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Dr Reader
Dr Hans Zinsser
Dr Paul Robinson
Dr Lorentz

REMARKS

THE HONORABLE HUBERT H. HUMPHREY

AMERICAN GERIATRICS SOCIETY (Federal Programs)

PEBBLE BEACH, CALIFORNIA (D - 2 colleges - Hubert)

MARCH 16, 1969

I am delighted to participate in this dialogue with such distinguished experts in the field of geriatrics.

Before I go farther, you should know that I'm not a bit fooled by that term. "Geriatrics" is half way between medical jargon and a euphemism for "old timer", variously applied to California gold prospectors, Mickey Mantle, and any Democratic politician who can remember back to the National Convention of 1948. So, welcome aboard.!


Elderly-Poor
Black-Elderly
Race,
Poverty,
Elderly,
Health Care-Elderly
Nutrition

But, I have not come here to make a political speech.

~~In fact, to do so would require me to break a promise I made to myself~~ last November ~~upon~~ following the election; I resolved to make no political statements until the new administration got started.

Of course, if they don't get started pretty soon, I may have to break that promise. . . but not today.

Instead, I want to share with you some of my concerns for public policy in the field of health care and to raise briefly the issue of ~~how~~ our capacity to deal with this problem, ~~as well as many others, ultimately depends on the priorities we set for ourselves as a democratic society.~~ Planning our Cities & Public Facilities

+ Some Specifics about Health Care for the Elderly

+ Time does not permit us to discuss many of the factors which bear upon our living environment - forces and pressures which affect the mental, spiritual, + physical health of us all - Our cities, + Slums, Smog, Poisoning Traffic, Noise, Frustration

Poverty in the Rural Areas

Freedom from want
Freedom from fear
Freedom from Disease

Science and engineering have placed within reach of all men the prospect of freedom from superstition and tyranny -- freedom from hunger and the toil of simply raising food and fiber for survival.

Science and engineering have offered man a longer life, free of disability and disease. In fact, we find the contributions from science and technology so commonplace today that we take for granted the miracles of heart transplants, tv broadcasts from the moon, supersonic transports, and life saving drugs.

But here we find a nagging paradox. While the power of scientific discovery has been employed for positive social purposes, science has also become a blight -- as well as a blessing.

We have conceived weapons which can wipe out humanity.

We have displaced citizens from their jobs through automation.

We have mismanaged our natural environment and permitted pollution of our air, our streams and our landscapes.

We have created unsightly cities, slums, traffic jams, smog, noise and frustration at all the mechanical gadgets that stop working at the most embarrassing moments.

But The applications of science and technology -- for good or ill -- do not depend solely on the decisions of scientists and technicians. To the contrary, the truly challenging and awesome applications of science and technology depend upon values and priorities set by the people, as interpreted and acted upon by our political leaders.

Because Science is neutral - It is man and his decisions that make the difference.

More specifically, how can our improved concepts of governmental responsibility, our magnificent economic engine, our foremost technological systems, our paramount educational institutions, our gigantic pharmaceutical enterprises, our unprecedented medical research, our massive public and private medical facilities and our highly trained practitioners — how can these many forces collaborate effectively to deliver good health to the people who make all these enterprises possible?

Or

How, in other words, can the most affluent and technologically-advanced society in the history of the world meet the basic health needs of all its citizens? Consider the following:

(Race, Poverty, Elderly!)

Item: Although the War on Poverty has raised 6 million people out of poverty in the last four years, we still have 29 million poor people in affluent America -- 29 million people who need jobs, education, food programs, and health care -- 29 million people who are not receiving, ~~and whose children and grandchildren are not receiving~~, the most basic necessities of life which they see are available to their 170 million neighbors. 1/2 of all People Pretage 65 Live in Poverty!

Item: With all our affluence and medical competence, the men of 20 countries, and the women of 11 countries, live longer than American men and women.

Item: Among the nations of the world, the United States ranks sixteenth in terms of infant mortality. And the Mortality rate of Non-White babies is 58% higher than for whites.

It appears that infant mortality argument

What does this mean in human terms? It means that, compared to Sweden, for instance, the failures of our medical and health system needlessly [redacted] lot die 50,000 American babies last year. —

Item: While we are all properly concerned with the need to check inflation, our health costs today are increasing at a rate more than double that of general price levels in our economy. Hospital costs up.

