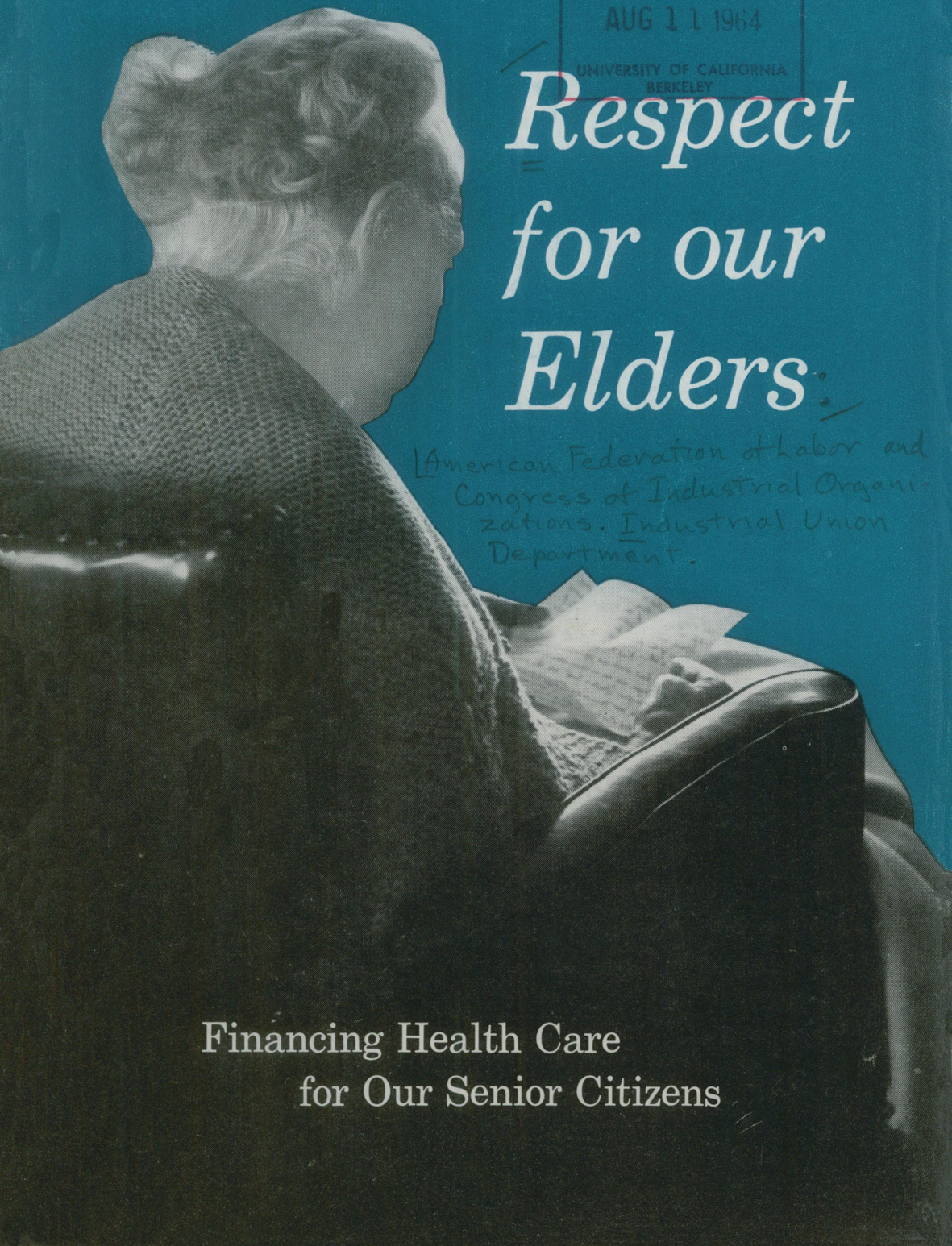
Respect for our Elders.



Financing Health Care for Our Senior Citizens

FOREWORD

THE WORTH of a nation, it has been said, must be judged not by what it has but rather by what it does with what it has. America will be judged by the measure of social and moral responsibility we demonstrate in converting our material wealth into human values and reflecting our great technological progress in terms of human progress, human happiness, human dignity, and the expansion of opportunity for maximum fulfillment for all of our people.

There are many important items on the agenda of American democracy's unfinished business. One of the top priority items that commands our immediate attention and our whole-hearted support is the matter of meeting the medical care needs of our senior citizens. Today, more than 17 million of our citizens are past the age of 65; two-thirds (68 percent) of them have an annual income of less than $1,500.

The source of the very real and tragic problem that we face in providing medical care for our senior citizens is that in the latter years of their lives their income is drastically reduced at the same time that their medical needs and the cost of medical care greatly increases.

As a free society, we have three choices—first, we can continue to ignore the problem; abdicate our moral obligation and social responsibility and continue to neglect the medical needs of our older citizens; or, second, we can subject our older citizens to the humiliation of public charity and the means test and rob them of the sense of human dignity which is their priceless heritage; or, thirdly, we can do the rational and responsible thing--amend our Social Security system to provide medical care as a part of the Social Security benefits so that the cost of such care may be spread over the productive life of the worker and so that a worker may look forward to retirement with a sense of security and dignity during the autumn years of his life.

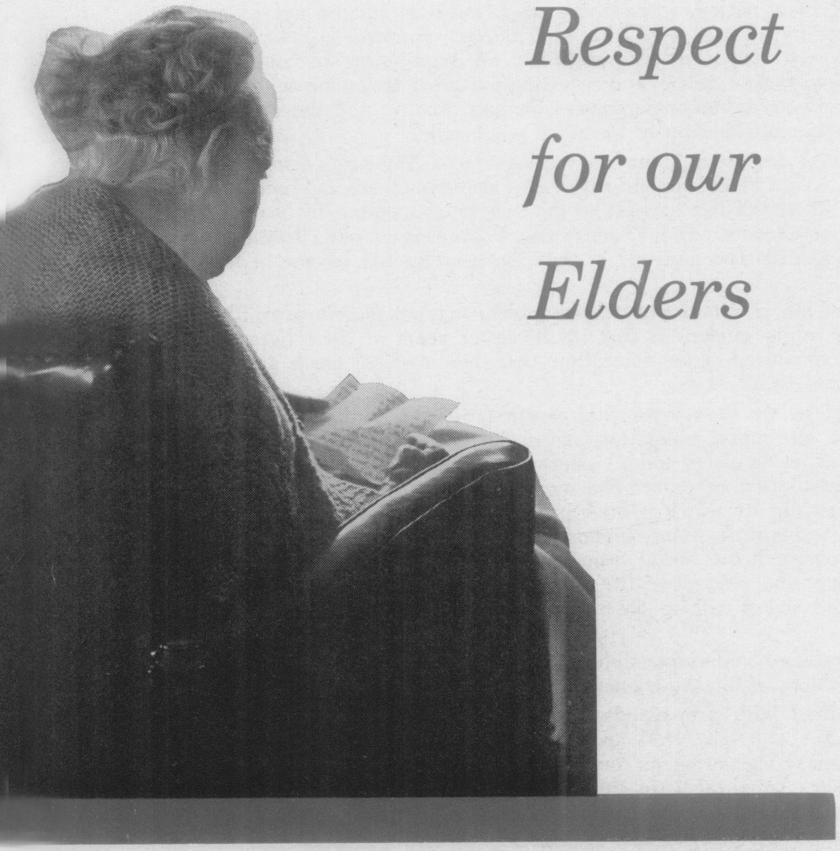
This is the rational and responsible, sensible and sound way of meeting this critical human problem within the framework of our free society.

