dunnick, Ph.D. Anti-viral Program Officer, Nat. Inst. of Allergy and Infectious Diseases, are most spectacular for these types of atherosclerosis and arterioatherosclerosis. These cases are untreatable except with metronidazole. The results have been accurately reported in a scientific manner. Two of these patients had reversal of their severe ischemic heart disease, Mrs. Swager and Mr. Carmichael. Mrs. Swager had malignant small artery occlusive disease of the myocardium complicated by diabetes mellitus. Mrs. Swager has a strong family history of all of her brothers and sisters, either being treated for or having died of cancer. She has been taking metronidazole for over ten years. The other patients had complicating severe circulation problems of the brain because of cerebral arteriosclerosis. These patients were Edith Sankey, Irene Kolman, and J. H. Hartenbauer. They all had cognitive disturbances of the brain tending toward senility. Senility is the progressive loss of cognitive function due to the anoxia and finally death of higher brain cells. These three cases of cognitive function improvement was sustained by maintenance on metronidazole. The vission of all three patients improved, however two of these three patients were all ready legally blind from bilateral macular disease. Bilateral macular degeneration which the A.M.A. Journal says are untreatable. These two patients regained their vision from treatment with metronidazole for their cerebral arteriosclerosis.

Marion Swager, Edith Sankey had chronic Herpes Virus One infections of the lips for many years, they both were dying from arterio-atherosclerosis of the heart and brain respectively. Ten and 12 years later they continue to lead relatively normal lives. Their herpes infection is controlled as long as they continue to take their metronidazole. Their arterial disease has regressed. These two patients remind me of several Catholic priests who are my friends. Monsignor Henry Gardner of Queen of the Holy Rosary Church, Overland Park, KS has had chronic Herpes Virus One eruptions on his lips, just over four years ago he had a cardiac pacemaker installed and had coronary by-pass surgery for ischemic heart disease. Father John Cosgrove, a Priest at Redemptorist Fathers Church, Kansas City, Mo., has severe visual problems apparently due to continuing cerebral arteriosclerosis. Notwithstanding Father Carl Zawackie, Queen of the Holy Rosary Catholic Church, Overland Park, Kansas has severe multiple sclerosis but he does his best to keep a full schedule. I believe all of these men would respond well to metronidazole therapy. Do you think they have the right to be treated? Two of the seven patients are younger women, who had chronic herpes one viral infections which made their lives miserable with symptoms found with continuing viral infections. They appear to have the viral induced "Tired Housewives Syndrome." Both patients were seen by Drs. Pugh and Dunn, of the University of Kansas Medical Schools Section on Cardiovascular Diseases. Dr. Joseph Woehl, a former professor of neurology, saw Mrs. Bonnie Gale Strode, prior to metronidazole therapy. Dr. Dunn and Dr. Pugh recorded the curing of Mrs. Bonnie Strode with metronidazole therapy. Mrs. Patricia Earl was referred to the Obst. Dept. of the University of Kansas Medical Center prior to treatment of her central nervous system involved Herpes one following the birth of her last child.

This patient was so depressed from her infection she contemplated suicide. After six weeks of metronidazole therapy, she was seen by Dr. Marvin Dunn, who complimented me on her spectacular cure following metronidazole therapy. Her therapy was one 250 mg tablet of metronidazole daily for six weeks. She has done well since. It is indeed significant to see how these untreatable patients, Mrs. Sankey, Mrs. Swager, Mrs. Patricia Earl, and Mrs. Bonnie Strode responded to metronidazole therapy for their Herpes Virus one infections which were either cured or arrested. Just think how many untreated similar patients are longing to know how metronidazole can change their lives from despair to hope.

C. Richard Minick, M.D., Catherine Fabricant, M.S. et al reported in the American Journal of Pathology, Vol. 96, No. 3, Sept. 1979, pp 673 to 707 their article titled, "Atheroarteriosclerosis Induced by Infection With a Herpesvirus." Their comments on page 689 are most enlightening. It has been suggested that virus infections may be important in the pathogenesis of atherosclerosis in humans. There is extensive evidence to indicate that viruses may lead to arterial disease in human and animals. Infection with hepatitis B virus and Coxsackie viruses have been implicated in arterial disease in humans. Infection with viruses has also shown to lead to arterial damage in immune complex disease in New Zealand mice, lymphocytic choriomeningitis virus infection in mice, Coxsackie virus and encephalomycarditis virus infections in mice, Pichinde virus infections of hamsters, Aleutian disease of mink, equine viral arteritis and infectious anemia. African Swine fever and cholera (hog), bovine malignant catarrhal fever and mucosal disease of cattle. Border disease of sheep, and Bolivian hemorrhagic fever in nonhuman primates. Results of our experiments indicate that infection with a herpesvirus can lead to atherosclerosis in chickens that closely resembles that in humans. In this regard it is important to note that there is wide spread infection of human populations with up to five herpes viruses. These viruses are herpes simplex One and Two, varicella zoster, Epstein-Barr virus, and the cytomegaloviruses. Infections with herpes-viruses are well known to persist for long periods as latent or reactived latent infections." Dr. Minick is echoing the importance of continuing viral infections in animals as well as humans. Now I believe we can understand more clearly the viral arrest phenomenon which took place in the increased lifespan in the Noninbred Rats, which did not occur in the control series rats.

