Old age- Medical care
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Health Insurance for the AGED

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by

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FOREWORD

Sometimes the quietest changes that come about in a society are the most profound. One such unseen revolution is taking place before our eyes today. Scientific improvements in health care have brought about marked changes in the characteristics of the population. Aged persons in the country are rapidly increasing, and their percentage of the total population is also growing.

Magnificent human achievements in the scientific sphere which allow man to live longer have brought with them a host of new problems in the social-economic sphere—how to provide a healthy, useful and meaningful life in the later years. These problems are not easy to resolve.

We have failed to meet the needs of our older citizens and the difficulties they face in the pursuit of their daily lives grow more intense. The political repercussions of the privations undergone by the community of older persons are just now beginning to be felt. A recent issue of the magazine *Business Week* dealing with the growing aged population commented:

> Clearly, there is a nation stirring, a sense that something needs to be done—even if that something is not plainly defined. The stirring seems to have more depth than any since the New Deal era that produced the Social Security Act.

This pamphlet discusses the single most important public and political issue relative to old age—the financing and administration of good health care. The United States is the only major industrialized nation whose government does not accept responsibility for the health of its people. It is difficult to conceive of a graver injustice that a wealthy and civilized society can impose on any citizen than allowing him to be without needed medical attention, provided in a way that preserves his personal dignity, when it could be made available. Millions of elderly Americans are so deprived.

The author discusses the proposals that have been advanced to meet the health needs of the older population. The Forand

and McNamara bills which provide medical benefits under the Social Security System, the Kennedy-Anderson amendment, the Eisenhower administration proposal, the Javits amendment, and other plans are examined and evaluated.

Mr. Seidner, a graduate of Hamilton College and the Woodrow Wilson School of Public and International Affairs at Princeton University, has had experience in both the legislative and executive branches of the Federal Government. His study, *Federal Support for Education—The Situation Today,* issued by the Public Affairs Institute in 1959, was widely discussed and much quoted. Earl J. McGrath, former U. S. Commissioner of Education, called it "the most comprehensive statement on this subject I have ever seen."

In making the present study, Mr. Seidner has been given every opportunity to confer with experts in the fields of health care and social security. He has talked to political and academic leaders concerned with health care of the aged, and has made an intensive study of the available literature on the subject.

The fight for a solution to the problem in the 86th Congress ended in stalemate. The only legislation which passed makes a moderate increase in public assistance medical help for needy persons, aid that can only be received after submission to a "means" test. It does nothing whatsoever toward providing a permanent answer to the health needs of the large community of elderly citizens.

As the aged become an increasing proportion of the voting population, and as their relatives become less able or less interested in providing for their health needs privately, so the people involved and others who face the uncertainties of aging turn to the Government. They ask the Government to organize the collection and disbursing of funds to which all have contributed through payroll taxation on the insurance principle of coverage of unpredictable illnesses of individuals. They naturally turn to the Social Security Administration to collect and disburse the fund. For experience has developed an efficient, nonpolitical, nonpartisan administration and accounting system that fully protects the funds collected. No criticism has ever been made of its honesty and reliability.

In offering this study of a highly controversial subject, the Public Affairs Institute has followed its long established practice of selecting a topic of timely interest and concern and of choosing a competent expert to explore and present it. Thereby the reader is assured of a high degree of scholarship and integrity.

Each individual conclusion drawn does not necessarily accord with the Institute's own judgment. On many of them the Institute has not expressed a view. The obligation of this educational research institute is to give the reading public access to a body of research which capably presents the situation under examination. Thereafter, whatever conclusions, if any, the readers choose to draw from this report rests entirely with them.

DEWEY ANDERSON,
Executive Director

Part I

THE INESCAPABLE ISSUE

Two separate trends combine to produce a crisis with an impact on today's political scene as perhaps no other single domestic issue. The first trend is the increasingly large percentage of the population made up of aged persons. The other trend, a direct result of the soaring costs of health care, is a growing demand by consumers for a greater voice in the economics of medicine. The era of unilaterally established physician's fees and hospital rates is drawing to a close. The widespread use of prepayment plans for health care, specialization and group practice are giving the consumer a wider influence in determining the way health services will be organized and paid for.

The aged have been isolated from the trend toward a larger role for the consumer in medical policy. The majority of older persons have no health insurance. Those that do seldom have adequate coverage. They often cannot get it, for one thing. When they can, the costs are usually prohibitive.

Deprived of the opportunity to participate in prepayment plans, most older citizens are left to their own slim resources when illness strikes. The aged are thus without protection at exactly that time of life when sickness hits hardest and most often, and when the means to pay for care are least likely to be available.

The 86th Congress tried to grapple with this issue, but ran aground. Despite the noise, the verbal pyrotechnics and torrential debate, the problem of establishing a system of health insurance for elderly persons was left unresolved. The law which emerged, P. L. 86-778, adds to existing grants for public assistance, a commendable step in itself, but hardly a substitute for a real insurance plan or a solution to the needs of America's 16 million elderly citizens. Participation in even the limited relief program offered by the new law is optional on the part of the states, and several states, including New York, have balked at accepting its provisions.

Rather than disposing of the issue, the political battle in the 86th Congress on health care for the aged leaves it more unsettled than ever. This pamphlet aims, by examining critically the proposals that have been made and the evidence which has been presented, to point the way toward a final satisfactory solution. The study is divided into two parts. The first cites the inadequacy of our present methods of dealing with the health needs of the older population. The second deals with suggested solutions.

The Older Population

Growing Numbers

Growing interest in the problems of the aged has brought forth a great deal of valuable study by scholars and interested groups in the past several years. Expert testimony before a number of congressional hearings has put into the public record significant and startling data on the characteristics of the aged population. A White House Conference on Aging, called by the President for January, 1961, is also arousing a great deal of work and public interest in the field.

At the turn of the century there were only three million persons in the country over 65, today there are 16 million. While the number of Americans over 65 grew by over five times since then, the total population only slightly more than doubled. In 1900 persons over 65 composed four percent of the population, today they constitute nine percent of the total.

The population over 65 is growing at a rate of one million in every three years, so that it is expected to total over 20 million by 1970. Population experts predict an aged population of over 30 million by the end of the century. If significant breakthroughs are made in medical research, experts believe the number could go as high as 40 million.

Statistically, 13 out of 18 people now 40 will live beyond the age of 65. Medical science has enormously increased the human life span. Four hundred years ago the average man could not hope to live more than two decades. Today the average life span in the United States is 70 years. Physiologists predict that by the end of this century the average American will live to be 82. Scientists predict that as science scores further victories against disease it will become increasingly common for men to live to be 125.

Of all persons over 65 in the United States today, more than one-third are older than 75. One in seven is over 80. The life expectancy of a man at 65 is 13 years, for a woman of 65 it is 15½ years. There are twelve women for every ten men over 65 and fourteen for every ten over 85.

Because women live longer, and because men normally marry women younger than themselves, the aged population contains a large number of widows. More than half of all the women over 65 are widows. Only one out of every three aged women is living with a spouse but two out of three aged men are living with a spouse.

Most aged persons—about three-fourths—live with a relative. Of the others, fifteen percent live alone in their own household, four percent live with nonrelatives, three percent are in institutions and three percent in hotels, boarding houses, etc. Although the percentage of older people that are institutionalized is relatively small, the number is rising rapidly. This is true of institutions for the aged and nursing homes as well as for mental hospitals.

Low Income

Older persons are probably the most deprived group in the country. Job discrimination and forced retirement make it difficult for even those elderly persons who are able and willing to work to do so. In June, 1958, only twenty percent of both men and women over 65 had a paying job. This means that almost thirteen million aged persons are completely dependent on sources other than employment for their income. The large majority of older persons must subsist on meager pensions, small savings, social security benefits, or welfare.

The percentage of older men in the labor force has decreased steadily in the past twenty years. During the war the demand for labor made it possible for about half of the men over 65 to be employed. Today only about one in three is employed.

Employment drops very sharply as age increases. In 1957, for instance, 83 percent of men from 60 to 64 were employed. Of men between 65 and 69 the percentage was only 53 percent and for men 70 and over 28 percent.

To become convinced of the underprivileged existence of most aged persons one needs only to glance at the official government statistics of their pitifully meager average income. In 1958, three-fifths of all persons over 65 had a total income of less than $1,000. Only one-fifth had over $2,000. About half of the couples in which the husband was over 65, and who had their own household, had incomes of less than $2,600 in 1958. Only fifteen percent had incomes of over $5,000. Fully half of the aged population living alone, or with nonrelatives, but not institutionalized, had incomes of less than $939. Nonmarried older persons who were living with relatives had even lower average incomes.

The total 1958 income of the population over 65 was only $25 billion. This represents about five percent of our national income even though the aged constitute almost twice that percentage of the population.

By June of 1958 about 58 percent of all persons over 65 were drawing social security benefits. Social security benefits were never designed to be sufficient to live on. They are grossly inadequate for that purpose. But shocking as it sounds, large numbers of old persons do live on these benefits. They have no other source of income. Monthly old age insurance benefits range from $28.60 to $81.40 for individuals, and from $49.50 to $174 for couples. Benefits average about $72 for individuals. The median benefit for a couple on social security is about $125. Thirty percent of the couples receive less than $100 a month. Old age insurance benefits for widows average $56.

Roughly 2.5 million older persons—sixteen percent of the population over 65—had to seek old age assistance in 1958. For almost two million of these persons it was the major source of support. Assistance payments in mid-1958 averaged only $61 per month. Some half a million persons receive old age assistance as a supplement to old age insurance.

Although a minority of aged persons do own some capital which they have accumulated through the years, the vast majority have no assets. A Federal Reserve Board summary made in 1957 of family units in which the head of a household was over 65 showed that only thirty-five percent had assets valued over $2,000 while forty-five percent had less than $500, or none at all.

Poor Health

The health problems of the aged are more numerous and difficult than those of younger persons. Illness occurs more frequently and is normally more prolonged. The illnesses of age are often recurrences of chronic conditions or permanent impairment of a bodily function. Eight out of ten of the aged suffer from one or more chronic illnesses as compared to four out of ten in the total population.

Partial or total disability and invalidism are not uncommon among the aged. Serious diseases and malfunctions which are considerably more prevalent among aged persons than the young include high blood pressure, arthritis, heart disease, cancer, and vascular lesions of the brain. The latter three are the leading causes of death. A large proportion of the population in institutions providing long range care are aged individuals.

Persons over 65 average over twice as many hospital days in a year as do persons under 65. The National Health Survey demonstrated in a study made in 1957-58, the wide disparity which exists in the health of various age groups. Days of "restricted activity" among persons over 65 were found to be almost three times as high as for persons under 65. Similarly, "bed disability days" were over twice as high, and there were six times as many persons over 65 whose activity was limited by chronic conditions than persons under 65.

Susceptibility to chronic afflictions is, of course, among the major health hazards of old age. Older persons are far more prone to be disabled by crippling long term diseases than are young people. The Senate Subcommittee on Problems of the Aged and Aging reports that the aged constitute over 55 percent of all persons with limitations in mobility due to chronic illness. Senator John Kennedy pointed out in a Senate speech made in January, 1960, that in the last several years, more than 600,000 persons 65 or over died annually of cardiovascular disease. Every year about 300,000 persons 65 or over are totally disabled from rheumatic disease and over 135,000 succumb to cancer.

Because the aged use more medical care than younger persons their average medical expenses are higher. A 1957-58 study by the Health Information Foundation of New York under the direction of Odin Anderson, revealed that the average yearly medical expenditures of persons over 65 was $177, excluding nursing home care. This compared to the $84 average for the rest of the population.

Although the average annual income of persons over 65 is less than $1,000, fifteen percent were found to have average medical expenses of $700, not including nursing home care. The costs of medical care have risen by at least twenty percent since this survey was made. Especially destructive are the costs of long term illness. Secretary of Health, Education and Welfare, Arthur S. Flemming, testified at a Senate Finance Committee hearing that "$6,000 is a conservative estimate of total medical expenditures incurred by persons who are continuously ill for an entire year."

Americans like to think that health care in this country is the best in the world. Actually, while the United States leads in many medical developments, and while the best facilities available in this country are equal to those anywhere, large numbers of Americans are receiving distinctly inferior health care.