The air is filled with propaganda and misrepresentation on this important question. The AMA and the NAM are in an unholy alliance to block this desperately needed social legislation as they fought to block other needed social legislation in the past. Medical care through Social Security will not undermine medical standards, will not interfere with the doctor-patient relationship, and will not impose government control over the practice of medicine. Medical care through Social Security does not determine how medical care will be practiced—it only provides how medical care will be paid for.

It is time for America to put an end to this senseless propaganda contest and get on with the practical task of meeting this pressing human problem. It is shameful that America alone among the industrial nations of the free world leaves its elders to fend for themselves in providing medical care.

This booklet has been written so that those who are truly interested will have the truth at their disposal. Armed with the truth, the forces of decency and responsibility in this nation—the overwhelming majority—will surely prevail.

WALTER P. REUTHER, *President,*
Industrial Union Department, AFL-CIO



Respect for our Elders

The moral tone and lifespan of a civilization can be measured by the respect and care given its elderly citizens. . . .

–Historian Arnold Toynbee

Last year's hearings on old-age health care before the Ways and Means Committee of the House of Representatives filled four volumes totaling nearly 2,300 pages.

This was the third set of hearings since former Representative Aime Forand introduced his bill for Social Security coverage of old-age health care in 1957. Hearings held before the 85th Congress filled volumes; those held in the 86th Congress were equally lengthy.

The tragic story of the unfilled health care needs of our elders drew headlines when senior citizens spoke for themselves in the "Town Meeting" field hearings of the Senate Subcommittee on Aging in 1959. They were dramatized again when the American Medical Association suffered a setback at the White House Conference on Aging, held in the final days of the Eisenhower Administration.

Millions upon millions of words have been spoken and written on this issue. But all the words since the nation began cannot truly describe or hide the plight of the aging. The unmet health care needs of the nation's seniors will continue to cast a long shadow over the nation's conscience until they are adequately met. All the verbal tranquilizers of the doctors' lobby can neither ease the insecurity and worry of the aging nor remove their needs from the nation's sight.

The problem is economic and national in scope. Because it is both of these, it will continue to have top political priority. Unless the responsible leaders of both political parties move forward toward a satisfactory solution, political demagogues will arise to exploit the plight of the aged for their own narrow ends.

It is time for a summing up. Above all, it is time to transfer the major costs of old-age health care from the uncertain backs of our elders to the strong shoulders of the national economy.

OUR ELDERS WANT NO CHARITY

America now can best honor its fathers and mothers by providing guarantees of adequate health care in old age. This care must be provided as a right to all who have been useful citizens over the years.

> **Our elders sicken of the bitter bread of private and public charity. They deserve better than to be treated as paupers and castoffs. They want least of all to become burdens upon children who must support families of their own.**

Old-age health care financed through a national pooling of resources would tax each individual less than the cost of a pack of cigarettes each week. It would assure immediate health care to the majority of those already retired and to all others who will some day join the ranks of Social Security beneficiaries. The Social Security system provides a ready vehicle and a logical answer.

America is rich beyond the dreams of yesteryear. President Kennedy has predicted an output of goods and services totaling $570 billion this year. Within the near future, the $600 billion mark will have been passed. Only the blind will declare that this nation cannot afford the billion dollars required to defray costs of minimal health care for the aging.

Far poorer nations serve their elders better. Few of our industrial nations require their aging to pay the costs of medical care from meager funds when earning power has vanished. Conquest of the moon will be small comfort if we fail at the same time to take up the challenges thrust upon us by a population that grows progressively older because more of us live longer.

The Administration's budget calls for an expenditure of $3.8 billion to speed the time when a few of the more daring among us will explore the outer reaches of our planetary system. Surely it is equally important that a third of this sum shall be set aside annually through the Social Security system to speed the day when our anguished elders will be supplied with health care adequate to their needs.

OUR ELDERS CRY OUT

"I am writing you for some information about medical bills for the old aged. I don't know whether any of them has been passed yet. Mr. Kennedy, my wife is 72 years old and I am 74. We only get $51 a month Social Security between us both. I own a small house of my own so we don't get any old age pension. My wife had an operation the other day and the bill is so big we just can't pay it. The welfare doesn't want to help. So I just don't know what to do," a desperate senior wrote to President Kennedy last year.

"I had to keep on milking my bankbook and since I retired in 1952 I was operated on and a doctor which was a friend of mine said to me, 'Alex, how do you get along?'; I said, 'I am getting $60 a month Social Security.' He said, 'You can't get along on $60.' I said, 'I got some money in the bank, and then my daughter helps. . . .' He charged me $250 and I paid him. For the last few months I was to the doctor, $5 a visit, and he is a fine man, the work he is doing is worth more than the $5. . . . I belong to Blue Cross. When Blue Cross started I paid $1.65 for me and my wife. Do you know how much I pay today? $8.85. Can I afford to do it? Can I afford to go once in a while to a doctor?" a witness asked at a "Town

Meeting" field hearing of the Senate Subcommittee on the Aging.

> **Multiply such cries by the million, and the human picture comes more closely into focus. The anxiety and heartbreak almost defy the imagination. The need has grown more acute with the passing of each day.**

Every day, a thousand more Americans enter the ranks of the nation's seniors. Since the start of the present decade alone, some three quarters of a million persons have passed their 65th birthday, and there are now 17 million in their Golden Years. These already represent one of the most potent voting blocs in the nation's history.

INCOME IN THE GOLDEN YEARS

Despite overwhelming evidence to the contrary, the American Medical Association and its allies have sought to convey the impression that the nation's over-65 population is relatively well fixed financially.

Typical is a statement by Maurice H. Stans, former Eisenhower budget director, who said in a weekly newspaper column: "Those over 65 account for nine percent of our population and despite retirement, they still account for eight percent of all personal income."

Such statements are cruel distortions of the truth. The over-65 age group actually accounts for nearly 16 percent of the adult population. While it has a total income of some $30 billion, a relative few receive a significantly disproportionate share of the total.

One-fourth of the over-65 group continues to be gainfully employed. This group receives two-fifths of all over-65 income. Private pension plans provide only about $1.5 billion of over-65 income, despite attempts to prove that industry provides well for those retired because of age.

The Life Insurance Institute, made up of private firms, issued a study of old age problems five years ago. This study found that the two major problems in old age are finances and health. It re-

ported that those with good income and good health were not at all bored in retirement.