Item: 30 million Americans have no health insurance at all. And despite the great efforts of the insurance industry, supplemented by Medicare and Medicaid programs, which, all combined, have written some form of health insurance for 4 out of every 5 citizens, two-thirds of all personal health care costs remain uninsured. —

We spend 6½% of our GNP for health care - last year that was over $55 Billions yet millions of our people had inadequate health care.

Item: Based on minimum standards of quality set by Medicare, one-third of all hospitals are not accredited, and 10% of all hospital patients are admitted to non-accredited hospital beds.

These few statistics are common knowledge, not revelations, to the people in this room.

But, what do these statistics tell us? They reveal serious deficiencies in the basic planning, design and operation of our health-care system. a Model T Health Care system in the Jet Age.

And they reveal further, a failure of our society to establish the national priorities which are necessary to provide every citizen full access to humane and comprehensive health care.

Need National Health Plan

Lincoln: The legitimate object of government is to do for a community of people whatever they need to have done, but cannot do at all or cannot do so well for themselves in their separate and individual capacities."

The time has come in this country to get both our priorities and our systems straightened around and functioning properly.

Historically, we have been a nation of tinkerers, not planners. And we have been satisfied with a long series of remedial, crash programs which inevitably are more expensive and less efficient than doing the job right in the first place.

For example, we know that the demand for health care -- both geriatric and general -- dangerously outstrips our supply of physicians, nurses, paramedical personnel, hospital beds and related health services. These must be Expanded

But a major factor in this critical shortage is a largely unplanned, unsophisticated, unresponsive health-care system which is unable to use our existing health resources efficiently and economically. - Particularly for Poor + Elderly
- Out Patient Clinics
- Neighborhood Health Centers
- Hospital Mobile Units.
- Kiddie Care - Pre Natal
Post Natal

There must.

To the Services to the People

The fact is that a well conceived and coordinated system of health care, one which deployed doctors and hospital beds rationally, and one which provided universal health care, could probably be achieved without drastically increasing the number of physicians and without even replacing the sub-standard hospitals which, nevertheless, should be abolished for other reasons.

It is, I repeat, a question of priorities and planning.

* * *

We must act as promptly as possible to relieve the most immediate injustices in the present system -- injustices which afflict most directly the poor and the elderly on fixed retirement and social security benefits.

During the Presidential campaign, I suggested a series of urgent steps that should be taken:

-- Increasing Social Security benefits by 50 percent across the board in steps over the next four years.

-- Making benefits inflation-proof after retirement by raising them automatically to reflect cost-of-living increases.

-- Making it more attractive for the Social Security beneficiary to earn more by liberalizing the provisions which reduce benefits when a person is employed.

-- Financing a part of the increased benefits from general revenues to ease the burden of social security contributions on the workers.

Statement - ~~Possibly be~~ If these Projects get started & stopped then maybe worse than no Stat -
(· Fight first)

⊕ [illegible]

and have I urged taking the next steps in improving our Medicare program:

-- Putting the doctor bill part of Medicare on the same social insurance pre-payment basis as the hospital part, thereby making it unnecessary for older citizens to pay $4.00 a month out of their retirement incomes for medical insurance.

- Providing protection against the heavy cost of prescription drugs which account for about 30 percent of private expenditures by the aged for health care.

-- Extending Medicare's protection to disabled Social Security beneficiaries who, like older people, have unusually high medical costs at a time when their overall income is sharply reduced.

These are short-term, easily-taken steps which would relieve some of the more immediate needs in the health-care field.

But we must not permit short-term advances to blind us to the even more critical necessity of restructuring our entire health-care system.

In this regard, I am impressed by the comprehensive program of principles and action set forth by the Committee for National Health Insurance. — Emphasis on group practice

This is a balanced and thoughtful approach which takes seriously the vital interests and concerns of all groups in our society that are essential to a successful system of health-care services.

By the same token, any health-care system will require the concerted and good-faith planning of the health professions, public health officials, the insurance industry, and other interested associations and groups, such as the American Geriatrics Society.

A restructured health-care system -- founded on some form of [redacted], pre-paid insurance with emphasis on group practice - will have to fit our unique American institutions and traditions.

It cannot be copied from Great Britain or European National Health Plans. It will have to assure maximum flexibility and options, both for the consumers and members of the health professions.

X

(1) Will it add to our Security - no
(2) Does it improve the international political atmosphere - no.
(3) Is it reliable - Doubtful

But, this kind of health-care system will be possible only in a society which has its priorities straight -- a society which has decided to direct its energies from the works of war to the works of peace.