Most Western European countries demonstrate lower death rates for certain population groups than the United States counterpart. Within the U. S. itself there are considerable variations between racial and socioeconomic groups and sections of the country. The southeastern and southwestern states generally have the highest infant mortality rates and the highest death rates from communicable diseases.

There is a far higher incidence of ill health among persons at the lower end of the income scale than at the top. Numerous studies exist to document the fact that ill health in population groups varies directly with income. A study made in Michigan, for example, found that among persons with incomes of less than $1,000, 45 percent had one or more untreated symptoms. This was true in only 10 percent of persons with an income of $5,000 or over. Research has also established that nutritional deficiencies are far more common in the lower socioeconomic groups. One study of vitamin C deficiencies in an institutional population found that 42 percent of those with a shortage were in the low economic group. None were in the high economic bracket.

The Negro population has a lower life expectancy than the white population. Differences between Negroes and whites are attributable to the fact that most Negroes fall in the lower income groups, where poor living and health conditions prevail.

Most of the older persons in this country, falling low on the income ladder, cannot afford proper medical attention. Nor is there the same pattern of family care that existed when we were predominantly an agricultural nation. That is why the health of the aged in the United States is not as good as that in countries which offer health benefits to their older citizens. Contrary to popular belief, Americans over 60 have a lower life expectancy than comparable groups in Canada, Cyprus, Denmark, West Germany, Iceland, Israel, Japan, The Netherlands, Norway and Sweden.

Mental Health Problems

No less a problem among the aged than physical health is the maintenance of psychological well-being. The inadequate income of most elderly persons plays a large role here, too. Because they are a marginal group income-wise, the aged must rely more heavily on others than they would need to if they were financially independent. Feelings of dependency or rejection among older people often result in psychological maladjustment. Elderly persons who must live with relatives often create great hardship for the household in which they reside as well as suffering psychologically themselves.

Retirement from gainful activity also occasions a sense of dependency or feeling of uselessness. The problems of adjustment to retirement are extremely grave for a person who has worked his whole life and who lives in a society which looks at inactivity with disfavor. Being cast aside is not easy for anyone.

Chronic depression, melancholia, or overly rigid behavior are prevalent expressions of psychological maladjustment among the aged. Chronic mental illness is also a grave problem affecting large numbers of the older population. The significant relationship between age and mental illness can be seen from figures of first admission rates to mental institutions. These figures, compiled by the National Institute of Mental Health, are for all forms of mental illness per 100,000 population:

2.3 for persons under 15; 76.3 in the 25-34 age group; 93.0 in the 35-54 age group and 236.1 for persons 65 and over.

According to Dr. Maurice Linden, Director of Mental Health in the city of Philadelphia, "it has been estimated that approximately 10 percent of the older group of citizens at any one time have mental problems of sufficient severity to be considered appropriate for institutional care." Dr. Linden reasons that if even half of this number were actually hospitalized "they would occupy all the institutional space available for all diagnostic entities of all age groups throughout the country." His figuring is as follows: 5 percent of the population over 65 is more than 750,000 individuals, a number larger than all of the mental hospital beds available in the country.

The most worrisome feature of mental illness among the aged is that it is increasing at a rate that is more than twice as fast as the growth of the older population. Between 1904 and 1950, while the population over 65 grew by about four times, the number of first admissions to mental hospitals of persons over 65 showed a ninefold increase.

Suicide, resulting from the most extreme and grievous form of mental disturbance, alienation and frustration, is another growing problem among the aged. A recent report, *Mental Health Problems of the Aging and Aged* issued by the World Health Organization, reveals a large rise in the incidence of suicide among the aged in all industrialized countries. The report sees industrialization and urbanization, with the resulting isolation of the individual, as largely to blame for high suicide rates. Mental illness is most common among persons deprived of human contact. The WHO study found that the rate of both mental disturbance and suicide was highest among those aged persons who were living alone.

The High Cost of Health Care

Hospitals and Nursing Homes

The cost of medical care has surged upward at more than double the rate of other items in the family budget. The price of health care began to rise sharply during World War II and has not yet begun to level off. During the post-war period, from 1947 to 1959, the Bureau of Labor Statistics' *Consumer*

Price Index showed an average rise of 24 percent for all items on the index. In the same dozen years medical care rose 49 percent, the largest gain for any item in the price index.

Hospital care is the single aspect of medical costs which has soared the furthest. In twenty years, from 1938 to 1958, while the price index rose 105 percent, the cost of hospital care gained by 300 percent. In the period from 1947 to 1959 costs of hospital care rose 105 percent, more than double the 49 percent rise for all medical costs.

A two-year study of nonprofit health insurance plans by Columbia University made available in June of 1960, estimated that hospital costs would rise by at least another 50 percent between 1957 and 1967. Dr. Ray E. Trussell, director of the study and chairman of public health at Columbia's School of Public Health and Administrative Medicine later called the estimate "quite conservative."

A primary reason for the steep rise in hospital costs is the revolution in techniques of treatment which calls for expensive equipment and facilities. Many of the laboratory and medical procedures which are basic to a modern hospital were unknown only a few years ago. Almost all hospitals now have such items as clinical laboratories, diagnostic X-ray, metabolism and electrocardiograph units and such services as bloodbanks, electroencephalographs and physical and X-ray therapy units are becoming available in an ever larger number of hospitals. Not only are these techniques and the equipment needed expensive in themselves, but they utilize valuable space and require operation by trained personnel.

Costs of building, repairs, general equipment and administration have also risen greatly. Hospitals today have a demand for skilled manpower in a large variety of capacities—laboratory technicians, nurses, therapists, social workers, dietitians, etc. Shortages of trained professionals of this kind have prevailed in recent years forcing salaries higher. Unskilled hospital employees, notoriously underpaid in most places, have also recently been active in seeking fairer wages.

Because payroll costs for most hospitals reflect roughly three-quarters of the rates charged to patients, better pay for employees is bound to raise hospital costs still further. As hospitals operate on an around-the-clock basis, the general reduction in employee work hours has also contributed to higher payrolls. Hospitals do not "produce" in the same sense as an industrial concern "produces." Salary increases, therefore, obviously can not be cushioned by increases in "production."

One other important change has contributed to the rise in hospital rates—the higher utilization of hospital facilities. There has been a significant increase in the number of persons going into hospitals. Modern medical techniques have reduced the average length of stay in hospitals but increased entry has served to nullify the hospital use thus saved.

The average length of stay decreased from 9.1 days in 1946 to 7.6 days in 1957. However, the total days of hospital care per 100 persons in the population actually went up in the same period, from 89 per 100 in 1946 to 93 per 100 in 1957. Hospital costs for services and administrative expenses are higher per day for a short stay than a long stay. The combination of more stays for shorter periods serves to raise average per day costs. The inadequate compensation received from public agencies for care given to indigent patients also contributes to the financial squeeze in which hospitals find themselves.

The services provided in many hospitals leave a great deal to be desired. The facilities and buildings used are often outmoded. For reasons of economy many hospitals have been forced to curtail important functions, especially outpatient and emergency services.

Nursing homes are an especially bleak spot on the American health care landscape. These homes, which serve primarily as long-stay institutions, have come into increasing use in recent years. There are now some 25,000 private nursing homes with a total of 450,000 beds. The number is still insufficient. A study of private nursing homes made by the Public Affairs Committee of New York City and released in June 1960, stated that an additional 323,000 beds were needed immediately. The report concluded that the demand for an intermediate kind of service between the hospital and home care would continue to expand along with the growth in the older population.

By far the largest proportion of nursing home beds are occupied by aged persons. A 1953-54 survey of proprietary nursing homes revealed that 90 percent of the patients were

65 and over. One half of all the patients financed their stay in part or in whole by public assistance. Because so large a proportion of nursing home patients depend on inadequate public assistance grants or social security benefits to meet the costs of residence, good service is bound to be the exception. Public assistance or social security benefits are simply too low to support even the most rudimentary or Spartan standards of care.

Prevailing conditions in large numbers of nursing homes have been described by health authorities as "disgraceful" and "scandalous." Most use antiquated buildings, many lacking any kind of fire preventive devices. Overcrowding, lack of medical supervision, and makeshift quarters are common. Patients are often ignored, or subject to oversedation or even abusive treatment. Too many nursing homes take in persons, such as tubercular or mental patients, for whom they are not equipped or licensed.

The Fee For Service System

The prestige and popularity of the medical profession is at ebb tide. Complaints about unusual or irregularly high fees abound. Charges of "gouging" are rife. The "fee for service" system, long deified by the medical fraternity, is coming under increasing fire. Yet most physicians continue to cling to this archaic system of payment under which the doctor is himself the sole arbiter of what his service is worth.

By historic precept the physician is presumed to adjust his fee according to his own notion of what the patient can afford to pay. As a method of payment such a "fee for service" system may have been suited to the era of family doctors and home visits, but it is far from satisfactory in the days of specialization, complicated surgery, hospital care, laboratory services, etc. Dr. James Howard Means, a former president of the American College of Physicians, observed in his book *Doctors, People, and Government* that:

> Doctors by and large tend to work too long and too hard either for their own good or for that of their patients. The competitive nature of their work is largely responsible for this situation. The fee-for-service method of payment, in my opinion, is the chief source of trouble. Under that system of private

practice, the more fees he collects the better off the doctor is. Naturally he works hard to get them and charges what the traffic will bear. . . .

Fee-for-service is scientifically indefensible, because it makes little if any provision for preventive medicine, and because it actually makes the patient reluctant to call the doctor even when really ill. For most laymen it makes medical expense unbudgetable. Organized medicine nevertheless clings to it and is willing to fight to the last ditch to retain it.

A prime reason physicians are able to command fees that often are inordinately high is the shortage of doctors in the United States. In 1900 there was one doctor for every 578 persons, by 1957 there was only one doctor for 935 persons. Even these figures tend to overstate the actual number of physicians available to patients, however, because doctors doing research or otherwise not actively practicing medicine are included.

As the population of the nation increases, and especially the aged population, which has a greater need for physicians, the number of doctors is becoming less and less sufficient. The existing shortage of research physicians is very grave. Medical schools have difficulty in recruiting staff. The shortage of physicians in mental hospitals and public institutions which cannot compete salary-wise is especially acute.

The most unfortunate aspect of the shortage of physicians is that it is largely unnecessary and artificially created. There are not enough medical schools and they are not turning out enough doctors. The American Medical Association for many years actively sought to limit the supply of physicians. It has minimized the need for additional medical schools and has vigorously fought every attempt to build more schools or expand existing ones with government aid. Doctors of medicine, or at least the key organization representing them, have thus consciously created a scarcity of their own kind. This may have been in their selfish monetary interest, but it has obviously been detrimental to the public interest.

The scarcity of practicing physicians is made worse by the fact that they are unevenly spread throughout the nation. A disproportionate number of doctors practice in the wealthier sections of the country, especially in large cities, where they can command the highest fees. Even here, however, the number of physicians is far from abundant, as anyone knows who has ever tried to get a doctor to his home in time of stress. The scarcity of doctors in rural areas, where the income of the population is low, is very great.

The worst effect of the shortage of physicians is not that it contributes to the high cost of medical care, even though this factor causes hardship to millions of persons. The cruelest result of the shortage is that suffering and illness are prolonged and lives lost—needlessly.

The shortage of physicians has now become so acute, and the pressures for government action so great, that the AMA has had to beat a retreat. In an effort to head off legislation to provide federal funds for tuition and subsistence of medical students, the AMA has developed its own "plan" which would create fifty medical school scholarships.

Aid to fifty medical students a year cannot be considered as even a drop in the bucket. Yet it gives evidence of mounting concern among the medical brotherhood about the damage their policy has wrought. "A few years ago we wouldn't have given such a proposal serious consideration," Dr. Walter S. Wiggins, secretary of the AMA's Council of Medical Studies, was quoted as saying by the *Wall Street Journal.* ". . . Today, it's one of our most urgent moves."