"What struck us most," Dr. Harry J. Johnson, president of the Institute reported, "was that money seemed to be a very important consideration so far as happiness in retirement goes. We found 85 percent of those who claimed to be unhappy, bored, etc., were those with incomes of less than $5,000 a year. Only six percent of those with $5,000 or more of income said they were unhappy in retirement."

Longevity has made massive the problem of health and income in old age. For all but a small minority, the economics of the Golden Years are bleak and forbidding.

For most, income drops cataclysmically at the very time that health needs become greatest. With the constantly rising cost of medical care, the burden has become overwhelming for millions of seniors who feel with justification that they have been abandoned.

The findings of the Senate Subcommittee on Aging make a mockery of the comforting claims of Mr. Stans and the American Medical Association. The Subcommittee's report showed that for the majority, old age is a time of deprivation, anxiety, and, often, needless suffering.

"A major problem for millions of older persons throughout the nation is how to maintain a decent, independent American standard of living on an income below or barely at the subsistence level," the Senate Subcommittee on Problems of the Aged and Aging reported.

The subcommittee found that at least half the aged "cannot afford decent housing, proper nutrition, adequate medical care, preventive or acute, or necessary recreation."

Taking all aged individuals—including those still holding jobs—nearly 60 percent had annual money incomes of less than $1,000 only two years ago. Another 20 percent had incomes between $1,000 and $2,000.

Two of every three senior citizens had liquid assets of less than $2,000 in 1959. Two of every five were unable to muster $200 in liquid assets to cover emergency costs.

Last year, old age benefits under Social Security were increased slightly. Based upon figures available before the increase, it would appear that the average benefit to an individual recipient is now about $75 a month and that benefits for retired couples average about $125. Average widow's benefits are still less than $60 monthly.

Whether by choice or of necessity, most oldsters live alone or with a spouse. About two-thirds live away from children or other younger relatives. Because of low incomes, housing generally is inadequate to needs.

A disproportionate number of the aged live in a single room

at one extreme and, at the other, a disproportionate number live in eight-room houses purchased during working years while children were growing up. A far greater proportion of homes occupied by the aged are run down than are those of the population at large. An even greater proportion lack indoor plumbing.

The nearly one-third of the seniors who do not maintain their own dwellings generally live in private homes with relatives or friends. In most cases, these homes are too small to accommodate three generations in comfort—grandparents, parents, and children.

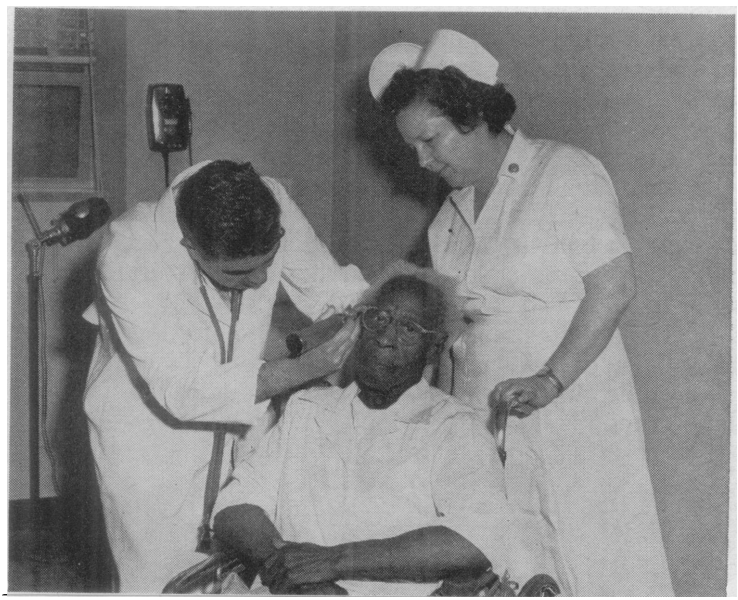
"Because of the limited size and facilities of many housing units, the addition of an older person or couple in a house designed for one family frequently produces grave physical and psychological problems for both the older and the younger generations," the Senate Subcommittee found.

MEDICAL CARE NEEDS AND COSTS

Chronic illness among the aged is far more prevalent than among the population at large. The National Health Survey has reported that nearly eight of every 10 of our elders are affected in some degree by a chronic disability. The aged now use almost three times as many days in the hospital annually as the general population, and 40 percent more doctors' visits.

Behind the figures lie the harsh truths of aging. Heart disease, arthritis, respiratory ailments, cancer, blood diseases, and a long list of other ailments strike without pity as the lifespan shortens.

Such are the facts of modern life in our affluent society that income declines and the physical environment worsens as the need for health care grows. A dollar may seem small enough to the gainfully employed, but it looms large in the economics of the retired.



A 1956 McGraw-Hill survey found that the general population had an annual per capita medical care expenditure of $96. The nation's elders were then spending an estimated annual $150 each.

Medical care costs have soared far higher than the over-all cost of living, and have been a significant factor in the cost of living rise. Between 1950 and 1960, living costs went up by a fourth. Medical care costs rose twice as fast, while hospital costs doubled.

The present fight for old-age health care centers on hospital and nursing care costs because these have loomed so large in total costs in recent years. With the Golden Years, there come many more days that must be spent in a hospital bed.

Last year, those under 64 years of age averaged 883 days of hospital care per 1,000 persons. The over-65 group averaged 2,332 days of care per 1,000 persons. Hospital costs per patient day, meanwhile, had risen from $15.26 in 1950 to $32.23 a decade later.

The high costs of hospitalization and other medicine are depriving millions of the aged of care adequate to their needs. The medical profession has sought to picture senior citizens seeking hospitalization under Social Security as malingerers who want free care so that they may use our hospitals for needless rest cures and handouts. The AMA attitude is an insult to decency.

VOLUNTARY PLANS AND THE AGING

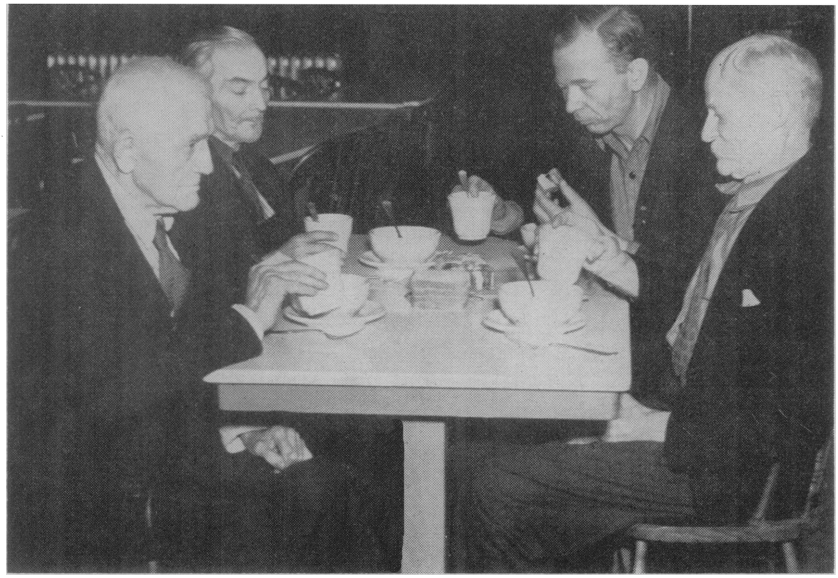
The American Medical Association and the American Hospital Association have joined hands with the insurance industry in an effort to show that voluntary plan usage is so widespread that no further action is needed—even among the aging.