That is why I have in recent days spoken out against deployment of the anti-ballistic missile system and urged instead the beginning of prompt negotiations with the Soviet Union to seek the reduction of both defensive and offensive strategic nuclear weapons. - Taking a risk for peace - We have time with safety.

It is in this spirit that I am honored to participate in this stimulating dialogue on social policy issues in health care of the aging.

ABM - We needed a bold initiative by the U.S. in halting the arms race - be Chance of a lifetime;
- We need to decide these questions of arms control or new expansion in weapons with the background of National Priorities - needs

THE AMERICAN GERIATRICS SOCIETY

A SEMINAR ON

PUBLIC HEARING ISSUES FOR THE AGING:

A CURRENT DIALOGUE

March 16, 1969

3:00 p.m.

Del Monte Lodge

Pebble Beach, California

Presiding: HANS H. ZINSSER, M. D.

President, American Geriatrics Society

George G. Reader, M. D.

Seminar Chairman

BRAY & O'DALY
CERTIFIED SHORTHAND REPORTERS
MONTEREY COUNTY
SALINAS, CALIFORNIA

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DR. ZINSSER: Mr. Humphrey is a little ahead of schedule. Some of you will get a chance to know more about the important questions that we hope he is going to answer. I think we will get this Seminar of the American Geriatrics Society started now.

I am Hans Zinsser. I am President of the American Geriatrics Society. I want you to know a few of the other people we have here, Doctor Hammond, Past President, and present head of the Board of Directors of the American Geriatrics Society Research Foundation of which we have high hopes in getting aid to solving some problems is also here.

I would like now to introduce to you George Reader, President Elect of the Society, who is earning his presidency by having done all the work of getting you here and I hope having a very useful workshop seminar with you today.

(Applause).

DOCTOR READER: The purpose of the seminar is to focus attention on one of the major problems of the day, that is, the problems of the rapidly aging population of the United States.

As most of you know perhaps even better than I the population of the United States over the next twenty-five years will become much older and much younger so that the elderly component of it will enlarge considerably percentage wise. By 1990 there is expected to be thirty

million people over sixty-five in the United States. Because of this we will have many problems confronting us that are at the present time minor compared to what they may be expected to be in the future.

This Seminar of the American Geriatrics Society then will take up these problems, will call upon your expert advice today to orient us to what the action should be for the future. We will have the benefit of Mr. Humphrey's advice on the subject also, and the way we want to stage this afternoon's program is to begin by giving you an opportunity to express yourselves in a general public discussion about some of the things that you feel should have the highest priority, some of the things that you feel are the greatest problems, and Mr. Humphrey then will speak in terms of what he believes are some of the answers to these problems and what choices have to be made that face some of the difficult choices.

Then we will have an opportunity to have a question and answer session so that you can pose questions to Mr. Humphrey and as a result of this we hope will focus national attention on these issues.

The Society will then go on for two more days in group discussions of how to deal with these problems.

Tomorrow we will have four expert papers on health, man power, on standards, and quality, and on the economics of health care of the aging.

We will also have the benefit of the advice of the representatives of other major health organizations and a panel discussion on how their organizations propose to deal with these problems.

And finally on Tuesday morning we will end up with a panel which will give us the benefit of some of the leaders in Government who are preparing themselves now to deal with these things in a substantive way.

Mr. Humphrey is expected eminently. When he comes I want to give him an opportunity to hear some of the discussion before he launches into his own talk. His own talk we have planned to begin at about 4:00 p.m. so from now until 4:00 we would like to have you participate in a discussion. And I would like to call on you to have you volunteer. But if we don't get enough volunteers we will call on some of you to express position of yourself and your organizations as to what you think these priorities are, what these issues are, what you think ought to be done about it.

All that is going to be presented will be recorded. The proceedings will be published and we hope that the distribution of the proceedings will have a major impact on all those who concern themselves with these important problems.

Does anyone feel called upon to start the discussion? When you speak I would like you to identify yourselves

and your organization for the benefit of both the audience and our stenotypist.

Perhaps we can begin with Mrs. Sproles, who comes from Salinas, has been active here locally and I know in conversations with her that she has quite strong feelings about some of these problems. Mrs. Sproles, would you get up and introduce yourself and tell us the background of your interest in the aging.

MRS. SPROLES: Thank you very much, Doctor Reader. I am Mildred Sproles, and I have been interested actually for about eighteen years in the senior problem.

DOCTOR ROSS: Can you use a microphone?

MRS. SPROLES: Yes. There is no other microphone available, is there, Doctor?