There is a widespread feeling that the dominating influence of the self-seeking medical trust over the health scene must be broken and that the balance in the economics of health care must shift significantly toward the consumer. Many observers of medical economics share the opinion of Richard Carter who wrote in *The Doctor Business,* published in 1958, that "man is no longer so credulous as to remain forever convinced that only physicians are qualified to establish the health policies of a nation." Mr. Carter believes that it is imperative that the public "upgrade medicine from the bazaar." He says:

> As the payers of bills, consumers are in position to modify the catch-as-catch-can fee system and put medical economics on a rational basis. This obviously cannot be done by the individual patient from his sickbed. It is a problem for healthy people, a group problem, a community problem, and in many respects, a national problem. It can be solved by consumer

> organizations in negotiation with groups of physicians or, if necessary, it can be solved by legislation. In scattered sections of the United States, progress has already been made. . . . So far as I have been able to discover, progress of this kind has never been made at the initiative of organized medicine.

Administered Drug Prices

No discussion of the cost of medical care would be complete without mention of the shocking revelations of administered prices in the drug industry made by the recent investigation of the Senate Subcommittee on Antitrust and Monopoly Legislation headed by Senator Estes Kefauver (D., Tenn.).

The high cost of drugs is of immediate interest to everyone, especially aged persons. Over a quarter of the $16.5 billion spent on medical care in the United States in 1958, went toward drugs and medical appliances. Even more money was spent in 1958 for drugs than for doctor's services.

The cost of prescriptions has gone up by about a third in the last decade. Sales of "ethical" pharmaceuticals—those drugs sold only by prescription and advertised only to the medical profession—totalled roughly $2 billion in 1959.

The Kefauver inquiry turned up startling evidence on the pricing practices of the leading drug firms. Incredible price markups—some ranging up to 10,000 percent—were brought to light. One example was a markup of 7,079 percent by the Schering Corporation on estrogen hormone drugs, used in the treatment of female ailments. Merck and Company, another pharmaceutical concern, charged druggists $170 for 1000 tablets of a steroid hormone drug which cost only $13.61 to produce. Carter Products sold Miltown, a widely used tranquilizer, for 5.1 cents, although it cost only 7/10 of a cent to make. Many other examples were put into the record. (See: *How to Get Safe Drugs and Cut Their Cost,* by David Cushman Coyle, Public Affairs Institute, 1960).

The toll taken by these practices in terms of human suffering and deprivation can only be imagined. Testimony was given that many persons were confined to mental hospitals who could remain in the community if they were able to pay for the high cost of certain tranquilizer drugs. Many aged sufferers of arthritis are unable to gain relief because the cost of cortisone derivatives is too high. Indications of dismay among older persons about staggering drug prices abound. The Kefauver committee received over 10,000 complaints within a few weeks about the cost of drugs. The American Association of Retired Persons and its affiliate, the National Retired Teachers Association, have set up a mail order pharmacy to sell drugs to their 640,000 members at discounts. This is only one evidence of growing consumer resistance.

Among the facts brought to light by the subcommittee was that small drug firms often sell the same drugs as large firms at far lower prices. The price to the druggist of 100 five-milligram tablets of prednisone, a drug used for the relief of arthritis, for example, when sold by Shering, a major producer, was $17.90, a markup of 1,863 percent. At the same time Nysco Laboratories, a small firm in Long Island, sold the identical product for $2.70.

It was also revealed that drugs identical to those sold in this country under trade names sell in other countries for a small portion of the price. However, the major American producers, by expensive advertising campaigns directly to doctors, the use of "detailmen" sent to persuade physicians to prescribe drugs by brand name, and other tactics, are usually able to corner a large portion of the market despite wide price differentials.

Advertising campaigns do not always maintain the high level that drug manufacturers pretend they do. In a 1959 campaign Pfizer Laboratories mailed to every physician in the country a release describing a new antibiotic which included the names and addresses of eight doctors using the drug. The *St. Louis Post Dispatch,* in checking on the doctors listed, uncovered the fact that they did not exist.

Through monopolistic practices the drug industry has been able to make large profits at the expense of ailing Americans. A study made by the Federal Trade Commission has revealed that the drug industry has a higher rate of return on its investment after taxes than any other industry. The return for the drug industry, in the figures given by the FTC, is 21.4 percent as compared to such other high-profit industries as automobiles at 15.5 percent, and steel at 12.4 percent.

The drug industry has attempted to defend its pricing policies on the ground that it spends a great deal of money on research, some of which never leads to saleable products. However, a subcommittee study of 20 major drug firms demonstrated that research accounted for only 6.4 percent of all revenue. The profit, after taxes, of these companies, on the other hand, is 13.1 percent of revenue, and sales activities accounted for 24 percent of revenue.

Testimony before the subcommittee also indicated that much of the "research" being done by large drug makers is directed at finding minor, patentable, variations of successful drugs already in existence. The major result of research by drug firms is thus a rapid obsolescence of drugs rather than genuine medical progress.

Perhaps the most depressing aspect of the revelations made in the pricing of drugs is the reaction of the industry to the investigation. Industry spokesmen expressed great resentment of the inquiry, as if a topic of such immediate and immense concern to so large a body of citizens was beyond the legitimate role of investigation by Congress. Rather than acknowledging the antisocial results of its policies and seeking to change them, it has stubbornly defended and attempted to justify its actions. Typical of this attitude was a speech delivered on December 9, 1959 by Dr. Austin Smith, president of the Pharmaceutical Manufacturers Association, before representatives of leading drug companies. He said:

> I am sure that all of us feel the greatest compassion for elderly people who find it difficult to pay for medication. If the pharmaceutical industry is at fault here, it is because it has helped to create a pool of millions too old to work by prolonging their lives.

Numerous measures to curb drug firms have been suggested. A more vigorous enforcement of existing antitrust and food and drug laws is clearly called for. Amending the latter to require the Food and Drug Administration to pass on the efficacy and usefulness as well as the safety of new drugs would serve to discourage the endless introduction of nearly identical drugs under new brand names. A revision of the patent laws in regard to drugs may also be required. Some critics of the existing practices believe that only actual price control of drugs by a federal agency will bring the large drug makers into line. Other observers hope that public discussion and exposure will result in the same end. They feel that if the public can be made aware of the situation, and if doctors can be persuaded to prescribe drugs by generic rather than brand names, the large producers will find price gouging practices difficult to continue.

Existing Methods Cannot Do the Job

Free Medical Care

The reigning philosophers of organized medicine talk at great length about free medical care. Their leitmotiv is that anyone in the country, old or young, can obtain medical attention if he needs it.

This statement is true only in the narrowest and most literal sense. But the theme brims over with hypocrisy. Free care can be obtained by needy persons only in the most humiliating way. The myth of abundant free care for anyone that needs it would soon be exploded if the offer had no strings attached, for the offices of physicians would be filled with persons ready to accept it.

Some four million men over 65 and women over 62 are not eligible for Old Age, Survivors, and Disability Insurance. About a quarter of the aged are thus left entirely to their own devices in supporting themselves and maintaining their health. To the substantial majority of aged persons who have woefully inadequate or no health insurance, and who are unable to pay for medical care on a private basis, few alternatives to public assistance are available.

Private hospitals do provide some "free" care, but it is increasingly limited and restricted. Some of this service is paid for by endowment funds or private contributions, but mainly it is financed by charging higher rates to self-supporting patients. As costs climb many private hospitals are curtailing or eliminating free services to indigent patients.

Public hospitals provide free care, or care at reduced rates, to indigent persons. This "free" care, however, is usually accompanied by a severe means test which is humiliating and even debasing to the person forced to submit to it.

Municipal hospitals in New York City, for example, have a rate of $28 per day. When lower rates are charged the patient is made to undergo a financial investigation of his assets—bank deposits, insurance, real property, etc. All his personal financial affairs are gone into, and even his income-tax returns are inspected.

There are many places in which no free public or private care is obtainable. In these areas public assistance becomes the sole manner in which an individual without funds can obtain any medical help. If the needy person happens to be ineligible for public assistance, he must entrust his case to whatever private charity is available.

Public Assistance

The old age assistance title (Title I) of the Social Security Act is meant to meet the needs of elderly persons with no other source of support. Old age assistance in many states is grossly inadequate, and especially so in relation to medical care.

Public Law 877, passed by the 86th Congress, liberalized public assistance payments somewhat, but it appears doubtful that it will have any great effect on the general public assistance picture. Many states, hard pressed for matching funds, have already indicated an unwillingness to participate.

A number of states now impose arbitrary maximum limits on public assistance payments to individuals which are designed to meet their bare subsistence needs. When emergency medical needs arise in addition to the other demands of living the situation for the recipient often becomes desperate. The sum put into the program by states varies considerably. In 1958, the Federal Government carried 80 percent of the total burden of old age assistance in Mississippi, but only 33 percent in Connecticut. Other states ranged in between.

The pattern of aid available through public assistance is extremely uneven. There is a deficient legislative base for the program in many states, and inadequate appropriations and administrative complexities add to the difficulties encountered.

Many older persons suffer and go without care rather than apply for help from a public welfare agency because of the "need" test. Often sick persons will greatly aggravate their condition by not seeking aid. When they finally do get help it may be too late. In the case of many dangerous diseases like cancer it is vital that the illness be diagnosed and treated at an early stage. But most persons tend to seek public assistance only when their condition has reached a desperate state.

The "means" test applied in many states is extremely harsh. Laws often require that liquid assets be almost entirely exhausted and the amount of assistance received may constitute a lien against other assets. In some states relatives must contribute toward the support of the needy person before any money can be made available. This requirement adds to the reluctance aged persons feel about applying for public assistance. It imposes an obligation on relatives whose own resources may be limited.

Tightly administered "need" tests also serve to eliminate from eligibility older persons whose income is sufficient for everyday living but who cannot cope with extra medical expenses. In some jurisdictions needy persons cannot get any aid, no matter how dire the circumstances, if they do not fulfill residency requirements, which may demand up to one year's continuous residence in the local jurisdiction. As population mobility is considerable in the country today, residence requirements for public assistance impose an added hardship on untold thousands of people.

In testifying before the Ways and Means Committee Walter Reuther, president of the United Automobile Workers, compared medical care provided through social insurance to medical care given through public assistance in the following way:

> Is it better to have a system of insurance which spreads the cost over a long period of the working life of a worker, in which he shares the cost with the employer, in which he gets benefits as a matter of right, not as a matter of public charity, in which he gets his medical care needs met with a sense of dignity?
>
> Or do we want a program of public charity which inadequately meets these needs, forces a worker to go through a means test, forces him into all kinds of embarrassments, loss of a sense of social status and worth and dignity, in order to get access to basic health care? A relief system may cater to the needs of the physical man, the outer man, at the cost of demoralizing the spiritual inner man.
>
> What we want is a system that will provide medical care to the aged who need it, as a matter of right, with head up, with a sense of dignity.

Few Aged Are Covered By Insurance

Few older persons can afford the high premiums charged by private insurance firms to cover the financial risks of illness in later life. While voluntary health plans have gained wide use and acceptance in recent years, this is not true among aged persons. The most popular insurance—hospitalization—was bought by less than ten percent of the population in 1940. Today about 70 percent of all Americans have some measure of insurance for hospital care. But for older people, it is another story. Although no accurate statistics are available, indications are that at best only 40 percent of the population over 65 has any hospitalization insurance at all.

The disparity of coverage between the aged and the total population is even greater for insurance covering surgical care than it is for hospitalization. In 1957, 65 percent of the total population had insurance covering some surgery. A year previous to this, only 24 percent of the aged had some surgical expense insurance coverage. There is nothing to indicate that the gap has been closed perceptibly since then.

Statistics on the number of persons covered by health insurance are limited by the fact that they are gathered largely by means of surveys or polls. People who only *believe* they are insured are usually classed as covered. A 1957 survey of persons receiving social security benefits found that many recipients who were classified as covered by hospitalization insurance got no benefits when actually hospitalized. Because of cancellations or limitations written into policies, because insurance has unknowingly run out, because persons mistakenly believe they have insurance when they do not, or because persons are unwilling to admit not having insurance, figures on coverage are very often overstated.

Private Medical Insurance

There is no longer any doubt that privately run health insurance cannot meet the needs of older persons. Private health insurance fails for three reasons: 1) Costs are high, usually prohibitively so. 2) Policies are often unavailable. 3) The benefits are inadequate and the restrictions imposed seriously limit coverage. These facts are interrelated.