Thanks to collective bargaining, welfare benefits of various kinds have spread through industry. Spurred by union action, even nonunion employers have added group coverage—in most cases paid in whole or part by employees through checkoff systems.

Seeking to head off tax-supported programs, insurance companies and voluntary plans have begun to expand coverage to senior citizens. Even so, benefits under such plans are generally inadequate, while premium costs have continued to rise with monotonous regularity.

Health Insurance Council figures—those of the industry itself—show that private insurance companies wrote 66 million hospital coverage policies, 63 million surgical plan policies, and 30 million medical care policies in 1956. Blue Cross, Blue Shield, and other "nonprofit" programs covered 53 million for hospital care and 34 million for medical care.

With 115 million covered by 1956—the majority by private companies—health insurance has become big business. This explains the determined opposition of business and financial interests to tax-supported plans for the aging.



Despite the growth of voluntary plans, insurance reimburses Americans for only a fifth of total medical care expenditures. In some cases, the costs of medical care—especially hospital costs—have continued to spiral upward and voluntary plans have reacted accordingly.

New York is typical. Last year, New York's Blue Cross sought an increase of 37 percent in rates because of declining reserve funds. It won approval of a 33.4 percent rate increase in hearings before the state's insurance commission.

Individuals covered by New York group plans now pay $3.56 monthly for coverage under a "standard" plan, while family coverage costs $8.72 monthly. Individuals not covered by group plans—and this would include virtually all of the over-65 group—now pay $4.65, while families pay $10.35. Standard coverage pays hospital costs, subject to specified limitations, for the first 21 days, but only half of costs for the next 180 days.

Such a plan—costing a family from $104 annually in group coverage to $124 on an individual unit participation basis—is expensive for even the gainfully employed and sadly out of reach for the aged. Because of a big market area in which to pool risks, New York's Blue Cross plan is probably better than many others in costs and benefits.

Prepaid voluntary insurance, personal financing of health care needs, and public assistance are the most prevalent means of financing old-age health care. Voluntary plans now cover only a small part of total costs, despite claims to the contrary.

The Senate Subcommittee on the Aging has reported that about two-fifths of the nation's seniors now have coverage under Blue Cross or insurance company plans. It has found that these plans fail woefully in their declared mission of providing adequate financial relief for those covered.

A survey of the 43 percent of old age Social Security beneficiaries with voluntary plan coverage showed that 73 percent of married couples hospitalized and 68 percent of the nonmarried had less than half of costs met through such insurance. This in itself is a ringing indictment of the so-called "voluntary" approach.

"The balance of such medical costs was met in the vast majority of cases—over four-fifths—by the Social Security beneficiaries themselves, even those with large bills," the Senators reported.

The report found that medical bills result in using up meager assets, increasing debt, and, in many cases, turning to relatives for aid. With continued illness, some are forced to turn to public assistance for subsistence as well as medical care financing.

Many of the over-65 groups are no longer eligible for the economies of group coverage under voluntary plans after retirement. Opportunities for the already retired to buy coverage remain limited. Widows of those covered upon retirement also continue to be denied the right to participate in voluntary plans.

The monthly cost of over-65 coverage for a two-person family under Michigan's Blue Cross program illustrates graphically the need for a tax-supported program with risks pooled throughout the gainfully employed population. Hospitalization only—under terms of a standard plan—cost from $11.48 to $12.63 monthly in 1959, depending upon whether or not coverage was under a formal welfare program before retirement. With surgical care, monthly costs run from $16.13 to $17.75—up to $213 annually. Such plans obviously are beyond the reach of many senior citizens—especially when they do not cover the full costs of medical care.