DOCTOR READER: I think we can hear perfectly well.

DOCTOR ROSS: Her voice isn't reaching this area.

DOCTOR READER: I don't think we have a portable microphone. Why don't you come up here, Mrs. Sproles.

MRS. SPROLES: This is fine. I think they can hear from here. Can you hear my voice now?

I am Mildred Sproles and about eighteen years ago -- sounds like a long time, but it doesn't seem so long -- we became aware in Salinas of the fact that we didn't offer our seniors anything at all there in the way of group activity. So in a very small way with the sponsorship of the Soroptimist Club at that time we started recreational

work. It has grown I might add and the group has become a separate entity and it has flourished very well independently of any public assistance there.

More recently I have become interested and am now working in Medical Services with the Monterey County Welfare Department and in that capacity I deal with nursing home patients and a number of nursing homes in Salinas.

I might add that I am very happy indeed to have the interest focused on the seniors in this area.

As far as saying any words of wisdom that you don't all know about the seniors, I don't think I can. The principal thing that I see is needed here in our area is an interim care situation. We do quite well for the seniors in the nursing homes. We don't do too well for them in independent housing, specially in Salinas, we don't have enough independent housing. We don't have adequate board and care facilities. And my own personal feeling too is that we need something in between the independent home and the nursing home.

There are patients who need a little bit more than they can provide for themselves in their own home but not quite as much as a nursing home needs to give them. And it would be a matter of a savings for the taxpayer as well as a matter of maintaining the dignity of the individual if we could work out something that would fill this interim need.

DOCTOR READER: Thank you very much, Mrs. Sproles. Is there someone else who would like to speak next.

Tape#5

DOCTOR ELIZABETH ARVAD: I am Doctor Arvad, and I am from Rancho Los Amigos Rehabilitation Hospital which is ten hundred and eighty beds and five hundred are allocated for the Geriatric Department. We have quite a Stroke Center. You perhaps may have heard of it for stroke rehabilitation and the aging. And our biggest problem -- I was interested in hearing talk about board and care and that's one of the problems when they no longer need to stay in the acute part of the hospital we have the long term wards. But then the problem is Medicare and Medical paying for it in a hospital that is not considered a rehabilitation center and we are constantly put to it to look for nursing homes where they can be taken care of adequately. And we have a number of patients who are, as she says, Mrs. Sproles said, do not need nursing home care but need more than being alone in a home with a family or something. And so it's the board and care.

But then the problem arises of payment and this seems to be one of the biggest features of who will pay for what. And that's one of our problems. If anybody can help us, why, we will be delighted to have you come and help.

DR. READER: Thank you very much.

DR. FEIGENBAUM: I am Doctor Feigenbaum from the University of California Medical Center and I have essentially

a two part issue, one of which has to do with relocation of older people in areas of redevelopment because we know that changing the location of an older person adds to the possibility of psychological damage.

Following this, the other issue is that of Medicare which seems to me to make a very strong exception for outpatient psychiatric care for elderly people. And it seems to me that in this area particularly some revisions need to be made.

DOCTOR READER: Do you have any to suggest at this point, Doctor Feigenbaum?

DOCTOR FEIGENBAUM: Yes, I think the restriction of eighty percent of our patient care up to a total of two hundred and fifty dollars a year is an unreasonable one and that it should not be based on that kind of issue. It should be based on the issue of health need.

DOCTOR READER: Thank you, Sir.

MR. HALVORSON: I am Lloyd Halvorson, of the California Association of Homes for the Aging. I would like to introduce a different subject. Obviously since we are concerned with the nonprofit private sector in its care of older people, this is my area of concern.

We are moving rapidly these days in talking about a total community approach to the care of older people which enlists and coordinates the private and the Governmental sector and the private agencies and the organizations in

the community to take care of all older people and we have had now increasingly over the years, and the former Vice President has been well aware of this in the area of the Government saying we ought to be partners with the private sector in developing services in caring for older people.

The issue which I hope can be discussed here is how can we implement this concern which is joint on the part of both Government and the private sector to really move farther than to express the interest but without finding ways to implement it.

DOCTOR READER: Thank you, Mr. Halvorson.

Doctor Lee, would you like to say a word about your strong feelings on this subject?

DOCTOR LEE: I am Doctor Russell Lee, from the Palo Alto Clinic. I would like to express two points in the matter of Medical care of the aging.