Because elderly persons need more medical attention than the rest of the population they are poorer "risks." As they are considered bad "risks" by most old line insurance companies, they either cannot get insurance at all, or only at forbiddingly high rates. When the premiums charged are proportionately lower, benefits are naturally lower, too. Many policies available to older persons are so hemmed with restrictions and limitations as to be almost useless.

The great majority of persons over 65 who buy health insurance are able to do so only because they have continued insurance begun at an earlier age. It is extremely difficult for a person over 65 to purchase any adequate health insurance if he has not had it before.

In 1957, the *National Underwriter* checked 104 insurance companies and found that only ten of them had no maximum age beyond which health insurance could be purchased. Fully half the companies would not sell insurance to anyone over 65 under any conditions. Even where age is not automatically a disqualifying factor, the applicant may be rejected on the basis of his medical history or physical condition. Comprehensive statements on the health of the applicant for insurance are almost always demanded and standards of acceptability are rigid. In many cases insurance companies can also refuse to renew a policy once an insured person has been ill.

Blue Cross and Blue Shield

Over 1,000 organizations in the country sell some form of health insurance. Largest and best known are the Blue Cross and Blue Shield plans. Two thirds of those people over 65 who have some kind of health insurance belong to Blue Cross. Blue Cross normally sells only hospitalization insurance and Blue Shield normally sells only insurance for surgical expenses. In several places, however, the plans are combined or one fulfills the function of the other.

Blue Cross and Blue Shield, regarding themselves as "service" organizations, run on a nonprofit basis, have made a real effort to maintain coverage for the aged. This attempt has taken its toll. Commercial companies which provide cheaper rates by excluding older persons are successfully undercutting Blue Cross and Blue Shield. Commercial companies have made inroads by selling health insurance to employee groups that exclude retired persons from participation. Active employee groups often fight the retention of coverage for retired workers so as to keep rates at a minimum. The result has been that commercial companies have managed to skim the "cream" off the market, i.e. young active individuals, while Blue Cross has gained an even larger percentage of old persons.

The outcome of this trend is serious financial difficulty for Blue Cross. It largely explains the fact that Blue Cross plans lost $8 million in 1957 and went into the red by fully $40 million in 1958. In an article in the *Reporter* magazine of October 29, 1959 discussing the financial difficulties being encountered by Blue Cross, Edward T. Chase presents this assessment of the situation:

> The plain fact is that unless the healthy, productive young partially subsidize the ever larger number of aged by paying for more than their 'actuarial' share, the aged will be confronted with impossibly high rates and Blue Cross will inevitably have to abandon community-wide nonprofit service.

The real fear among observers of the competition between Blue Cross and commercial companies is that Blue Cross, to survive, will have to adopt the tactics of its competitors. Blue Cross plans may be forced to introduce more restrictions into their policies, limit coverage, or reduce benefits. A few plans are already experimenting in selling insurance with narrowed eligibility.

The grave financial difficulties Blue Cross finds itself in, lend impressive weight to the view that no private scheme, even one that is nonprofit, can hope to solve the problem of adequately insuring the nation's aged population against the costs of health care.

High Cost of Insurance

There are surprisingly large variations in the cost of health insurance, even among similar types of insurance. Differences in various parts of the country, in benefits, restrictions, etc., make it difficult to summarize policy costs. Noncancellable policies, for instance, are considerably more expensive than cancellable insurance.

Blue Cross plans differ considerably in the cost of premiums and the amount of benefits. The number of hospitalization days provided by 1958 Blue Cross plans ranged from three weeks to a year. Blue Cross, unlike most other private health insurance, pays hospitals directly for benefits they provide. It does not pay cash to the insured patient against his expenses.

Hospitalization plans vary as to the type of facilities paid for—most allow semiprivate accommodations, some allow only ward care. Coverage of other charges such as operating room, X-ray and laboratory services, also varies.

In 1958, the annual cost of Blue Cross group conversion plans, i.e. group insurance that is convertible to individual insurance, ranged all the way from $19.20 to $87.00 for individuals, and from $51.00 to $200.80 for families. The median cost for individuals was $42.20, for families it was $84.70.

The cost of Blue Cross and other insurance is going up, in various degrees, everywhere. In 1958, 29 of the 78 Blue Cross plans boosted their rates. Rates in many places have climbed sharply since then. Blue Cross in New York requested a 37 percent rise in 1960. These rates are more than the ordinary retired person, living on a modest pension, can afford. They are clearly prohibitive to an aged individual doing his best to eke out an existence on his social security benefits of $75.00 a month.

Insurance companies have made available some hospitalization and surgical policies designed for groups of retired individuals. Insurance industry spokesmen claim these policies answer the needs of the aged. Even a cursory examination of the policies, however, shows how far they fall short of adequate health insurance. Rates on the policies are even farther beyond the means of the average retired person than Blue Cross. Benefits are embedded with restrictions.

A typical policy costs $72 a year per person. Benefits are limited to $10 per day for 31 days of illness, half of miscellaneous hospital expenses up to $125, and surgical expenses up to $200. Half a year must pass before payments are made again on the same or on any related illness. These benefits are obviously inadequate to cover the costs of care in a modern hospital. Ten dollars is only about half of the average cost for room and board in a hospital. "Miscellaneous" expenses mount rapidly in today's hospital bills, often exceeding the cost of room and board. A third of all hospitalizations among persons over 65 last more than the 31 days allowed.

The markup commercial insurance companies use on many kinds of health insurance is disturbingly high. Blue Cross is not vulnerable on this ground; 97 percent of Blue Cross income was paid out in benefits in 1958. Blue Shield did somewhat less well—slightly under 90 percent was paid in benefits by the 66 Blue Shield plans. Companies selling insurance to groups paid out 85 percent in benefits.

The markup on individual insurance, especially noncancellable individual insurance, is astounding. Information supplied to the Ways and Means Committee by the Department of Health, Education and Welfare, shows that only 48.6 percent of premium income received on individual cash indemnity accident and health insurance was returned in the form of benefits. And only 40.8 percent of premium income on noncancellable individual insurance was paid out in benefits.

Making Better Use of Facilities

Overuse of Hospital Facilities

An unfortunate by-product of the increased use of hospitalization insurance is the overutilization of hospital facilities. Patients prefer to enter a hospital even when their condition does not warrant it to get their "money's worth" out of their insurance. Physicians, as often as not, go along with the patient's wish to enter the hospital. They often prefer to have their patients hospitalized, rather than scattered about, to make their own task easier.

This abuse of medical insurance results in further packing already overloaded hospitals, and contributes to the high cost of hospital care. Where such hospitalization is unnecessary the blame must be put on the physician, without whose recommendation the patient cannot be admitted to a hospital.

The same thing is true of physicians who perform surgery that is not needed. Every time a doctor allows a patient to enter a hospital unnecessarily he adds to the cost of medical care and insurance. The physician who performs unnecessary surgery is even more culpable. For in addition to overloading hospitals and draining insurance funds he unnecessarily endangers the life of the patient.

In a perceptive article on the role government should play in medical care in the September, 1960, *Atlantic,* Dr. Osler L. Peterson observes that:

> The practice of medicine presents many situations in which choices between action and inaction, surgery or medical treatment, hospital or ambulatory care must be made. The pressure is usually on the doctor to 'do something.' The decision runs the risk of being biased when 'doing something,' such as surgery, means a larger fee.

Unnecessary surgery or hospitalization can and does occur through misjudgment or error unrelated in motivation to the fee involved. Nonetheless, examples of questionable or incompetent surgery abound. The United Mine Workers Welfare and Retirement Fund first began to build its own hospitals and hire its own doctors following a bitter dispute over this issue with physicians in coal mining areas.

There is mounting evidence to indicate that fees tend to climb, and surgery more likely to occur, when paid for by insurance. Doctors are more prone to recommend an operation when they know that the patient is covered by a suitable surgical plan. Any successful government-sponsored health insurance will have to meet the problem of unnecessary use of hospitals and unnecessary surgery.

Some of the proposals for federal health insurance for the aged furnish incentives for home and outpatient care and in so doing would help to eliminate needless entrance into hospitals. Some degree of control over the need for, and quality of, surgery must also be introduced into any prepaid plan for surgical care if unnecessary operations are to be avoided.

Preventive Medicine

A problem closely related to the unnecessary use of hospital facilities is the tendency to overstress curative care in hospitals at the expense of preventive care. When hospital bills are more or less covered by insurance there is a tendency to neglect the preventive and rehabilitative aspects of medical care. Too much stress is put on treatment only within hospital walls. This approach is especially noticeable in the treatment of the aged. Dr. Berwyn F. Mattison, executive director of the

American Public Health Association, told the Senate Subcommittee on Problems of the Aged and Aging that:

> A number of diseases which contribute very considerable numbers of disabled or bedridden patients in the later years can be reasonably well controlled if detected early. For some of these the methods of early detection are being very inadequately utilized. . . . Because, as yet, at least, we can't prevent aging, there has been some tendency to assume that preventive medicine had little to offer in this segment of our population. Nothing could be further from the truth.

More effective use of rehabilitative and preventive medicine is dictated on the grounds of both economy and good medical practice. A great deal of experimentation is still needed to determine the best organizational arrangements for the care of elderly patients. Hospitalization insurance has forced too much use to be made of facilities actually designed only for the acutely ill. More economical and probably as effective use can be made of various outpatient arrangements and home care.

The day-hospital is a new type of unit which will probably receive increasing use for convalescent patients. It is especially appropriate for aged persons. The report on the mental health problems of the aging by the World Health Organization states:

> The day-hospital has the immense advantage that the place of the old person within the family is not disturbed, for many seem only too willing to continue looking after their aged provided they are relieved of caring for them during most of the day. A wide range of treatment for both psychiatric and physical disorders can be satisfactorily provided on a day-hospital basis. The unit is comparatively cheap to run, is economical of nursing staff, and can cater to large numbers on relatively small premises.

Errata: (bill numbers reversed)

L. 2 is H.R..12580
L. 20 is H.R. 4700

Part II

FILLING THE NEED

When, on September 13, 1960, President Eisenhower signed into law an omnibus social security bill H.R. ~~4700~~, it provided 12580 the anticlimactic finale to a titanic battle waged in the 86th Congress over health care legislation. The bill, which became Public Law 86-778, includes provisions to increase old age assistance funds for medical services for needy aged persons. It satisfied no one but the conservative coalition which had used it to successfully sidetrack serious, full scale measures to deal with the health needs of the older population on a permanent basis.

The pressures on Congress from all sides during the debate were intense. "No other question," reported the *New York Times* on April 11, 1960, "is producing anything like the volume of congressional letters and postcards, and none has caused greater political discomfort among members up for re-election next November."

Like most important legislation, the proposals that received the most attention were tailored to the demands of the political situation. The major Democratic measures—the Forand bill 4700 H.R. ~~12580~~, the McNamara bill S. 3505, and the Anderson amendment to H.R. 12580 all used the "social security approach"—i.e., the Old Age and Survivors Insurance mechanism—to provide health benefits. The Eisenhower administration proposal S. 3784, and the Javits bill S. 3350, were the most significant measures using alternative approaches.

The failure to pass a meaningful health plan does not end the story. With twenty percent of the nation's eligible voters now 60 or over, health insurance for the aged will continue to have profound political significance.

Proposed Solutions

Past Legislation

Past health proposals have generally fallen into one of four categories: 1) federal protection or subsidization of private insurance carriers, 2) federal grants-in-aid to states to improve health care, 3) national health insurance, either federally operated or administered through the states, and 4) health insurance as a part of the Social Security System.

Some proposals of the first type exempted private insurance companies from the antitrust laws, others regulated the terms under which health insurance could be sold e.g., prohibited unilateral cancellation of medical insurance policies on the part of the company. Several bills sought the creation of a federal reinsurance corporation which would repay insurance companies from federal funds on large claims or on net losses incurred.

Numerous bills providing grants-in-aid to states for the improvement of medical care have been introduced by both Republicans and Democrats. The late Senator Robert Wagner of New York sponsored a bill in 1939 to aid states in paying for medical services and supplies. Former Senators Robert Taft and Henry Cabot Lodge, Jr., also introduced legislation of this type, though of a more limited nature.