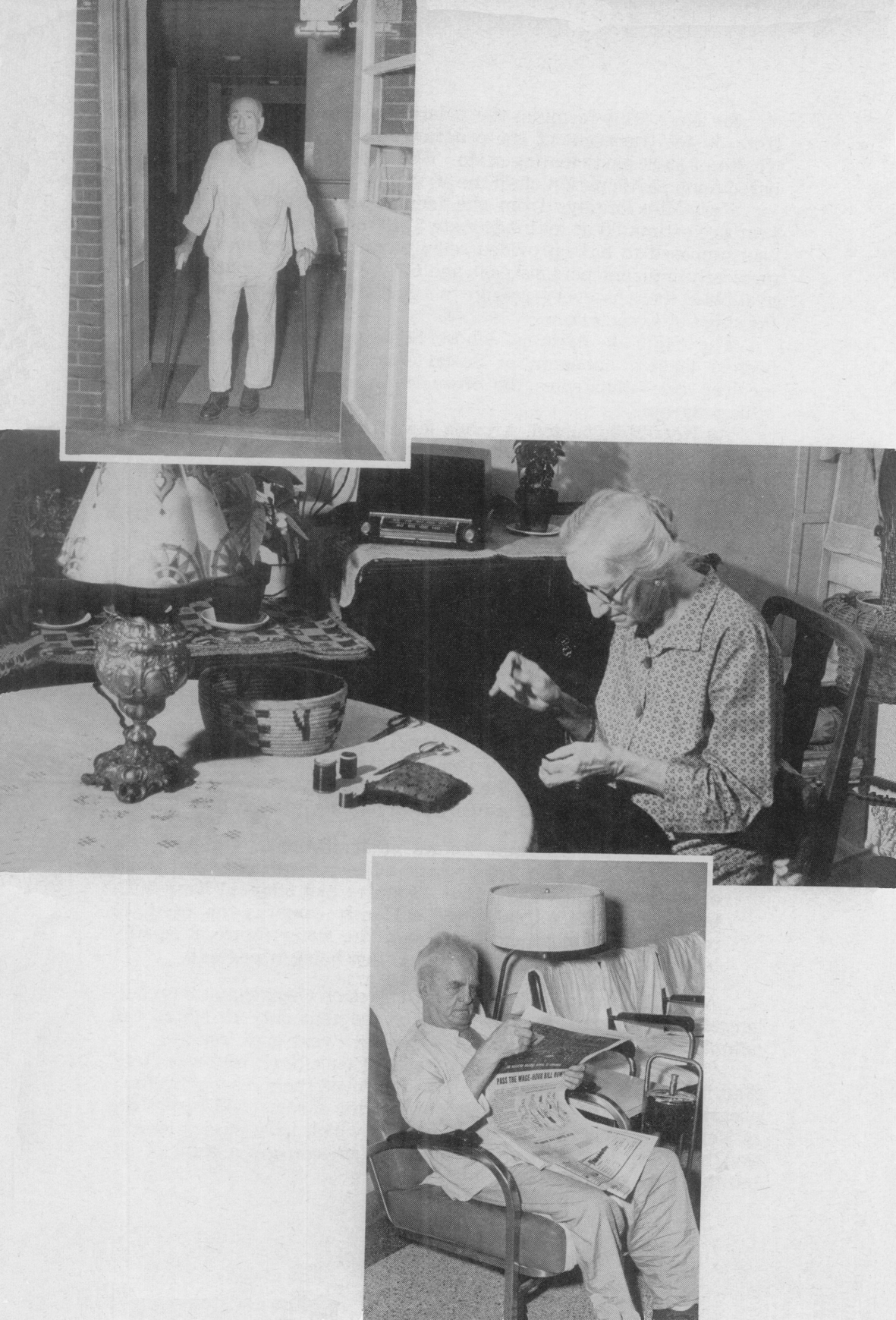
KERR-MILLS FAILS THE AGED

The 86th Congress passed the Kerr-Mills Act as a substitute for a Social Security old-age health care program.

Kerr-Mills now is hailed by the AMA and the insurance industry as a solid answer to financing health care for the aging and was supposed to still the clamor for a Social Security bill. Kerr-Mills has had a fair trial and has been found wanting, except, perhaps, as a supplement to the Social Security approach. The best proof of failure is the now louder-than-ever cry for a Social Security measure.

> **Kerr-Mills is a relief program, intended for the neediest. It inflicts a pauper's oath—a means test—upon those needing health care. It is dependent upon continuing state grants from the legislatures. In some cases, it has already become a substitute for state old-age medical care relief programs. It has not begun to meet the medical care needs of the senior citizen.**

The bill was supposed to have cost the federal treasury $202 million of general tax revenue in its first year. Within five years, the federal share of costs was supposed to rise to $340 million. Un-


PASS THE WAGE-HOUR BILL NOW

der the Kerr-Mills formula, the federal government was to assume from 30 to 70 percent of the program's costs, depending upon the wealth of each participating state. The $340 million projection was based upon participation of all the 50 states.

Kerr-Mills outlays from the federal government for its first year are estimated at an inadequate $140 million. The Act initially was supposed to have provided relief payments to some 1.3 million medically indigent persons past age 65. While figures are not yet available, there is every reason to believe that results have fallen far short of expectations.

The State of Arizona—whose Senator Barry Goldwater has been a leading opponent of Social Security financing of old-age medical care—illustrates the obstacles even to an effective Kerr-Mills program.

As Kerr-Mills passed, Arizona law strictly prohibited participation by the state in medical welfare programs. Arizona may have been an extreme case, but others were without medical aid programs of any kind, and in most, enabling legislation was required.

The American Medical Association has now begun a numbers game to confuse the issue. As the 87th Congress met for its second session, the AMA issued a "year-end" report asserting that 38 states had joined the Kerr-Mills program and that the medical care needs of the senior citizen had been met.

"In just 15 short months, Kerr-Mills has been widely accepted across the land with each passing day proving that it can do the job," AMA Pres. Dr. Leonard Larson told the press. He added that the need for "compulsory" old-age health care through Social Security now is "totally unnecessary."

Although Dr. Larson stated blandly that 38 states had enacted Kerr-Mills legislation, he failed to reckon with his friends. Former Budget Director Maurice Stans put the figure at 26, although he added that a dozen more states were "moving toward it."

The numbers game knows no limitations. On April 19, 1961, the AMA ran a four-page ad in a representative group of papers which alleged that 47 states had adopted Kerr-Mills legislation. Its retreat to 38 evidently came as the result of more mature judgment—although the latter figure is equally intended to prove that the need is fast being wiped out.

AFL-CIO Social Security Director Nelson Cruikshank has challenged the AMA figure. He has reported that only 19 states had actual programs at the time of the AMA "year-end" report.

"We don't need to go into details," Cruikshank told reporters, "but if you take the states that have improved their relief or welfare programs without acting under the specific medical aid provisions of Kerr-Mills, and add to that the states which have passed legislation but have made no appropriations, you can get a total of 38, but that's the only way you can get it."

The AFL-CIO expert noted that Georgia, New Mexico, and Iowa have passed enabling legislation. He pointed out that this does not mean "the old people in these states are going to be helped," since no appropriations have been forthcoming from the legislatures. The same is true of most other states. Not even the barest edge of need has so far been blunted.

In December 1961, only 72,159 seniors received help under state medical aid for the aged programs, and 51,549 lived in three states —New York, Massachusetts, and Michigan. Ninety-two cents of every AMA dollar was being spent in these states. HEW figures showed that only 17 states had actually appropriated any money at all for aged medical aid.

In Louisiana, only eight persons were actually receiving benefits. In New Hampshire there were 25, and in Utah there were 27. Benefits available varied according to state rather than need, and eligibility requirements were such that a person counted a pauper in one state was too well off for benefits in another.

The same day that the AMA released its "year-end" report, the State of Pennsylvania announced that it had reached agreement with the Department of Health, Education, and Welfare on a state Kerr-Mills program. The cost was estimated at $11.6 million for the six months then remaining in the state's fiscal year and was to be shared by the federal and state governments.

Pennsylvania has a population of 11.5 million, of whom, 1,130,000 are 65 or over. The majority of these receive Social Security benefits directly or through a spouse.

The Pennsylvania Kerr-Mills program promised help only for 62,000 of the aged. Those who receive aid will in most cases be eligible for public assistance programs. Governor David Lawrence candidly labeled the program a "stopgap" measure. He stated that

he continues to favor the Social Security approach and that the new program is simply better than nothing at all.

Those receiving aid under Pennsylvania's new program must subject themselves to a means test. Aged persons having assets greater than $1,500—$2,400 in the case of husband and wife—are automatically banned.

The Pennsylvania Kerr-Mills program provides 60 days of hospital care in a ward, visiting nurses' care at home if prescribed by a doctor, post-hospital care at home if the hospital has such a program, limited nursing care in a county institution if the county matches federal funds.

Care is about the equivalent of that provided under city and state public assistance programs. While the program is probably as good as any so far established, it is, in effect, only an extension of existing state welfare programs. Kerr-Mills depends upon regular appropriations from state legislatures which tend to be dominated by rural legislators with extremely conservative economic views. When legislatures fail to make adequate appropriations, programs are slashed. Economy at the expense of welfare is all too common at the state level.

The aged in West Virginia now are reaping the harvest of local control. As this year began, the state's medical aid to the aged fund had almost run out, threatening the program's continuity.

West Virginia was the first state to sign up for Kerr-Mills. The recession-bound state badly needed help in all its welfare programs, and moved fast to take advantage of any available benefits under the new law.

West Virginia's program became effective in October of 1960 and by June of the following year its monthly cost was $388,000. But the legislature appropriated only $1.3 million to carry the program forward.