Recently, a team at the University of Alabama Medical Center, developed a practical test which has identified the leading cause of neonatal infection as being caused by cytomegalovirus. Dr. Stagno reported congenital infection rate in middle class patients is 0.4%, contrasted to 1% of all newborns. The incidence is up to 2.5% among poor, often black infants. Chief target for the test is the typical CMV patient, who is from the disadvantaged subpopulation, is asymptomatic, and susceptible to complications that include sensorineural hearing loss, intellectual impairment, growth retardation, and retinal lesions. Dr. Stagno states though there is no known effective treatment for the infection, identification of subclinical cases is still important. Could metronidazole control and arrest CMV infection in affected women and substantially lower the incidence of impaired children caused by in utero infections. Do these infants have a right to life?

Can other in utero viral infections be cured, controlled or arrested with metronidazole to reduce the number of spontaneous abortions and virally damaged infants? Are these not searching questions to be answered?

Senator Dole, Senator Danforth, I believe you can now see the tremendous value of a broad spectrum anti-viral drug, such as metronidazole. This agent would help millions of viral infested patients and younger more susceptible patients. This is why, I reiterate again the need to immediately investigate why the unscientific onus placed on metronidazole by the F.D.A. should not be removed. The more quickly this is done, the more quickly, those suffering from viral disease, the helpless, the unborn, the young, the sick, and the aged, can be helped. Millions of people will benefit. This effort would sharply reduce our national health care costs by many billions of dollars. This would seem a more sensible way to actually treat the cause of the problem. Do we continue to provide symptomatic, costly, palliative care and treatment of viral diseases of the young, the susceptible, and the aging? This care is woefully ineffective for viral diseases. Specifically aimed treatment programs for viral diseases can not fail. Will you not go look and see? I have always lived as a physician with the Catholic thrust to my life. I have felt it was my own special burden to care for those who were spurned, and those without hope. As a Roman Catholic, what I have done in medicine has been reaffirmed by the Holy Father, Pope John Paul II. He said, "Human life is precious because it is the gift of a God whose love is infinite; and when God gives life, it is forever."

JAMES B. MERCER, M.D.

A physician, who came to search for truth, and found it.

P.S.—I would hope I could serve my profession as a physician as ably, as my friend, Father Carl Zawackie, serves the Roman Catholic Church. Supportive documents, sent under special cover, Michael Stern, Staff Director, Committee on Finance, 2227 Dirksen Senate Off. Bldg., Washington, D.C. 20510.

KANSAS FARMERS UNION GREEN THUMB,
McPherson, Kans., April 16, 1980.

Hon. ROBERT DOLE,
U.S. Senator, Dirksen Senate Office Building, Washington, D.C.

DEAR SENATOR DOLE: Thank you for the invitation to be present at the Public Hearing held by the Subcommittee on Health in Kansas City, Kansas, on April 11, 1980.

I would very much appreciate the attached testimony being entered into the official record of the hearing. Your interest and support for programs designed to help the Older Kansas is greatly appreciated.

Yours very truly,

ART E. GUSTAFSON,
State Director, Kansas Green Thumb.

TESTIMONY OF ART E. GUSTAFSON

Thank you, Senator Dole, for this opportunity to speak on the general topic of health care for the elderly. I know that we share the concern of how to best utilize the dollars allocated to the elderly for health care and at the same time, assist the Older American to remain independent of premature institutionalization.

The recently completed Needs Assessment conducted for the Kansas Department on Aging revealed what many of us have long known—there is a high level of poverty among our elderly; social security payments are the primary means of support of the majority of elderly, and health care is a critical need, particularly for the persons over 75. The survey pointed out that the "young old", those persons under 75, did not see health as a limiting factor in meeting their needs. Most often it was lack of sufficient income.