The most furious legislative battles of past years have raged around proposals to establish a federally operated system of insurance. Many such bills have been introduced. One of the first, in 1938, required coverage for all nonagricultural employees earning $1,800 or less in a health scheme providing both hospitalization and physician's services as benefits. Other persons could enter the plan on a voluntary basis.

The well known national compulsory health insurance proposal was first introduced in 1943 by Senator Robert Wagner of New York, Senator James E. Murray of Montana, and Congressman John D. Dingell, Sr., of Michigan. The legislation, which became known as the Wagner-Murray-Dingell bill, was reintroduced in the same or similar form in every succeeding Congress.

In substance, this legislation sets up a compulsory scheme of health insurance covering almost all employed civilians. The plan is administered by a National Insurance Board which either clears state plans in those states which choose to run the program themselves, or administers it directly. Benefits include most physicians' and dentists' services, as well as hospitalization and nursing home services. The administering agency in the state determines the cost of services rendered and reimburses the doctor or hospital. Physicians are allowed to choose the method under which they are paid—through straight salary or by services and number of patients.

The Wagner-Murray-Dingell proposal has received substantial support throughout the years since its first introduction. Organized labor, for the most part, has given it enthusiastic backing. The Truman administration favored passage of the legislation. The forces battling this and other proposals involving federal participation in the financing of medical care led by the American Medical Association and the insurance industry, have, however, been successful in blocking its passage.

Several proposals to make health insurance part of the Social Security System have been put forward over the years. In 1942 and for several years thereafter legislation was introduced to extend hospitalization benefits to everyone *covered* by Old Age and Survivors Insurance, and their dependents, a large percentage of the population. Recent legislation would provide medical benefits only to those eligible to *receive* OASI benefits. Senator James E. Murray (D., Montana) introduced the first bill of the latter type in 1952.

Legislation extending medical help to social security beneficiaries has come to the forefront of the struggle for health care due to the realization that these proposals attack that phase of the health scene—the needs of the older population—where the demand is the most immediate and profound. The bill which received the most publicity in the 86th Congress was the Forand bill, named after its sponsor, Representative Aime J. Forand (D., R. I.), the second ranking Democrat on the powerful tax-writing Ways and Means Committee of the House of Representatives.

Representative Forand first introduced his bill toward the end of the first session of the 85th Congress, in August, 1957. He reintroduced it, without substantial changes, as H. R. 4700 in the 86th Congress.

Organizations such as the AFL-CIO which formerly backed the Wagner-Murray-Dingell proposal are now concentrating their efforts on legislation of this type. Many of these organizations still are on record for national compulsory health insurance. The shift in attention is partly tactical—the Forand, McNamara, and similar measures are less controversial and have more support and attack the most obvious problem first.

The Forand and McNamara Bills

The Forand bill establishes a system of health insurance protection within the existing framework of Old Age and Survivors Insurance. It does this by amending Title II of the Social Security Act. Benefits are paid from the Federal Old Age and Survivors Insurance Trust Fund. The program of health benefits would be administered by the Social Security Administration of the Department of Health, Education and Welfare. In utilizing the administrative mechanism already in existence, the minimum possible demands are made for additional personnel and equipment. Records, data, and other invaluable administrative equipment and "know-how" are extended to cover the new program of health benefits, eliminating the need to initiate an entirely new governmental or quasi-governmental agency.

All persons receiving Old Age and Survivor's Insurance under the present social security laws, or who are eligible to receive them, would also be eligible for medical benefits under the Forand bill. This includes men over 65, women over 62, and dependents and survivors of insured persons—an estimated 13.5 million persons in all.

The changes introduced into the Forand proposal by the McNamara bill were the result of prolonged study by the Senate Subcommittee on the Problems of the Aged and Aging.

Among the major criticisms leveled against the Forand bill is its failure to provide for the approximately 30 percent of the aged population not eligible to receive OASI benefits. The McNamara bill aimed at remedying this defect by extending benefits to all men 65 and over and all women 62 and over, *whether or not they are eligible for OASI benefits.* Retired railroad and federal employees are the only persons excluded, but even these groups have an option to "buy in." In doing so, however, it excludes dependents and survivors, as well as elderly persons who continue to have an income. Unlike the Forand bill, it provides that only persons who are actually *retired* can receive benefits. In Senator McNamara's view "it is this group among the aged who have an undeniable need for such protection."

Provision for persons not covered by OASI is an outstanding feature of the McNamara bill, not only because it is intrinsically fair and just and because it answers the needs of perhaps the most deprived portion of all the aged population, but also because it negates a very effective criticism of the use of the social security approach.

Neither the McNamara nor Forand bill provides for the disabled, an unfortunate omission. The exclusion of survivors and dependents from the McNamara bill is also regrettable. Under the Forand bill, OASI beneficiaries are insured for up to sixty days of hospital care a year. Skilled nursing home services are also covered if the patient is transferred from the hospital and treated for the same ailment. The period of combined care in the hospital and nursing home can total up to 120 days a year. Covered hospital services are similar to those usually provided by hospitalization plans such as Blue Cross.

The Forand bill also provides for the payment of surgical services performed in a hospital and certified as being necessary by a licensed physician. Elective surgery, defined as "surgery that is requested by the patient but which in the opinion of cognizant medical authority is not medically required" is not allowed. Oral surgery, however, when performed in a hospital is permitted, as in emergency or minor surgery in the outpatient department of a hospital or in a doctor's office. The patient has a completely free choice among both licensed hospitals and surgeons.

Among the most potent criticisms of the Forand bill is that it leaves too many health needs unmet. *Business Week* reported on April 16, 1960:

> The main weakness of the Forand bill, as specialists in the health field see it, is not that it does too much, but too little. They condemn it as too narrow and as an encouragement to 'hospitalitis'—the tendency inherent in many of our present voluntary insurance programs, to put the sick into hospitals because there are no provisions for covering treatment at home or in doctors' offices.

The McNamara bill strikes at "hospitalitis" by broadening the range of benefits. In addition to increasing hospital benefits from the sixty days of the Forand bill to ninety days, it adds home nursing services, a feature omitted in the Forand measure. These are defined as visiting nurse services provided by a nonprofit agency in the home. Therapy, medical-social and homemaker services are included. The bill allows a patient up to ninety "units of service" a year. A unit of service is equal to one hospital day, two days of nursing home care, or 2⅔ days of home health services. In other words, an individual can use up to 180 days of nursing home services and up to 240 days of home health care, but each hospital day used is equivalent to two days in a nursing home or 2⅔ days of home care. This "unit of service" feature of the McNamara bill is especially commendable because it cuts down on needless use of hospital facilities by providing a strong incentive for home care.

Two other desirable health benefits are included in the McNamara bill. The first provides payment for diagnostic services without hospitalization of the individual. This program would include hospital procedures like blood tests, X-rays, or electrocardiograms. Like home nursing services, this provision cuts down unnecessary hospitalization by making available laboratory services to patients not actually requiring a hospital bed. It achieves the same aim in another, even more desirable way, by making more probable the early diagnosis of serious health problems and thereby preventing the need for ultimate hospitalization.

The second benefit included in the McNamara bill is partial payment for the cost of drugs. All drugs used during periods of hospitalization are covered. Drugs used at other times are paid for when the cost is over a specific amount fixed by the Secretary of Health, Education and Welfare. The drugs must be prescribed by generic names unless the physician states that no substitution for a brand name may be made.

While adding these excellent features, the McNamara bill omits surgical benefits entirely. This deletion seriously weakens the bill as a measure designed to enable elderly persons to obtain adequate medical attention. The high costs of surgery often form a major portion of the bills that must be paid when serious illness strikes.

Medical coverage that does not protect against the cost of surgery leaves an enormous hole in the fabric of good health protection. The reasons for the omission of this important feature from the McNamara and some other bills are attributable to the priorities of politics rather than the priorities of medical economics. Because doctors are affected most directly by this provision it has been opposed even more violently by the AMA than hospitalization and other benefits.

Many authorities maintain that, especially in the case of the aged, the inclusion of nonsurgical doctor's care in a health insurance bill is equal in importance to the inclusion of surgical or hospitalization benefits. They stress that many aged patients suffer from ailments which require frequent trips to a doctor's office. The total costs of care over a period of time for such a patient are high. These authorities are thus convinced that only legislation which provides comprehensive medical care including all medical and doctor's services can give the aged full health protection. Dr. Allan M. Butler, of the Harvard Medical School, in testimony before the Ways and Means Committee, stressed the importance of nonsurgical doctor's care in the following way:

> It is well known that the major types of illness afflicting the aged are not surgical—they are the diseases of the heart and blood vessels, and nervous system, the degenerative disorders and a wide range of other medical conditions which collectively outnumber the major surgical problems of the aged. Moreover, even the individual requiring surgery frequently must receive care also from a nonsurgical specialist or general practitioner before, during or after surgery. Lastly, regular medical supervision and preventive services are essential to minimize or prevent the impaired health and major disabilities caused by the aging process and chronic disease.

The cost of the medical benefits provided by the Forand and McNamara bills to eligible OASI recipients is paid for by small increases in the taxes paid into the Old Age and Survivors Trust Fund. In addition, the McNamara bill calls for some expenditures from general revenues to cover other retirees.

Both bills raise the payroll tax a quarter percent on both employers and employees and three-eighths percent on the self-employed.

In testimony before the Ways and Means Committee, Secretary of Health, Education and Welfare, Arthur Flemming, estimated the 1960 costs of the Forand bill would be 0.53 percent of the nation's total taxable payroll, or about $1,120 million. Enemies of the Forand bill made wild charges that it would cost two billion dollars. The two billion dollar figure was arrived at by the Health Insurance Association of America. E. J. Faulkner, spokesman for the insurance industry, attributed the large difference between this estimate of cost and that given by Secretary Flemming to "the overutilization of services which we are convinced would develop under the proposal." Other testimony presented suggested a cost below the Health, Education and Welfare figure.

Department of Health, Education and Welfare actuaries believe that cost—put at 0.53 percent of payroll in 1960—will rise gradually in future years. They set the "estimated level premium costs" i.e., the average long-term cost over the period between now and the year 2050 at .79 percent of payroll. This figure, they believe would not be reached until the eighties or nineties, and then would continue to climb gradually after that. Estimates of this kind, however, are difficult to make because they depend on a large number of variables. Often they prove wrong. They become especially hazardous as they are projected farther into the future. Economic factors, unexpected population growth or decline, or any number of other factors can easily change the projections that are made.

The cost of the McNamara bill is estimated at $1.5 billion. The cost the first year would be less—$1.1 billion—because some benefits like drug costs and nursing home care would not become available immediately. Over $1.1 billion of the needed revenues would come from the additional social security payroll taxes, the rest—about $370 million—comes from general revenues. A large part of the latter sum—an estimated $238 million is already being spent on the non-OASI retired aged through various existing government programs. The Federal Government, for instance, contributes about $153 million annually toward vendor payments for medical care under old age assistance.

Both the Forand and McNamara bills specifically prohibit federal interference or control over hospitals or the practice of medicine. They state that "nothing in such agreements or in this Act shall be construed to give the Secretary supervision or control over the practice of medicine or the manner in which medical services are provided."

The Forand and McNamara bills are important landmarks in the history of health care legislation, not because the details of either are perfect or inviolable, but because they form the basic framework from which any sound program will have to be worked out. A broader range of benefits than is provided by either bill should be included if the burden of medical costs faced by older citizens is to be eased in a fair manner. These benefits ought to include physicians' services. An elderly person who needs no surgery or does not have to be hospitalized but whose condition is such that frequent visits to his doctor are mandatory should not be discriminated against. His total medical expenses may be higher than those of a patient with a one-shot illness requiring hospitalization.

The principle of deductibility can be introduced into a Forand-type bill without necessarily doing violence to the principles of social security. Coverage of all medical expenses with some deductibility of initial costs is perhaps more equitable in the long run than complete coverage of a few medical costs. In addition, deductibility of some of the initial expense assures the responsible use of benefits and cuts down on the abuse of medical services.