The first is a very great necessity of preventive and predictive medicine. Most of the disabilities of aging are preventable if you know what is the construction of the individual so more than any other group the aging group are candidates for these forms of multiphasic screening which are getting increasingly effective. The ordinary comprehensive medical examination at two hundred dollars a copy is too expensive for old people. And we have to look for other alternatives.

Now, one of the best is multiphasic in that you will find about eighty-five percent of the correctable defects. Then the next important thing is the application of what we call predictive medicine, predicting what is going to happen to this individual and then take some proper measures to see that he does not become incapacitated and so forth.

I firmly believe that most of the disabilities of aging, including senility, senile psychosis, is preventable with a program that we put in operation as soon as we find the tendency.

So this requires more than any -- now I will revert to my old roll of an apostle for group practice -- this requires more than anything else a group approach because older people more than any other group require all the skills of the various specialists. They get cataracts, they get hypertrophy prostates, they get neurological disorders, they are very prone to skin diseases as well as the psychiatric. So to properly care for large groups of older people almost requires the group practice approach but headed -- and this is the plea I made two years ago at this Society -- for the Geriatrician. We need more and more people. Geriatrics from an economic and humanitarian point of view is much more important than Pediatrics, for instance.

I think Doctor Bortz can talk about this preventive and prophylactic type medicine more than I can if you can induce him to, George.

DOCTOR READER: Can we? Mrs. Russell.

MRS. RUSSELL: I'm going to follow along to some extent with Doctor Lee and talk about the community.

I am Bonny Russell, Chairman of the California Commission on Aging -- the State Commission on Aging. I think most of you know our State Commission has a statutory responsibility for working with the communities of the state with individuals and organizations both public and private.

During the last three years we have been responsible for the administration of the Older Americans Act in California and during this period some forty-one programs have been sponsored by us and in part by the community. Many of these programs have had programs within them having to do with the health problems of the older person.

A good deal of emphasis has been placed on the Multi-purpose Senior Center in which there are programs of prevention in the field of health, in which there are some single screening programs such as tuberculosis, glaucoma screening, and others such as this.

We do have some emphasis on trying to promote multi-phasic screening and others such as this. We do have some emphasis on trying to promote multiphasic screening, have been unsuccessful in most programs but do have some at the present time.

We have a good deal of emphasis on food and nutrition of a great variety, some having full meals each day for

the older person in Centers or delivered to their homes. One program which we are very interested in is at Downtown Center in San Francisco which has a twenty cent a day luncheon program, a very effective program, can be prepared in a half hour and served from one pot, twenty-five people, or it can be served in a larger scale for many more people -- a very inexpensive program, one that people can sustain by themselves.

Programs of education in the field of health are also very, very important. But the most important I think is the involvement of the older person in these programs. Older people prove that the title free programs in California have begun to provide many of the services that are necessary to promote further health services for older persons and some of the people are doing it on a voluntary basis, others are being paid for the cost that is involved. Others are getting a very low salary but they are being incorporated into the programs. They are beginning to have a voice in the community in requesting the kind of programs they need.

I think these are very important steps that are essential if we are going to have a total program in this country.

DOCTOR READER: While we have you speaking, either you or Mr. Skoien, I wonder if you could say just a word about how MediCal has worked out. Doctor Feigenbaum indicated that Medicare does not fill all the gaps

and that hopefully MediCal might match them up. Could you say just a word about that, you or Mr. Skoien?

MR. SKOIEN: Basically our mission is not involved directly with the MediCal program. It would be nice if we had Carl Moger here to really explain the integral parts of the program.

Our whole attitude in the field for aging Californians -- we call our seniors Senior Californians now which we think is going to bring the dignity and prestige back to the individuals that our elder citizens had many years ago, and we believe that society basically has to accept the older person now and more and more by working with the local communities, the thousands and thousands of local communities in our State. We are going to have the community itself accept the seniors, not segregate the seniors. I think this is what we are trying not to do in California, not to set them aside into a segment or a portion of this community but they should be integrated in the total community, they should be a part of the Recreation Commissions and City Planning Commissions, all the different phases of the community. This is our aim.

The MediCal program is hopefully our program in California and we feel it has been put under very good administrative procedures. I think our administration in the last twenty-four months or twenty-six months has proven that MediCal can be very advantageous to the individual

person, but it also has to have administrative controls that we are working on in California.

DOCTOR READER: Reverend Duffy, I wonder if we could call upon you for a few words.