This last factor, limited income, points to the special need that is filled by Green Thumb through the Senior Community Service Program, and indicates a method whereby health care can be provided in the home to the benefit of the provider and the recipient. Green Thumb has the rural work experience to develop a program where Green Thumb workers can be trained and utilized in Physical Therapy, Home Health Services and Home Chore Services. In this manner, those persons who do not require institutionalization can receive care in the home at a fraction of the cost. There are many terminally ill persons, who with a minimum of care, can remain in their homes and receive the care and attention of loved ones in a familiar environment.

We know that all persons lose physical faculties rapidly if not given rehabilitative therapy while bedfast. Even the astonauts, after a short period of being immobilized, had a loss of calcium from their bones, stiffened joints, clots in their blood, stones in the urinary tract, and impaired digestion. The same type of destructive effects have been noted by doctors in Senior Day Care Centers, where it has been noted that many of the older persons suffered more from the lack of exercise than from the effects of age. It is known that people who rest completely in a hospital for two or three weeks often suffer calcium losses from the bones, tissue losses from the muscles, and decreases in heart and lung function. Obviously, physical therapy would be of significant benefit to sedantary older persons and could be provided by Green Thumb workers under the supervision of a medical professional.

We also know that care in the home is far less expensive than institutional care, especially if that care is provided by trained non-medical persons. In addition, there is a great deal of evidence that many people who are presently in some type of institution need not be there and could be in their homes if their communities had one or more in-home services. Many non-medical tasks could be performed for individuals which would prevent premature institutionalization.

At the heart of this proposal is the belief that people from local communities are more effective in caring for home-bound persons and that they often are able to voluntarily develop other community resources in addition to and beyond the scope of funded programs. This last aspect is the only way to provide a level of care and, at the same time, reduce federal costs.

Finally, this type of a program will provide needed employment opportunities for older persons, thereby reducing their dependence on federally funded service programs.

There are some obvious problems with this concept:

1. There is limited funding under Title V of the Older Americans Act and any expansion of this type would create the need for additional allocations.
2. The low income guidelines established for participation in a Title V program are too low and might exclude persons who have useful backgrounds and experience.
3. This might conflict with existing or proposed programs—even though those programs have not fully met existing needs.
4. There would probably be objection from the medical community saying the training would be too lengthy and costly; however, Kansas State University has already developed an effective training program for Home Health and Home Chore Aides. Dr. Richard L. D. Morse could provide additional information on that aspect.

There are also some obvious benefits:

1. Care and rehabilitation can be provided in the home, rather than in institutions.
2. This care would be less costly and more individualized.
3. It would reach people in areas where there are limited numbers of facilities and/or medical personnel.
4. It would provide needed income and employment opportunities for Older Kansans.
5. It would provide the vehicle for involvement of local communities in the care of its citizens.

Senator Dole, again we applaud your time, interest and support on behalf of the elderly. As an organization, Green Thumb, Inc. has long and fruitful experience in identifying and meeting the needs of the rural elderly, and in Kansas we enjoy a respected position across the State. We stand ready and able to assist in any fashion.

TESTIMONY OF L. KATHRYN KLASSEN, R.N., M.S.

In 1975, Senator Moss requested the American Nurses Association to study the Health Needs of the Elderly. That study outlined the same basic concepts I recommend to you today. We appreciate this opportunity; however, without your action, as well as ours, these hearings, as the results of those in 1975–77 which I have attached, will only be empty words. In last weeks "Parade" magazine, Representative Claude Pepper was quoted as saying:

"If the people in charge of delivering services to the elderly had been in charge of constructing the Six Million Dollar Man, he would have ended up with blurred vision, two left feet, and cost $10 million."

We know what is needed. The important thing is to put it together in such a way that vision is clear so the elderly can walk with steady feet through the delivery system getting what they need. Again, today I outline from our perspective the causes of such a disarray of services, what changes should be made in service delivery, and finally, how these services should be delivered.

PROBLEMS IN SERVICE DELIVERY

In the early 1970's, an all out effort was made by HEW to establish a nursing home program that would be of a quality as to allow the elderly to have a place to live out their lives in dignity and self-worth with adequate medical care. This was supported and sorely needed. However, as is so often the case, certain regulations, as formulated, were and are very costly to the program. These same regulations did and continue to do nothing to increase the quality of care but drain funds that could be used to provide other needed services. For example, (1) physicians are required every 60 days to recertify that the elderly person needs intermediate care or another level of care. This procedure is a waste of money. Physicians know it is not medically necessary, thus they rebel at doing this recertification and view the state and federal governments as wasteful. The states are then regarded as out of compliance if recertification is not done.

(2) Recertification of adult care facilities is required annually with no consideration given to the caliber of the home. Some homes are outstanding but must be reviewed annually. Others should be reviewed much more frequently but there is not time for this due to the requirement to review all homes regardless of their known caliber of care.