While both the Forand and McNamara bills quite properly prohibit government interference in the actual practice of medicine and provision of services, this does not mean that the Government should not set up standards of quality. Certainly no federal health plan should pay for inferior surgery or hospital care. Dr. Peterson writes that:

> Instituting some form of prepayment for medical care does not solve the problem of poor or unskilled care.... It is most unlikely that the government would pay the well-trained and the partly trained doctor the same amount for an operation. Indeed, government subsidies of medical care would probably result in the limiting of surgical privileges to the fully trained and certified specialists.

Some experts who are sympathetic to the aims of the Forand and McNamara bills are nonetheless fearful that the country's present capacity to provide medical services of a high quality is not sufficient to meet the additional demand that would be engendered if health benefits were available to the aged. They are afraid that a government health plan would raise prices for medical care even further as elder citizens bid for services against younger people. The fear is legitimate, but probably overrated. Many medical services which are paid for by public assistance or private charity would merely be paid for by the individual through his social security medical benefits. Nonetheless, it is true that insufficient first rate medical services are available. The answer, however, as Walter S. Salant has pointed out:

> . . . is *not* that we should do nothing to enable older citizens to increase their spending on medical services. Rather it is that when we enable them to do so, we should at the same time give equal or greater priority to expanding the supply of such services.

Future health legislation will have to start where the Forand and McNamara bills leave off. For whatever shortcomings these bills have they point down the correct path. The social security approach is far more economically and administratively sound than any other that has yet been suggested.

The Eisenhower Administration's Position

On May 4, 1960, the Eisenhower administration unfurled its program for medical aid to the aged. It came after a long series of delays during which opposing factions within the Administration and the Republican congressional leadership fought over whether the Republicans should come up with any proposal at all and what kind it should be. For much of the session of the 86th Congress the Administration officially opposed any government program of insurance for the aged. On July 13, 1959, Secretary of Health, Education and Welfare, Arthur S. Flemming testified before the House Ways and Means Committee which was holding hearings on the Forand bill. He said:

> We are convinced that the objective of making adequate medical care reasonably available to our aged population should, so far as possible, be achieved through reliance upon and encouragement of individual and organized voluntary action.
>
> Steady progress has been made in extending and improving voluntary hospital insurance coverage of the aged under nonprofit and commercial programs. . . .

In view of the special efforts that are being made by nonprofit plans and insurance companies and in view of the experimenting that is taking place with new methods for extending coverage, it seems to me that we can look forward with confidence to 70 percent of the aged having some form of hospital insurance by 1965.

In the light of this situation, I believe that it would be very unwise to enact H. R. 4700. There is no question but that its enactment would bring to a virtual halt the voluntary efforts that are moving forward in such an encouraging manner.

Behind the scenes, however, Mr. Flemming's confidence in private insurance was not so pronounced. He led the elements within the Administration who were pressing for a strong administration alternative to Democratic proposals. The main opposition centered around powerful Republican congressional leaders and the Bureau of the Budget. The President himself seemed opposed to any program.

Mr. Flemming first attempted to sell the Republican opponents on a mild scheme of federally financed insurance for "catastrophic" illness among the aged. This proposal, in Mr. Flemming's words, would pay only for "illnesses over long periods involving major medical expenses."

When even this feeble measure was rejected by administration diehards, Mr. Flemming resurrected the idea of subsidizing private insurance carriers, a notion discarded by the Administration as impractical in 1957. Under the 1960 version of this concoction the federal and state governments would help to pay premiums on private health insurance policies bought by older persons on a voluntary basis. The size of the subsidy is adjusted to the income of the beneficiary. Mr. J. Douglas Brown, a distinguished economist and Dean of the Faculty of Princeton University, who has had long experience with the Social Security System, demolished this approach in testifying before the Senate Subcommittee on Problems of the Aged and Aging. He said:

This is, at best, a clumsy, hybrid arrangement, involving overwhelming administrative difficulties and excessive costs. It impairs the freedom of both the government and the private carriers to do their proper tasks well. To safeguard public funds, the private carriers would, of necessity, be subject to

> close regulation and inspection concerning costs, benefits, actuarial evaluations, overhead expenses, services, and reserves. For the government and the beneficiary, the economics and convenience of a large and uniform system of protection would be lost. A wide variety of competing private carriers would properly seek to safeguard their own interests as institutions and those of all their policyholders, old and young. The determination of a fair subsidy under diverse and changing conditions would, I am convinced, lead to endless bickering. Meanwhile the government would pay more, the beneficiaries would get less, and the private carriers would trade freedom for little profit and thankless regulation.

On March 22, 1960 a day before Secretary Flemming was scheduled to appear again before the Ways and Means Committee to present his new ideas, the President met with Republican congressional leaders. According to the *New York Times* account, "President Eisenhower, siding with his party leaders in Congress, ruled that the problem should be studied further before the Administration decided whether to submit recommendations to Congress." The next day the hapless Secretary of Health, Education and Welfare, could only weakly tell the Ways and Means Committee that:

> Before arriving at a final conclusion as to whether the Federal Government can devise . . . a practical program, it is going to be necessary for us to explore further some complex issues.

At his press conference on March 30, 1960, the President again called for the development of "a voluntary program" and suggested that "the people that are interested, the insurance companies, the doctors, the older people, everybody that seems to have a real worthwhile opinion" get together and work it out. As for compulsory insurance, Mr. Eisenhower thought it was, "a very definite step in socialized medicine. I don't believe in it and I want none of it myself, I don't want any of it."

Irreverent souls observed that for a man who was so opposed to government participation in medicine, the President has accepted a good deal of "socialized medicine" since his days at West Point. One angry 80-year old taxpayer posed a question to his Senator:

> May I in all fairness ask you and your colleagues how you can vote against this [Forand] bill when from

the President on down to the newest member of Congress, you will get free 'socialized medicine' at either the Walter Reed or Bethesda Hospitals. After all we retired old folks paid the taxes that erected these hospitals for our political boys to have no worries about sickness and its tremendous medical expenses.

The Javits Bill

The Administration's stalling seriously disturbed liberal Republicans in Congress who were worried about the political repercussions of continued inaction. On April 7, after it appeared that no administration plan was in immediate prospect, eight Republican Senators, led by Jacob K. Javits of New York, introduced their own bill. The sponsoring senators made no secret of their impatience with the Administration and their concern about the political appeal of the Forand bill. One of them, Senator John Sherman Cooper (Ky.) said: "I think it is incumbent on our Administration and the minority party to present a positive program."

The Javits bill, S. 3350,[1] sets up a program of joint federal-state subsidization of insurance provided by both commercial companies and nonprofit groups. The federal funds, which are taken from general revenues, would total about $480 million annually; the states' share of the subsidy would cost them about $610 million annually. The program is administered by the states, which also determine the size of benefits. The scope of benefits allowed is wide, including hospitalization, nursing home care, and medical and surgical fees up to certain maximum amounts. Partial payment is also made on the cost of drugs, laboratory tests, and visiting nurse services. The cost of premiums varies from 50 cents to $13 a month, depending on ability to pay. Anyone over 65 is eligible, but participation is voluntary.

While the Javits bill provides a generous spread of benefits, it is open to the same objections as earlier proposals to subsidize private insurance companies. The administrative problems are formidable. With commercial insurance companies eligible to participate there would be little assurance, without a great deal

[1] A later version of the Javits bill was offered as an amendment to H. R. 12580. This version added some features of the Eisenhower administration bill. If all states participated it would cost about $1 billion. Enrollees pay an annual fee of $10 to $12.

of federal supervision and control, that a large slice of the government subsidies would not wind up in the insurance industry's coffers rather than in health benefits for the older population. State governments, already in dire financial distress, would face extreme difficulties in raising the needed funds. An individual's ability to pay could only be established by some sort of "means" test. These are only a few of the more obvious shortcomings of the Javits bill.

The Administration's Bill

Soon after the introduction of the Javits bill the political pressures within and without the Eisenhower administration for a health measure became too great and the opposition to an administration bill folded. When Secretary Flemming presented his plan before the Ways and Means Committee on May 4, it turned out to be far more extensive than had been expected. The expense of the proposal, and the fact that it came under immediate criticism from all sides, appeared to confirm a widespread suspicion that it had been made as a political gesture rather than as a plan which would receive serious administration backing.

The denunciations came rapidly and from every corner. On the right, Senator Barry Goldwater (R., Ariz.) railed at the plan as "socialized medicine" and charged the Administration with having become a "Dime Store New Deal" that talked about balancing the budget but proposed measures for more federal spending. Representative Burr P. Harrison (D., Va.) a conservative member of the Ways and Means Committee termed it "the worst kind of fiscal irresponsibility." "This Townsend plan—Rube Goldberg scheme," he said "is more socialistic and more unsound and ultimately more expensive than the Forand bill." As expected, the AMA was unhappy, too. "The Administration plan is based," said Dr. Louis M. Orr, the association's president, "on the false premise that almost all persons over 65 need health care and cannot afford it."

The comments among those who favored a strong health plan for the aged were equally uncomplimentary. A sample of these included "absolutely stupid" (Robert Meyner, Democratic Governor of New Jersey) "cumbersome" (Nelson Rockefeller, Republican Governor of New York) and "confusing and inefficient" (Senator McNamara). AFL-CIO President George Meany labeled the proposal "worse than no bill at all."

The Eisenhower plan,[2] sets up a "Medicare Program for the Aged" which would be administered by the states under plans approved by the Department of Health, Education, and Welfare. Federal funds are provided on a matching basis with an equalization formula so that the states' share of payments would vary from one-third to two-thirds of the total spent.

The program is open on a "voluntary" basis to all persons of 65 and over whose income in the preceding year did not exceed $2,500. The maximum income allowed couples is $3800. Eligible persons enroll by paying an annual fee of $24, and after that the first $250 ($400 for a couple) of medical expenses. Persons receiving public assistance payments are not required to pay the enrollment fee or the initial $250.

After the initial payment the program pays for 80 percent of all additional expenses. The benefits include: 180 days of hospital care; 365 days of nursing home care, 365 days of home care services; up to $200 for laboratory and X-ray services; up to $350 for prescribed drugs, physicians' services, surgical procedures, dental services, private duty nurses, and physical restoration services. Persons eligible for the program also have the option of purchasing a medical expense insurance policy from a private group with the Government paying half the expense up to a maximum of $60.

Secretary Flemming estimated that with all states participating and with 80 percent of those eligible enrolling, the annual cost of the plan would be $1.2 billion with the states and Federal Government sharing the cost about equally.

When the plan is carefully examined the widespread criticism of it becomes easily understandable. For although at first glance it appears generous enough it is riddled with many defects. In rejecting the social security mechanism it avoids using a tested, working and universally accepted program in favor of an awkward new administrative device. The adminis-

[2] Although presented to the Ways and Means Committee by Secretary Flemming on May 4, the administration plan was never formally introduced as a bill in the House. When Secretary Flemming appeared before hearings of the Senate Finance Committee on June 29, he was criticized for presenting a plan that had not even been introduced as legislation. The following day Senator Leverett Saltonstall (R., Mass.) introduced it as S. 3784.

tration of such a program would be costly and the use of fifty state agencies would make it unnecessarily complicated. As a *New York Times* editorial put it "the complexity and diffusion of administration and control would be little short of bewildering."

Secretary Flemming was reported to have admitted to the Ways and Means Committee in executive session that the per capita cost of administering the proposal would be $17 a year as compared to $6 for the Forand bill. By further draining state treasuries, already sorely strained by lack of adequate tax sources, the plan would put many states into serious financial difficulty. Indeed, there is no assurance that all states would take part in the program, and the aged in each state are therefore put at the mercy of the state legislature or governor. The Federal Government thus abdicates direct responsibility, and the actual decision of whether the program will be adopted, and to what extent the participation will extend, passes into the hands of the states.

The "voluntary" nature of the Eisenhower plan is largely illusory. The taxes used to support the program come from everyone, including those who are not protected in the state in which they reside. Both those elderly persons who receive benefits, and those who are ineligible due to failure to meet the income requirements, continue to pay for the program through their taxes. Presumably few eligible persons would reject the benefits if taxed for them anyway. By the same token, medical benefits made available under a plan using the OASI mechanism could be turned down, too. The only sense in which the plan is "voluntary" then, is that persons with a retirement income of less than $2500 are free to refuse the benefit.