REVEREND DUFFY: Well, Mr. Chairman, I represent the San Francisco Council of Churches and a great deal of our work is with the elderly in thirteen Centers in churches throughout the City and two poverty funded programs, funded by the Office of Economic Opportunity Funds, one in Chinatown, in North Beach, and one in what is called the South of Market area of the City.

In these latter two programs we employ elderly poor people to go out and find and locate other elderly poor people who are hidden away from life, and to open the door for them to get the services, to make it possible for them to influence policy and decisions in the community concerning their needs.

I think this follows along the line of suggestions Mrs. Russell was speaking about and is one of the most important things we can do is to give older people a tangible opportunity to participate in their own destiny.

I think the poverty program is to be highly commended because of this emphasis on involving the poor in working out solutions to their own needs.

Now, we find many, many problems which require a great deal of assistance from the medical profession.

We have been pleased a great deal with the extraordinary cooperation from people like Doctor Feigenbaum, from several psychiatrists in the community, the Community Mental Health Program, the San Francisco Medical Society, the San Francisco Public Health Department, the California State Department of Public Health, the U. C. Medical School -- all have helped in many ways in the different kinds of work we do with the elderly.

There is much more that needs to be done and I am so grateful for a Conference which emphasizes looking at social problems concerning the elderly because we outside of the medical profession do not have a corner on the market of knowledge about solutions. We need help from the medical profession in working out some of these solutions and I look forward to learning more about how to do that here.

DOCTOR READER: Mr. Johnson.

MR. JOHNSON: Mr. Chairman, I am Bob Johnson, Director of the Concord Coordinating Services, that's an Administration on Aging of the California Commission Program for Suburban Communities. And our problem isn't our people's problem, namely, administration on age programs, three years is pretty short to develop things, you know, the three year projects.

We have focused on the loneliness, the involvement of seniors. We are on the right track and as far as problems that make the good life of retirement rough in Suburbia,

MediCal has relieved one major problem but the high cost of drugs and property taxes face us.

MISS VICKERY: I am Florence Vickery, formerly Director of the San Francisco Senior Center and now a Consultant with it.

I wanted to speak a bit more about Mrs. Russell's description of a project that has been undertaken with Older American Funds and project what now is the problem and where to me the problem lies in developing further services.

This is an outreach program from the San Francisco Senior Center dealing with older people which is a poverty area and we have in our community a number of poverty areas. In this project that I am describing we deal with members from all over the city. So many poverty people, older people from poverty areas, come to the San Francisco Senior Center. But that project, of course, itself cannot receive funds.

We have then a problem that when our demonstration is completed our main project is financed by the voluntary funds from our United Community Fund. When we look at the carrying on of this demonstration the money cannot come from older Americans longer. Our community says we haven't any more voluntary funds to give you because we have minority group youth, we have the problems in our inner city, and we have to finance these agencies.

I am concerned that the projects for older people are

really going to take secondary concern in our communities pretty soon because the other problems of the central city, and frankly even though the demonstration is excellent, it is needed, I don't know what the future of this is going to be and other voluntary financed projects.

I am looking for some federal programs that are going to make available funds to continue the life of these group services to older people who are in poverty areas, yes, but in a lot of other areas of our city are older people who have the same problems as the older people in the poverty areas.

DOCTOR READER: Thank you.

MR. ELLSWORTH: Ted Ellsworth, from the University of California at Los Angeles.

I'd like to support Doctor Lee's statement because I think the preventive medicine multiphasic screening is very badly needed. However, I would like to add a very important dimension to it, a very needed one in Los Angeles especially as in many other metropolitan areas there is a very serious problem of transportation for older people.

Our experience with the older people, even the ones who have money, is that unless we take services into the areas in which they live, that the services don't get to them.

In multiphasic screening programs the experiment here in Northern California with the Mobile Unit going

into the plants was very successful, a program the Teamsters had up here and still have. And I think that this would be a program that really would be of great benefit if we could get the Mobile Unit setups going for the multiphasic screening and follow up with the preventive medicine and good practice mentioned.

I also would like to mention that we have the same problem with demonstration projects that Miss Vickery mentions. We have two at the present time, one in the Watts area and one in the downtown hotel and the east side of Los Angeles. Both of them are running out of money, that is, the Federal money will run out. There are no other funds available. Their foundations, other aspects of getting money, don't exist in the community because there is such a concentration on youth. And I wonder, I am merely raising the question if possibly we have done more harm than good with some of these projects if we can't continue them, if we are going to have to have old people in a project for three years and then see no more money to support it. They might become more disillusioned than they were three years ago.