By December 1, 1961, state grants were exhausted and the entire program was threatened with collapse. Total medical care costs had amounted to $3.7 million for the first 14 months of the program, the state's share being slightly over $1 million. This did not include $1.5 million in unpaid bills on which the state owed $445,000, and administrative costs of $350,000 for which West Virginia was obligated for $210,000.

On December 1, the state cut back benefits in a desperate effort to salvage the program. Eligibility requirements were raised, although only 30,000 of the state's 173,000 seniors had been eligible to start with. With the first slicing, 12,000 were cut from the program despite admitted need.

The state also cut pay for doctors' visits from $3 to $2, cut hospital allowances from $35 to $20 a day, and reduced prescription allowances from a no-limit basis to wholesale prices plus $1.00 for handling.

The response from the state's doctors and hospitals was instantaneous, if not altruistic. Originally, 108 hospitals signed up for the program. All but 23 dropped out after the cutback. With the cut in doctors' fees, only 132 of 1,800 West Virginia doctors were counted as participating physicians at the very time the AMA declared that needs were being met by Kerr-Mills.

Welfare officials found that some doctors and hospitals enjoyed a rich harvest at the program's expense. They reported that one doctor had collected $17,000 in fees and was still owed $4,800. They reported that some hospitals with financial difficulties and beds to spare invariably found it necessary to hold a patient for 30 days to effect a cure—at a cost of $35 a day to the program.

"Doctors were found to be going into the drug-dispensing business (one collected $1,300 a month for drugs alone)," *Newsweek* magazine reported.

West Virginia Welfare Director W. Bernard Smith found that the program could still be salvaged with help from the medical, hospital, and pharmaceutical associations. "But our experience shows," he added, "a definite need for handling this problem under the Social Security system. A state just doesn't have the resources, along with its other obligations, to carry out an adequate program."

THE ANDERSON-KING BILL

Shortly after taking office in January 1961, President Kennedy sent to Congress a proposal to put old-age health care financing under the Social Security system where it belongs. The Kennedy proposal is summed up in the Anderson-King bill. The measure is a modified version of the original Forand bill. It was introduced into the House by Representative Cecil King (D., Calif.), and in the Senate by Senator Clinton Anderson (D., N. M.)

The Anderson-King bill is hardly a radical measure. It seeks

only to alleviate the heaviest medical care financial burdens of the aging. It has the full support of former Representative Aime Forand, now honorary chairman of the Senior Citizens for Health Care Under Social Security.

As already pointed out, the heaviest burdens of old-age medical care come as the result of lengthy hospital stays and the high cost of nursing care. These are the areas in which Anderson-King would provide major help. The bill would cover most costs of:

- Up to 90 days of hospital care in a semiprivate room in any single illness;
- Up to 180 days in a nursing home;
- Out-patient diagnostic services, including x-ray and laboratory costs in excess of the first $20 of costs;
- Health home services, including nursing care up to 240 days in one year.

The measure would not relieve the senior citizen of the total costs of such care, but would make him a partner with the nation in meeting these costs. The measure provides that in-hospital patients would have to pay $10 a day for each of the first nine days (not more than the first $90 of costs). It would, however, take care of the greater part of costs in illnesses requiring a long stay in the hospital.

The program would be financed by a fourth of one percent tax on the first $5,200 of wage or salary income upon both the gainfully employed and their employers. This maximum cost of a quarter per week for each worker and the same for the employer for each worker on the payroll, would yield the billion-plus dollars needed to finance the program.

The Anderson-King bill is admittedly modest. It would not pay doctor or surgical care bills. It would not pay all hospital costs. But it would make a significant difference to millions of seniors who must undergo lengthy hospital stays during their declining years. It would be a long step forward and an indication that this nation truly cares for its elders.

America now has had a quarter of a century of experience with Old Age and Survivors Benefits under the Social Security system. Despite warnings that it would create a nation living on handouts, the nation now produces more than ever and is better off than ever. Despite warnings that the new "welfare state" would be the start of an omnipotent totalitarianism, freedom has prospered. Social Security put a floor under old age income and has become one of the great stabilizers of the U. S. economy.

Social Security was a minimum program, and so is the Anderson-King bill. Warnings that Social Security would end personal savings programs and private pension programs have proved pointless. Today, the insurance industry prospers partly because Social

Security has popularized insurance and private pension plans. Anderson-King, obviously, is no substitute for private health and welfare programs, which will continue to grow. It simply puts a floor beneath the needs of the aged.

America is fortunate in its approach to the solution of such social problems as old-age health care. It has learned to legislate for an acceptable minimum—to place a floor under need. It has supplemented this minimum with voluntary action: collective bargaining, personal savings, community action, private pensions, and voluntary associations.

The claim has been made that the Social Security approach will encourage excessive hospitalization. With a $10-a-day charge for each of the first nine days still falling directly upon the retired, this allegation is without foundation. Few seniors have $90 to throw away for the dubious pleasure of spending needless time in the hospital.

The AMA has shed countless tears for those not now covered by Social Security—about 3.5 million—who are excluded from Anderson-King coverage. It would indeed be better if these were covered, but their exclusion is not grounds to deny to almost 15 million others the care that is their due. With Anderson-King, the Kerr-Mills bill will have a chance to meet the needs of the medically indigent, many of whom lack Social Security coverage.

THE SOCIALIST BOGEYMAN

The insurance industry and the American Medical Association have sought to frighten the American people away from Social Security old-age medical care by raising the bogeyman of "socialism."

Appearing before the House Ways and Means Committee on behalf of the Socialist Party-Social Democratic Federation last year to testify on HR 4222, the Anderson-King bill's House version, was Miss Jean Donnelly.

Miss Donnelly noted that the American Medical Association had sought to brand Anderson-King a "socialist measure" by quoting the Socialists out of context. According to the witness, the AMA "several times" commented: "If the Socialists don't know what socialized medicine is, who does?"

The Socialist Party spokesman continued: "For once we agree with the American Medical Association. It was thanks to our sister parties of Britain and Sweden that the people of those countries now enjoy the enormous benefits of socialized medicine. So let me state an expert viewpoint firmly and clearly and for the record: *HR 4222 is most emphatically not socialized medicine.* (Our emphasis.)

As the American Medical Association says, "If the Socialists don't know, who does?"

The AMA's outrageous position has become too much even for the staid *Saturday Evening Post,* which has had this to say editorially: "If medical care for citizens over 65 is financed through the Social Security system, says the AMA, we are headed down the broad highway toward socialized medicine. *To us this seems the sheerest sort of nonsense."* (Our emphasis.)

The Anderson-King bill would retain freedom of choice of doctors and hospitals in as great a measure as any voluntary health plan or commercial insurance scheme. It would permit those covered to choose their own doctors, and the doctors to select the hospitals, just as they do now. The opposition of the medical profession comes more from some real or fancied economic privilege than from any threat to traditional doctor-patient relationships.