The income test for eligibility is another serious weakness in the Eisenhower proposal. Even aside from the expense and difficulty involved in ascertaining and checking on the income of millions of persons, a means test of this kind converts the benefits into a kind of charity. The elderly recipients do not receive the benefits as something which they have rightfully earned and which properly belong to them but as a form of subsidy to the less fortunate. Inequities in the application of the $2500 maximum income rule would also be inevitable. Those retired persons who by dint of hard work and careful savings managed to provide a modest income for their later years exceeding the maximum figure would certainly be harshly punished for their thrift.

The sizeable deduction on the payment of benefits also makes the plan a good deal less generous than the wide spread of benefits causes it to appear. A patient must pay the enrollment fee of $24, the first $250 and 20 percent after that, a sizeable chunk for individuals whose annual income is $2500 or less, and probably under $1000. A patient with bills that come to $500 must pay $324 while collecting only $200. A person with a prolonged and serious illness that involves major expenses of, let us say, $5000, would owe $1224, about half of the total income allowed for eligibility.

The Legislative Battle

Opposition to Federal Health Insurance

The same coalition of powerful interest groups which for years succeeded in blocking national compulsory health insurance and every other measure for federal participation in health care is continuing an all-out battle against any legislation for medical aid for the aged.

Hard core opposition centers around the American Medical Association and the insurance industry. Groups like the National Association of Manufacturers, the U. S. Chamber of Commerce, and the American Farm Bureau Federation which appear always ready to oppose welfare measures, are lending full support.

Other influential opponents include the American Bar Association, the National Retail Merchants Association, the National Association of Retail Druggists, the American Dental Association, the National Federation of Independent Business, and the American Association of Undertakers.

As usual, the AMA is carrying a large share of the burden of the fight and is putting all of its considerable resources into the fray. The AMA's legislative record is not one to envy. The organization has fought just about every welfare measure ever proposed. In the health area it opposed, among other things, the National Tuberculosis Act, which requires the reporting of TB cases, compulsory smallpox vaccination, federal aid to states to prevent infant and maternal mortality, the creation of public clinics to prevent venereal disease, and free clinics to diagnose cancer and tuberculosis.

The AMA opposed passage of the Social Security Act in 1935 even though it was careful not to present testimony against it before Congress. The *Journal of the American Medical Association* repeatedly warned of the dangers inherent in the Act. In 1939, Dr. Morris Fishbein, longtime spokesman for AMA as editor of the *Journal*, addressing a conference of secretaries of State Medical Associations, denounced social security as "a definite step toward either communism or totalitarianism."

With its long and unenviable record of opposition to about every proposal for government activity in the health field, AMA hostility to the Forand bill and similar legislation was as inevitable as night following day. The grounds for its attitude are less easy to ascertain. "Why," puzzled a *Washington Post* editorial, "the American Medical Association, like the National Association of Manufacturers, should oppose this sensible form of prepayment for the inevitable costs of illness in later life is hard to understand—save as a symptom of the kind of occupational obtuseness which has become a characteristic of the AMA on such issues. Why the doctors should call this system of insurance 'socialistic' passes all understanding."

The fear that the hallowed fee system would be affected apparently underlies the near-hysterical reaction of the AMA to the Forand bill and similar proposals. In reality, passage of a Forand type bill would have little, if any, effect on the fee system. In the words of Senator Stuart Symington, (D., Mo.) "There is nothing in it that would affect the American system of free medicine. This plan deals only with how medical bills are paid. The doctors, the hospitals, the nursing homes, the way medical care is provided—they are all left alone."

The AMA "line" is that government participation is unnecessary because voluntary health insurance schemes can do the job. This argument would be less ironic and more convincing if the AMA had not for many years also bitterly fought voluntary health insurance plans like Blue Cross, as well as group medical practice. In 1933, in the pioneer days of prepaid hospitalization plans, the AMA *Journal* denounced the plans as "half-baked experiments in changing the nature of medical practice." In 1936, Dr. J. Tate Mason, president-elect of AMA, warned that voluntary prepayment schemes "drift inevitably, as do all plans initiated by private groups, into bureaucratically administered compulsory insurance under government control."

When compulsory national health insurance came close to passing under the Truman administration, however, the AMA changed its tune and became a strong advocate of voluntary insurance plans. Under the banner of "The Voluntary Way is the American Way" it has called for the improvement and extended use of voluntary health insurance coverage.

The American Medical Association has never let too much rest on chance or high level debate. Through the liberal use of money and with the assistance of professional public relations firms it has become perhaps the single most effective trade association lobby in Washington.

The AMA's notoriously successful campaign to defeat national compulsory health insurance was carried on with the help of Whitaker and Baxter, a California public relations firm. With $3.5 million to work with, Whitaker and Baxter carried on an emotional appeal, using such devices as pictures of a kindly country doctor accompanied by the slogan, "Keep politics out of this picture. When the life—or health—of a loved one is at stake, hope lies in the devoted service of your doctor. Would you change this picture?" Clem Whitaker, partner in the firm, advised a group of doctors to avoid debates on health insurance because, "They make a forum for the opposition which would be difficult for them to secure otherwise."

Nor has the AMA been laggard in fighting federal health insurance for the aged. The AMA's lobbying campaign against federal health insurance legislation began in early 1958 with the hiring of the New York City public relations firm of Ted Braun and Company. The AMA set up a "Joint Council to Improve the Health Care of the Aged" made up of the American Dental Association, the American Hospital Association, and the American Nursing Home Association, in addition to AMA itself. *Congressional Quarterly* of May 6, 1960 reported that "With the advice of the AMA's public relations firm, the four organizations comprising the joint council set out to prove to the public that they were doing all they could to solve the insurance problems of the aged."

During the first quarter of 1960 the AMA ranked first in spending of the 178 organizations who filed reports under the regulations of the Lobbying Act of 1946. The AMA reported spending almost three times as much as it spent in the same period the previous year. The reports filed under the Lobbying Act are almost meaningless because the lobbying organizations themselves decide what expenditures to include. The law designated no agency to enforce its provisions. Some organizations, the National Association of Manufacturers among them, do not file spending reports at all on the ground that they do not engage in "lobbying." Despite this, the fact that the AMA admitted to spending more than any other organization which filed, and the fact that its expenses increased threefold over the previous year, are probably not without some significance.

The AMA has gone to some strange lengths in its fight on federal health insurance. It has even been urging physicians to reduce fees for elderly persons. Although doctors traditionally have adjusted their fees to the means of the patient, at least according to the theory, it seems hardly fair, even if it were feasible, to ask physicians to subsidize the medical care of the large population of aged. In any event, it is highly doubtful that most physicians themselves are willing to proceed in this direction.

Even if they were willing to substantially reduce fees for older persons, this would still leave the cost of drugs, laboratory fees, hospitalization, nursing home care, etc., to contend with. In an article in *Medical Economics* of April 27, 1959, Dr. Harold J. Peggs wrote:

> All over the country doctors are being asked to accept reduced fees to help beat the Forand bill. This gesture is not only futile, but downright dangerous. . . .
>
> Why must we stand alone? In the name of common sense, why don't we put aside this quixotic gesture? Nothing doctors can do will solve the problem of the aged.

Dr. Peggs is not the only doctor whose position is at odds with that of the American Medical Association. Although the

AMA represents 193,898 of the nation's 228,295 doctors, polls have demonstrated the official point of view of the organization is often not the view of the rank and file physician. Several polls have shown, for instance, that a majority of doctors would like to come under social security. But adamant AMA opposition to coverage for physicians killed this plan in the 86th Congress after it had gained approval in the House.

The AMA does not suffer from an overabundance of democracy. As in the case of some other large national groups, its organizational structure permits an entrenched leadership to perpetuate itself even though it may not be representative of the membership. Important policy decisions of the AMA are made by an entrenched board of trustees which is selected by delegates from state societies, which in turn are composed of delegates selected by county medical societies. AMA office holders on the county level select the delegates. Through an historic system of controlled nominations a tightly held system of political power emerges.

It is difficult for a physician who does not join the AMA to get along. A doctor who is not a member of organized medicine will often not get referrals from welfare boards or from other physicians. He may find it difficult to get certification in his medical specialty or be barred from practicing in the hospitals of his community. A majority of hospitals make membership in organized medicine mandatory to obtain staff privileges. Medical journals are dominated by the AMA and a physician who opposes the official "line" finds it difficult to get material published. The tactics used by AMA are often of a most unsubtle nature. Representative Forand charged that doctors who favored his bill were subjected to extreme pressure:

> A couple of days ago, a very good friend of mine, a doctor, informed me that something was being done that was not in writing, but that the word had been passed around from headquarters of the AMA to the secretaries of the several State societies, to pass the word around to doctors, in an inferential way, telling them that if they should testify in favor of the Forand bill they might be violating the ethics of the profession and subject themselves to sanctions.

Before the 1958 election the AMA sent out a questionnaire to physicians in every congressional district. Among the questions asked were:

Who is the person or persons in each ward or county in the congressional district who is most influential with the Congress?

Who is the physician who knows and can work with each of the above?

Who are the four or five men in the Congressman's district who really influence him?

Who is the Congressman's personal physician at home and in Washington?

What contacts does the medical profession have or who knows the Congressman's top secretariat on his Washington staff?

These questions suggest the use of pressures by AMA, of a kind that are at best, ethically dubious. Commenting on the questionnaire, Congressman Forand merely said: "I am going to leave to you and to others an opportunity to think for themselves whether this was intimidation or an attempt to intimidate or not."

Backing for Federal Health Insurance

A large number of diverse groups representing large numbers of persons is on record as favoring passage of Forand type legislation. The grassroots popularity of health insurance is unmistakable. The drive to win approval of a federal health insurance program has been spearheaded by the 13½ million member AFL-CIO. Local unions around the country encouraged their members to write to Congressmen, which resulted in an unprecedented outpouring of mail reaching congressional offices throughout 1960.

Many unions held meetings to demonstrate support for the Forand bill. One huge rally held in Detroit, on March 27, sponsored by the United Auto Workers, drew 12,000 people to hear the then three leading candidates for the Democratic presidential nomination—Senators Kennedy, Humphrey and Symington, on this issue. On May 18th, another mass rally filled New York's Madison Square Garden with elderly persons who cheered Representative Forand.

The deluge of mail, the rallies and meetings, succeeded in drawing the attention of both legislators and the press to the issue. Front page stories and editorials in the leading newspapers as well as numerous insertions in the *Congressional Record* and floor discussions in both Houses made federal health insurance for the aged in the words of *Life* magazine the "hottest political potato" of the election year.

In addition to labor, other organizations which have given strong backing to federal health insurance legislation include the American Nurses Association, Public Welfare Association, National Association of Social Workers, Group Health Federation of America, National Institute of Social Welfare, National League of Senior Citizens, American Public Health Association, and the Golden Ring Clubs. The American Hospital Association, although officially opposed to the Forand bill, acknowledges that "federal legislation will be necessary to solve the problem satisfactorily."

Congressional Action

The House Bill

The Ways and Means Committee held hearings on social security legislation, including the Forand bill, in June of 1958. Five days of hearings on the bill were also held in July of 1959.

In February of 1959 the Senate created the Subcommittee on the Problems of the Aged and Aging through the approval of Resolution 65 which called on the Committee on Labor and Public Welfare to "examine, investigate and make a complete study of . . . the problems of the aging." Under the chairmanship of Senator McNamara the Committee held extensive hearings in Washington and throughout the country. The hearings invariably touched on health problems. In April of 1960 six days of hearings were devoted exclusively to the financing of health care for the aged. In its initial report the subcommittee termed meeting the costs of health care "the No. 1 problem of America's senior citizens," and recommended the expansion of Old Age Survivors Disability Insurance to include health benefits.

The subcommittee also made a number of other recommendations in the health field: federal action to stimulate and support community health activities; development by the Department of Health, Education and Welfare of minimum standards to be considered as a "floor" for states in their supervision of nursing homes caring for patients receiving federal public assistance grants; and federal aid to nursing homes which meet such minimum standards. The subcommittee made additional recommendations in the fields of income maintenance, employment and housing, and also urged establishment of a U. S. Office for the Aging.