Furthermore, with the establishment of this program, as well as hospital services, it was clearly stated in the regulations that in adult care homes cost related reimbursement was required. Hospitals must be paid their cost or charges. No other category of service is paid in this manner. As a result, 75% of the Medicaid (Medical Assistance) budget is applied to adult care home and hospital services. As long as these costs continue to increase with no relief in other categories, service delivery to the elderly will remain inadequate and force elderly into adult care homes (nursing homes) when alternate services would be far more acceptable and less expensive.

WHAT CHANGES SHOULD BE MADE IN SERVICE PROVISION

The greatest need of the elderly across the country, and certainly in Kansas, is a continuum of services from the most minimal needed to intermediate and skilled nursing home care. The regulations should allow flexibility to establish these with equal status to nursing homes. These services should include: (1) meal delivery, i.e. Meals on Wheels; (2) homemaker chore service; (3) non-medical day care; (4) non-medical night care; (5) transportation; (6) home health care; (7) health screening services at accessible centers; (8) medical day care; (9) medical night care; (10) attendant care by nursing assistant; (11) intermediate and skilled care.

These services could all be made available with federal participation. Special attention is called to non-medical day and night care, one type of care equally important with the other. Fear of being alone and having something happen is well founded with the elderly. Monies should be provided for group homes which are not medically oriented and provide for continued independence. Health screening services and attendant care supervised by an RN should be incorporated as necessary and be a vital part of this program. Medically related day and night care should have the flexibility of being supervised by an RN without the physician unless he/she is needed. Many of these services could be made more accessible and available if more flexibility were allowed in health care decisions being made independently by the RN who is a clinical specialist.

With such an array of services, many of the older citizens could remain in their own homes and communities. The ability to develop this service flexibility must be allowed in state options with equal status of all programs and provisions for less rigid requirements on physicians participation when a clinical nurse specialist could do the job more efficiently.

HOW SHOULD SERVICES BE DELIVERED

It is not enough to have services available and the capability of delivering these services throughout the state unless those in need are able to utilize them. Many would advocate providing the full array through a Department of Aging. This would only serve to dilute services needed and used by all the medically needy. It would result in doubling administrative costs because programs would still be needed by other categorically and medically needy. This would serve no useful purpose and would become a financial burden.

Rather, special consideration should be given to assist the older citizen in utilizing available services. We would recommend the establishment of an assessment and referral system based in at least every county of a state. The function of the assessment and referral staff would be to assist the older citizen in identifying the services that are needed. The assessment and referral staff would know the delivery system and what agency or department provides the needed service and what the entry point is. The older citizen would be helped through this system until he/she has actually obtained the needed service.

This system proposes that delivering services to the elderly is not the task of one department, one federal or state program, or one service area. It is a series of services on a continuum for those completely independent to totally dependent available when needed. This could be a reality with less emphasis on Title XIX hospital and nursing home services, and more on services to maintain independent living. Attached is a Home Health Study completed in Kansas in 1978 which supports these recommendations.

I respectively request that you look seriously into the needs of Older Americans. However, I feel that it is not the concern nor the responsibility of the Federal Government to provide this service.

At no place that I am aware of have the people of the United States mandated the Federal Government to accept our responsibility. I feel confident that only as a result of federal intervention people have become dependent on the Federal Government to resolve their needs.

It is my contention that the Federal Government through its programs have caused a dependency that will be the down fall of the country. When the rightful place for this type of service should be at the lowest level. The family or their church, community or state, these and only these are the ones who can best address the needs of their family members or particular constituents.

I also appreciate the many times people are left at the discretion of others. However, this is not a federal matter but a local matter and if properly placed on the citizen's of their community I feel we'll receive much better care and more personnal care than could ever be provided by the bureaucratic system.

I call your attention to the fact that what you do today for these individuals may not be costly, but in the near future with the continuing numbers of seniors that will come forward, it will be an impossible burden due to the lack of understanding and acceptance of responsibilities. I feel that many of us have given our birth right to the bureaucratic system to provide for us. This in itself constitutes a gross negligence on the part of the individuals.

The needs of the Older American are over-dramatized in many cases. In view of statistics at this time only 5 percent of the total senior population are in fact in the institutional care facilities. Another estimated 10 percent are considered home bound but can provide for themselves to some degree.

It is indicative of the scare tactics that are currently being used by a number of agencies to create a false impression that all older people are in fact unable to maintain themselves and need support from the Federal Government.

I call upon you as good and righteous men to take a true look at the Aging process and in turn, place the burden of providing at the lowest level not the Federal Government, not necessarily the State Government, but the community in which these people do live and reside.

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