DOCTOR READER: Thank you. Mr. Shissel, you wanted to say something.

MR. SHISSEL: Mr. Chairman, I am the Director of the Office of the Aging at the Mayor's office in San Francisco and I see as a tremendous problem in San Francisco the increases in property taxes, ergo the increases in rent.

It's axiomatic that anybody is better off in their sort of familiar home and in their own neighborhoods and if as the rent increases or the taxes increase people on fixed incomes can only go to one source, money and that is the food budget. And we have many, many older people suffering from avitaminosis and other such problems.

I also believe that we can keep a lot of people in their homes if we will bring food service perhaps, home health services, and many sort of basic services to them on a day to day basis.

DOCTOR READER: Doctor Feigenbaum, you wanted to say something again?

DOCTOR FEIGENBAUM: Yes, I wanted to add another facet, this is not to minimize the need for an approach to get to older people and improve their lot. However, there has been mentioned a number of times so far today of the roll of the medical profession. And I see it as an important one.

As co-author of a Paper which was published in the Journal that this sponsoring organization publishes we described medical student's attitudes towards geriatric patients and we find that their attitudes are generally those of the community, namely, negative.

It seems to me that a great deal of money and effort must be put into places like medical schools and other professional training institutions to educate those young

people who will be dealing with older people in ways that will change these attitudes from the negative to the positive. And if we can do that it seems to me at least that there can be a change in some of these terrible things that we are all faced with from day to day in dealing with older people.

DOCTOR READER: Doctor George Wolf, Dean of the Medical School, we might ask you to respond to this, Doctor Wolf.

DOCTOR WOLFE I think that it's quite correct that the medical students have tended to have a negative view of older people but I think this is more in ignorance than by plot as I am sure you will agree. They are indeed not exposed to older people in any kind of a natural environment so to speak. They are exposed to older people in the setting of the highly complexed Medical Center where the patient is usually terribly ill when he is admitted to the hospital with sometimes acute illnesses or some kind of a very hopeless chronic illness.

I would hope that the solution to this problem would be, relating to Medical Centers, more effective in the future with things like extended care facilities and nursing homes.

I think prior to this time the method of financing health care has mitigated against establishing an effective relationship with nursing homes and extended care facilities

but I expect this to be corrected in the future.

DOCTOR READER: Yes, sir.

DOCTOR KRAG: I am Doctor Krag, I am from Stockton. I practice medicine, take care of elderly people primarily.

I had two, since we are listing problems as we see them, one general that I think is pertinent, another one that I think also pertinent but unrelated. The one is that I think that regardless of rich or poor those who are designing our cities and our buildings are not taking into account their human needs of people. It's almost a terrifying experience for many older people to go out onto our city streets, out on to our sidewalks both day or nighttime. On the one hand they may be slugged, knocked down, killed, as it happens I have seen people just in the last few days, an elderly lady knocked down for her purse. At the same time older people try to drive their automobiles but they've got glaucoma and they have difficulty in driving. I see those who try to be a pedestrian on the sidewalks and the sidewalks are not made for people. I see older people who have some urinary tract problems. They can't be too far away from a toilet but they are afraid to go out in the streets because there is no such place.

Now, for example, what I have in mind is take a post office our federal government builds. Have you ever seen anything more difficult for an older person to make use of? Stairs to climb, doors that are hard to open, windows where

you have difficulty getting waited on, no toilets available.

I use this only as an example of the lack of imagination of the engineers in designing buildings and streets in our cities, our Suburbia and the like. I feel there are a great many needs to be taken care of in planning for old people.

Now, this problem of transportation is only symptomatic of this sickness -- almost a lack of planning. That's one pet peeve that I have.

The second thing is related particularly to California but I think this is being faced in a few other states, New York State I think Ohio, it will become more of a problem in the other states in the eagerness to close down large public owned warehouses for the mentally ill, particularly to move older people out in the eagerness to destroy what is looked upon as an evil kind of organization for taking care of sick people. They are closed down without adequate provisions for alternative services for older people. As a result today I think you could go into any community in this country of ours and find in nursing homes and convalescent hospitals patients who have psychiatric problems who under ordinary circumstances would be receiving better care as difficult as it may be, in a large mental hospital, they are receiving far worse care in the nursing homes because of the fact there is no trained staff able to manage people with these problems whether they be medical doctors, or the nurses, or the aids, or the social workers. As a result

the newer drugs that are so freely available through the public medical care programs are dispensed to these poor patients in hugh quantities with resulting stupor and early demise.