On March 31, 1960 the Ways and Means Committee dealt the Forand bill a grievous blow when it rejected a move to add it to the omnibus bill for social security program revisions. The vote was 17 to 8. Under pressure from the House Republican leadership all ten of the committee's minority members voted against the Forand measure. They were joined by seven of the fifteen Democratic members, including the committee's chairman, Wilbur D. Mills (D., Ark.)

Although Speaker Sam Rayburn announced in April that "If we do anything at all we'll do it through the Social Security approach," the Ways and Means Committee remained impassive. On June 3, after once again rejecting the Forand bill by a vote of 17 to 8, the committee approved a measure which gives barely a nod toward the medical needs of the aged.

The Ways and Means Committee's plan forsakes the insurance principle entirely and, in the name of health aid, provides modest increases in public assistance to take care of heavy medical expenditures in needy persons over 65. A complicated federal grant-in-aid program with optional participation on the part of states is involved. Benefits are available only to those low income individuals willing to undergo a means test. The committee estimated that 10 million persons over 65 would be covered, but that only between half a million and a million would "require" medical services each year.

Termed a "pauper's bill" by Representative Forand, the Ways and Means bill was described by the *New York Times* as a "hand washing performance" on the part of the committee. Two weeks later, on June 23, under a "closed rule" which allowed no floor amendments, the House passed the bill by the wide margin of 380 to 23. Most supporters of an adequate health bill in the House voted for the bill in the full expectation that the Senate would substitute legislation using the social security approach.

The Senate Bill

The strategy proved to be a failure. The Senate Finance Committee, under the leadership of Harry Byrd (D., Va.) who was on record as opposed to a Forand-type bill, held two days of dilatory hearings on June 29 and 30 to prevent any action before Congress recessed for the nominating conventions. The recess began in the early hours of the morning on July 3.

The platforms adopted by both parties promised health care for the aged. The Democrats promised to "provide an effective system for paid-up medical insurance upon retirement, financed during working years through the social security mechanism and available to all retired persons without a means test." The Republican platform, rather cautiously pledged the "development of a health program that will provide the aged needing it, on a sound fiscal basis and through a contributory system, protection against burdensome costs of health care."

Despite the strong Democratic platform, pessimism was rife by the time the Senate reconvened for the short special session on August 8. *The Washington Post,* a staunch advocate of health legislation, advised Congress to exclude consideration of the issue from the short session because "there are wholesale differences of approach between the parties and a tangle now would be likely to end only in frustration."

On August 19, after voting down three variations of the social security approach, the McNamara bill, the Gore bill, and the Anderson amendment, the Finance Committee with five of its 17 members dissenting, reported its own version of H. R. 12580 which differed in degree but not in approach from the Ways and Means Committee bill. Like the latter, it was basically a relief bill which provided added federal grants in aid for public assistance medical payments.

The Finance Committee bill was written by two Democratic "moderates," Senators Robert Kerr (Okla.) and J. Allen Frear (Del.), who argued that legislation using the social security approach would encounter a sure presidential veto. Their tactics angered supporters of social security-type legislation. Senator Paul Douglas (D., Ill.) called the Finance Committee bill the "Kerr-Eisenhower bill." *The Washington Post* referred to it as a "shabby joke."

Despite the criticism, the "shabby joke" managed to prevail over all major efforts to change it on the Senate floor and formed the basis for Public Law 86-778.

The advocates of a "social security approach" health bill, led now by Democratic presidential nominee John F. Kennedy, united behind the Anderson amendment, offered by Senator Clinton Anderson (D., N. M.) This amendment, more limited than either the Forand or McNamara bills, extends aid to persons eligible for Old Age and Survivors Insurance who have reached the age of 68 or over, some 9 million individuals. Its benefits include 365 days of hospital care with $75 deductible initially and again after 24 days, visiting nurse services, and up to 180 days of nursing home care upon release from a hospital. Surgical care, drugs and laboratory services are omitted. The total estimated cost is $700 million annually.

On August 23, with only one Republican, Clifford Case of New Jersey, voting in favor, and with the southern Democrats voting in opposition, the Anderson amendment lost by a count of 51 to 44. The Javits proposal was defeated the same day 67 to 28, with not one Democrat registered in favor. Commenting on the voting, Walter Lippmann wrote:

> The result proved that Kennedy will be quite justified in arguing that there is no prospect of a comprehensive medical care bill unless he is elected. For while the Nixon-Javits proposal has some merit, it would be enormously complicated to administer and almost certainly more costly to the general taxpayer than the Kennedy-Anderson proposal. Nixon, if elected would face the opposition of a large part of the powerful Democratic majority. On Tuesday they voted unanimously against him.
>
> The net result is, it seems to me, that while Kennedy cannot say that he has a united Democratic Party behind him, he can say that, if elected, he can, and that Nixon cannot, establish a comprehensive system of medical care for the aged.

H. R. 12580 went on to conference committee, where, by and large, the Senate version emerged victorious. By August 29 congressional action was completed with approval of both Houses of the conference report, and the bill was dispatched to the White House.

Public Law 86-778

Election year politics thus resulted in stalemate without even a start being made toward a system of health insurance for aged citizens. The legislation which was passed and became law does not even pretend to achieve the same end. It is a measure which provides more money for the needy on relief, not a health insurance system for the nation's aged. In its final version it amends Title I of the Social Security Act to allow an increase of $12 a month for the 2.5 million persons over 65 who already are on state public assistance rolls. The Federal Government pays 50 to 80 percent of this added payment, depending on the per capita income of the state and the present average assistance payments. The state must raise the balance.

The new law also amends Title I to authorize federal grants, again on a matching ratio of 50 to 80 percent, to furnish medical help to persons over 65 not presently receiving public assistance. The aid is supposed to go to individuals who, though normally not in need of public assistance, have insufficient resources to pay for medical services. The law gives broad latitude to the states in determining the test for eligibility.

While there is no statutory limit on the total amount the Federal Government will contribute on this portion of the program, the cost estimates indicate that it is not expected to reach a substantial number of persons over 65. Predictions are that only $116 million will be necessary to provide the medical services for those elderly individuals not otherwise on public assistance.

No sooner had the new law been signed than it became clear that many states would have no part of it. For some states it was simply a question of finances. In others there is a conflict between the program and existing state law. Many state officials object to the means test requirement. One of the most outspoken of these is New York's Governor Nelson Rockefeller. In announcing that New York State would in all probability not take part in the program he said: "Frankly, I do not regard it as any real solution to the great human problem of assuring that the nation's senior citizens have adequate health insurance."

In a survey of sentiment among state administrators, presented September 21, 1960 the *Wall Street Journal* found another common feeling. "There's no real Federal program" an anonymous official told the *Journal*, "Congress couldn't reconcile its conflicting viewpoints, so it passed the buck to the states."

Social Security is the Best Approach

The need for better health care among the nation's older citizens is uncontradictable and stands uncontested even by those opposed to federal action. It has been amply demonstrated that better medical attention cannot be given the aged without government help. The postponement of federal action to meet the crisis succeeds only in placing an ever larger number of aged persons in an ever deeper plight.

The problem is to assure the whole aged population good medical care through health insurance. The most feasible way of achieving this aim is to use the Social Security System. Experience has well demonstrated that private insurance, both nonprofit and commercial, is not able to make adequate insurance available to the aged at rates which they can afford. There is no reason to expect this situation to alter in the future.

The aged are a high risk and, consequently, a high cost group, and any insurance offering them good protection will be expensive. The only solution is to spread the cost as widely and as fairly as possible over the entire working population. There is no getting around the fact that the cost of financing proper health services for the aged must be borne by the whole community. The most equitable way to distribute the burden is through a small payroll tax on both employers and employees.

Private insurance plans are at the disadvantage of having to depend on the current payments of the aged themselves. Use of the social security mechanism spreads the burden instead among persons in their productive and earning years. There is no cost after retirement, when payments prove so hard to make. Under social security coverage, a man at 65, and a woman at 62, are paid up for life.

True to the insurance principle, social security taxes, set apart from the general tax funds of the Treasury, are used only for the purpose for which they are paid—security in old age. Commenting on this aspect of the Forand bill, Representative James Roosevelt (D., Cal.) said:

> In the title of the bill is the word 'insurance.' This is a word that perhaps the opponents of the bill prefer to overlook, because the insurance principle has proved to be a sound, budgetary approach to our social security law, providing retirement benefits based on contributions of both the employer and em-

> ployee. And certainly this concept of insurance protection, in one form or another, is an integral and successful aspect of our business and personal world. Yet, when a new application of this principle is proposed, suddenly certain groups charge an 'alien' flavor to it.

By using the experienced and efficient administrative mechanism of the Social Security System, insurance for medical care would benefit from low administrative costs. Existing wage records, tax reports, etc., can be utilized and relatively little additional staff would be needed. Compulsory coverage through automatic payroll deductions would also reduce the per-person cost of medical insurance. The large size of the covered group precludes the adverse selection which often accompanies voluntary community plans.

One fine feature stemming from the use of payroll deductions is that payments are not required when an individual is unemployed. When commercial insurance is used the individual is forced to pay even during periods of unemployment, or lose his policy. Payroll deductions are taken as a *percentage* of income, up to a limit of $4,800. Voluntary insurance takes no account of the insured person's income. The poor man pays the same premium as the wealthy man.

Another advantage of government insurance is that it could not be cancelled unilaterally or lost through nonpayment. Nor are there breaks in coverage through changes in residence or place of employment. Limitations such as a lifetime ceiling on payments, exclusion of pre-existing conditions, etc., written into many existing policies, would also be avoided.

Benefits due under the Social Security Act have been paid for, and hence are given as a matter of right. No means test such as that required by public assistance is demanded. The elderly person receives his medical benefits without first having to use up his precious savings.

By making medical benefits available under the Social Security System to a large proportion of the aged, a terrific burden will be taken from the public assistance, veterans, and other programs. The Federal Government spends over a third of a billion dollars a year for medical care for persons 65 and over, most of it through public assistance and veterans' programs. Some 600,000 aged persons now supplement their old age and survivors benefits with old age assistance. As heavy medical expenses cause them to exhaust all their other means, more and more Old Age and Survivors Insurance beneficiaries are being driven to seek public assistance.

A statement by the Department of Health, Education and Welfare, made in response to a query by Representative Forand declares:

> Future savings in hospital and other costs under public assistance as a result of H. R. 4700 might . . . be significant. An increasing proportion of old-age assistance cases are likely to be old-age, survivors, and disability insurance beneficiaries. And to the extent that the availability of hospital and other benefits under H. R. 4700 prevented exhaustion of assets and savings during periods of illnesses, older people in the future would have less need to turn to public assistance for support.

Social security is compulsory, not because compulsion is a good principle, but because its application in this instance results in the greatest good for the greatest number. In effect, it compels each person to provide for his old age so that he will not, through negligence or ill fortune, become a burden on his fellow citizens. It is a fair system, too, because each person pays into the same fund from which he later receives benefits.

When social security benefits are insufficient to pay for medical expenses so that an elderly individual must apply for public assistance, the general taxpayer pays the bill. When medical benefits are included in Old Age and Survivors Insurance, on the other hand, the recipient earns them through premiums he has paid during his working life. An adequate Social Security System, providing adequate benefits, is therefore, fairer and more equitable from every standpoint.

Just as the payment of medical benefits under Old Age and Survivors Insurance would take a burden from government programs such as public assistance, so it would provide much needed relief to private welfare organizations, hospitals, etc. Hospitals which now provide below cost care to indigent persons would be eased of a considerable burden, much of which is reflected in high rates charged to other patients.

Relieving voluntary insurance plans like Blue Cross and Blue Shield of their most burdensome high-cost group would greatly ease the financial pressure on them. This step, in fact, looks to be almost necessary if they are to survive at all. Free of the special problem of the aged, voluntary carriers would be able to revitalize their service to people under 65. Reduced costs of health insurance for younger persons would follow.

The extension of social security to allow older persons to get adequate medical attention follows naturally the principles under which the system was created—principles that seek to provide a maximum amount of personal security in an individual's later years. These principles, as well as the system itself, are now almost universally accepted. Health insurance incorporated into social security will allow it to achieve its aims more perfectly and more fully.