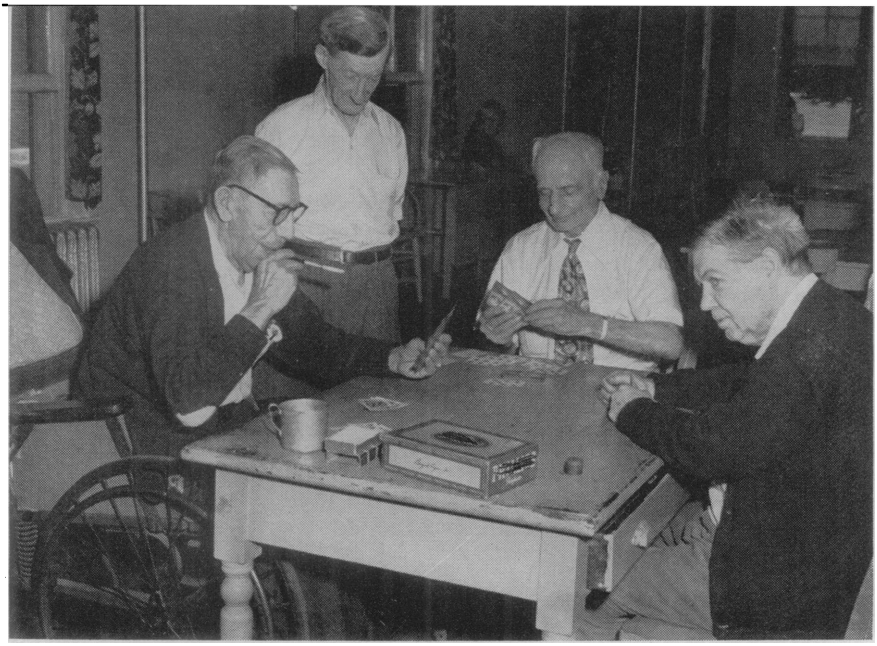
It would be difficult even for the American Medical Association to pin a "socialist" label upon Marion B. Folsom, former Eisenhower Secretary of Health, Education and Welfare, and Arthur Larson, an Eisenhower advisor. Both of these leading Republicans, however, have come out strongly for the Social Security approach.

Mr. Folsom told a 1961 White House Conference on Aging called by the Eisenhower Administration that he had become convinced that private health plans could not cover low-income senior citizens on a "reasonable basis" and that a contributory national insurance system "would fit more naturally into the philosophy of our whole system than a means test." Mr. Larson told the same meeting that he has believed for years that old-age financing is a proper function of the Social Security system and that government handling of the system has resulted in "maximum individual freedom."

While the American Medical Association is able to exert considerable pressure upon its members, a growing minority of the doctors now openly resist. Dr. Elkin Ravetz of Philadelphia spoke firmly for this minority at the 1961 White House Conference where he was a delegate. He charged that the AMA is still advocating "the concept of charity medicine." He termed the Kerr-Mills approach "degrading and debasing." He termed relief program medical care "low-grade medicine, inadequate for the nation's elders" and added that the AMA is "backing a jaded horse."

Despite opposition from former President Eisenhower, the insurance industry, and the AMA, the White House Conference on Aging of 1961 went clearly on record for old-age health care through Social Security.

The AMA has gone to extremes in backing its "jaded horse," and may be expected to continue these tactics. It has fought progress with a tenacity that should excite the envy of liberals. It has remained intransigent in its opposition to any pooling arrangement making it possible for the aged to bear the costs of old age.



A new ethical low was reached two years ago when the 86th Congress neared the voting stage on the issue. Ten key papers carried a full-page AMA advertisement, citing an allegedly impartial survey to prove that the aged are relatively affluent and that they neither want nor need Anderson-King.

The "study" was made by James Wiggins and Helmut Shoock, two professors at Atlanta's Emory University, who presented "findings" during a meeting of the International Association of Gerontology. It was later revealed that the "study" was financed by a $20,000 grant from the Foundation for Voluntary Welfare, dedicated to fighting all welfare programs. It was also revealed later that Wiggins was an unpaid consultant to the AMA's medical economics department. More importantly, it turned out in a subsequent Congressional subcommittee investigation that the "study" was loaded.

In a widely quoted press release issued simultaneously with the ad, the AMA declared that the Emory "survey" proved "that the great majority of Americans over 65 are capably financing their own medical care and prefer to do it on their own without government intervention." Investigation later showed that those surveyed were in the comfortable or relatively comfortable income brackets.

Clark Tibbitts, chairman of the International Association of Gerontology, was among those who expressed shock at the flagrant weighting of the Emory survey. "I was in the audience when Professor Wiggins made his presentation," he wrote in a letter to the Congressional subcommittee. "The basic figures on income differ by as much as 100 percent from those reported by other sources during the past decade, and from such standard sources as the Bu-

reau of the Census, the current Population Survey, and the National Health Survey."

The use of such a survey to fight adequate old-age health care for the nation's elders bespeaks volumes concerning AMA ethics. This year again the AMA is calling upon its 175,000 doctor-members to brainwash patients with anti-Anderson-King lectures.

The claim is increasingly made that social welfare taxes are becoming too great a burden for U. S. industry to bear. In truth, however, total welfare employment costs are lower in the United States than in any other industrial nation.

A report issued last year by the International Labor Organization puts the whole matter into proper perspective. The United States is 25th in expenditures for governmental social security purposes—percentage of national income so spent—and ranks with Portugal in this regard.

EMPLOYER COSTS NOT BURDENSOME

Total outlays by employers for fringe benefits—public and private—amount to about 7.5 percent of total payrolls of private industry. In France, social charges are 34 percent of wages, while in Italy charges are 43 percent.

Total employer Social Security taxes on payrolls now amount to $5.6 billion. Total workmen's compensation taxes amount to $1.4 billion. Total costs of unemployment insurance on industry amount to $3 billion. The largest single cost is for private pensions and welfare funds, accounting for $8.6 billion, or 46 percent of total outlays. Total payrolls subject to tax were $250 billion last year, while almost $200 billion of personal income was not subject to direct welfare taxes.

With the nation's output of goods and services scheduled to reach $570 billion in 1962, an added one-fourth of one percent tax upon employers and workers can hardly be termed burdensome. It is doubtful that it would result in any discernible increase in the outlays by business for social charges in terms of payroll percentages.

The argument is raised that everybody would have to participate in the program, regardless of desire. Attempts have been made to brand the program "compulsory" medicine. This is probably the most specious argument of all.

Both management and the rank and file employee come under Social Security, and all bear the cost. There has been no noticeable offer by management to get its members out from under this "compulsory" program. On the contrary, there is every reason to believe that well-to-do company executives who retire are not at all shy about applying for Social Security benefits, despite lush pensions. They are, of course, fully entitled to such benefits, but there is nothing in law which requires them to apply.

Equally, nothing in Anderson-King would compel anyone to accept benefits. Those not wanting them because they can afford better, or for some principled reason, wouldn't be required to accept available benefits.

MUDDYING THE WATERS

Each session sees involved substitutes for Social Security health care for the aged advanced in the press and the Congress. Without doubt, some are well-intentioned. Others are advanced for malicious reason. Regardless of intent, their net effect is to muddy the waters.

The American Hospital Association has recently shifted its opposition to the use of government funds to meet hospital costs. As the 87th Congress entered its second session, AHA joined with Blue Cross to propose a national private plan. Supposedly, the plan would cover hospitalization and nursing care costs to the aged.

The hitch is the cost to the aging. AHA-Blue Cross have proposed premium payments of $12 a month. These would be paid by the aging, with a subsidy by government for those unable to meet the cost. Supposedly, government would pick up the entire tab where extreme need is shown. With no other way to determine how much government would pay, a means test would be required.

> **Tax costs of the AHA-Blue Cross proposals would be higher than those of Anderson-King if a significant majority of the aging qualified for aid under the means test. Government would have to permit such third parties as insurance companies to participate on an equal basis with AHA-Blue Cross. Over-all costs to government and the aging would be $3 billion, according to F. R. Rawlings, head of Washington, D. C.'s Blue Cross.**

The argument is made that Anderson-King would bring government into the medical picture. The argument overlooks present government participation through the Veterans' Administration, federal employee medical plans, and medical research which is highly subsidized by the federal government. Few have argued against these programs and fewer have been able to prove harm to the nation because of them.

Hospitals have argued that Anderson-King would bring about negotiations between federal administrators and the hospitals regarding price schedules, and that this would be harmful. But the hospitals now agree that under their own proposals, negotiations would still be necessary.

The AHA-Blue Cross plan is costly and complex, and involves a charity approach. It is obviously intended to divert attention and support from the direct and simple Social Security approach.

Not to be outdone, the AMA has joined with Blue Shield to propose a similar senior citizens' plan for surgical care. Here, also, government would be called upon to subsidize a means test program for those unable to afford the $36-a-year fee. Here, AMA appears willing to negotiate with government on fees, although it readily denounces the "heavy hand" when Social Security programs are announced.

AMA-Blue Shield and AHA-Blue Cross programs were announced with great fanfare as the answer to "socialized medicine." Neither the hospital nor the surgical program, however, has actually had formal endorsement from the American Medical Association. In the words of AFL-CIO Social Security Director Nelson Cruikshank, "AMA has come up not with a program, but with a press release."

The AMA has carried its publicity barrage against Anderson-King a step further. It has called upon doctor-members to lower fees to aging patients to prevent "compulsory medicine." The nation's doctors have responded with thundering silence.

Senator Jacob Javits, New York's liberal Republican, has entered the fray with a compromise "that can unite all supporters" of old-age medical care. The Senator would accept Social Security financing, but would entitle persons continuing private insurance to $100 rebate. It would offer three alternatives—one, a "catastrophic illness" plan requiring the aged to pay the first $250 of costs and 20 percent of all costs above that. Javits would have the states administer the program under agreement with the Department of Health, Education, and Welfare.

The Javits program would be financed by payroll taxes in the same way as Anderson-King. It has served only to confuse and complicate the issue. It has been ignored in most quarters.

Anderson-King is the direct and understandable approach to a complex problem. It offers no profit to anybody. It would be the cheapest and most efficient program and would afford the greatest over-all measure of protection. It would establish old-age health care as a right for all senior citizens.

PEOPLE WANT SOCIAL SECURITY APPROACH

When the Social Security system went into effect a quarter of a century ago, opponents predicted that it would regiment the American people and force them to wear dog tags or numbers branded on their skins. The more violent also predicted that a Gestapo would arise to spy upon the nation, and that numbers would soon be substituted for names.

Despite the doomsayers, the Gallup Poll then showed that 63 percent of the people wanted Social Security. Today's Gallup Poll shows that some 70 percent want old-age health care through the Social Security system.

Senior citizens are enthusiastically for the measure. Dozens of their organizations have testified in favor before Congressional committees, and none have testified against. The National Council of Senior Citizens for Health Care Through Social Security has grown to more than half a million, although it was organized only a year ago.

Dr. Paul White, heart specialist and personal physician to former President Eisenhower, has tersely summed up the case.

"After careful consideration of the Anderson-King bill, I am glad to express my approval of it, which, if the safeguards incorporated in it are adhered to, should be of great aid in the case of the health of our aged citizens," Dr. White wrote last year to Representative Wilbur Mills (D., Ark.), chairman of the powerful House Ways and Means Committee.

Representative Mills has come out against the bill despite President Kennedy's strong support for it. He wields great power in the Ways and Means Committee. So far, the conservative GOP-Dixie coalition has been able to keep the bill bottled up in the Committee.

The Dixie-GOP coalition has made it clear that it will do all within its power to prevent enactment of Anderson-King in the 87th Congress. But if the measure can be brought to the floor there is a good chance of victory in the House because this is an election year.

In the Senate, a similar situation exists. Here, the GOP-Dixie coalition has brought its strength to bear in the Senate Finance Committee, which also has bottled up the bill. This committee is chaired by ultraconservative Senator Harry Byrd (D., Va.).

Maximum pressure must be brought upon Senators and Representatives to get Anderson-King out of Committee. With such pressures, means can be found either to pry the bills out of Committees or to bypass them by means available to a determined Congress majority. If action can be won in the House, victory in the Senate can be achieved.

Almost every American has a stake in winning passage. All

Anthony A. Oeding, Florissant, Mo., aircraft worker, is greeted by President Kennedy upon becoming the 15-millionth Social Security retiree last year. Looking on are Mrs. Oeding and HEW Sec. Ribicoff.

of us some day hope to join the nation's seniors. All need old-age health care coverage now, whatever our age.

Young voters will generally marry soon if they are not already wed. They need health care now because they are raising families or soon will be. Young families can ill afford to have resources drained off for catastrophic medical bills of aging parents. Almost all are willing to pay a small tax to assure care for parents now and for themselves when they too grow older.

The middle-aged now face the prospect of sending children to college or of saving for retirement, or both. Yet the burden of old-age medical care too frequently falls upon this group through no fault of the parents they love and respect. They need old-age medical care now. Few would deny a quarter a week to insure care for the nation's elders.

The nation's seniors want no charity, nor do they want their children to bear their burdens. They have lived useful lives and have reared the families that now carry forward the nation's work. They have sought self-respect throughout their lives and seek it now. They need and want medical care as a right.

A quarter of a century ago, the *New Yorker* magazine wrote of the newly passed Old Age and Survivors Insurance law:

"Fear accumulates in a man's life like fluffballs in his pocket, and the security program will for multitudes of people wipe out long, insistent dread of eventual poverty. This, not its monetary relief, is its most important benefit to the race."

These words can now be applied to Anderson-King. Its passage will initiate the time "when the long, insistent dread" of the costs of old-age health care shall be banished from this nation.

FOR OLD AGE HEALTH CARE

THROUGH SOCIAL SECURITY

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WASHINGTON 6, D. C. 1962?

PUBLICATION NO. 45

Printed in U.S.A.