I would say the death rate among these patients is far greater than it ever should be because these people are not getting care they should.

So I would make a plea that in those of you who have some responsibility for changing the way of things such as closing down large psychiatric centers that some provision be made for the follow-up care, alternative services to meet the needs of these very sick people.

DOCTOR READER: Thank you. Doctor Silver, how does the Urban Coalition view the problem of the elderly or is it primarily for the children of the poor?

DOCTOR SILVER: Well now, I think in developing a health program actually the coalition with its hocus on communities doing what is necessary as they see the priority to improve services and activities for the people in that community would certainly take into consideration the aged, the problems of the aged, and the kinds of programs and deficiencies in programs that have been talked about here today.

I think probably the most important thing is that it is relatively easier to focus on programs that attack problems in a geographic area. When you talk about the inner city,

this was mentioned before, that while there may be a concentration of people in the inner city, this isn't where all the people are and you must develop programs that will scan those who are not geographically eligible.

On the other hand, you know, there is a shortage of everything. We are short of money for programs, we are short of manpower to carry programs out, we are short of imagination to develop the programs that would be most effective in meeting the needs, and there has to be some kind of allocation of resources.

Now, one of the difficulties in the inner cities, and I won't speak for what happens elsewhere except I am sure that the same problem is theirs, that we have a tendency to reallocate resources. We tend to develop this "pousse cafe" effect where the old program is retained and then when new money comes in and a new program is put on top of it and then you sort of keep that up and you lose the benefit therefore of the opportunity of using the new money to produce more efficient economical programs that will benefit those that you are trying to serve with the new money as well as with the old. And I think that some of the points that were made today really zero in on that particular problem. So many things that need to be done can be done with a better use of the money that we now have.

If we try to make more effective use of old people to serve the community as well as using the community to

serve the old people, I think that the gentleman behind me made that point very well.

DOCTOR READER: Thank you. We have time for one more comment -- yes, sir.

MR. BOZZO: I represent the Senior California Educational Center. We are funded by the California Commission on Aging and many of the questions that have been raised this afternoon are kind of like what our project is all about. We are a multipurpose center and we are also an education and training component.

We have found that in going out and working with a lot of the projects that have been funded by various programs that there is a lack of training and education not only in the medical field but in a lot of the other areas, social workers. You can go on down the line but what we have attempted to do is to do some of the education and training so that we can better prepare our people to go out and work with our senior Californians.

Tape# 6

Another thing that we have found in the multipurpose center which has been found nation wide is the lack of nutrition in our older people and also the lack of care, medical and mental health care, not that it is not available in the community but these people will not go down to the centers that are located there because of transportation or for a lot of other reasons so for raising a question you might say that there is an awful lot of money in the

field today and more and more it's enhancing a lot of people so they do need the education and training and a project like the Educational Center can provide this type. There are two projects in the State, one in San Jose, the other in Los Angeles.

The other question that we might raise then is the fact that we do need these multipurpose centers because this is where the seniors would like to go better than they do to the large facilities. We do not have the stairs like the post office, so maybe the Center is a place where they can go. If this is the case then why not take a look a little further and say that -- take our medical screening units and put them in the Center and possibly come up with a nice package for our older Americans.

DOCTOR READER: Thank you. Doctor Bortz, you have a pressing comment?

DOCTOR BORTZ: My name is Edward Bortz from Philadelphia. For the last fifteen or twenty years we have been carrying on experimental observations on animals including the human animal and we have found out that with attention to the simple aspects of living such as diet and exercise, adequate rest, and a high motivation that individuals can be kept healthy and happy and integrated into the community. We think this is terribly important.

In our hospital in Philadelphia we have a Health Education Division with ten full-time employees and last

year we had more people coming to our Health Education programs than we did as patients. We are convinced that about fifty percent of the patients that are occupying hospital beds today should not be in the hospital. We are also convinced that we are as a Nation sickness minded rather than health minded.

We think that, as Doctor Lee pointed out, multiphasic screening would uncover a lot of preventable conditions and in our thinking we have gone a step further than that, in addition to predictive medicine we are thinking about developing the positive potentials of individuals and we think that here there is a new dimension in the human life span.

Unfortunately today medicine is hopelessly fragmented. We are episodic minded. We have super specialists 'til they know more and more about less and less. And they have in the past looked upon the individual who has been the family doctor and the health advisor to the family as an individual who is not quite up to the ivory tower standard.

Fortunately, this is breaking down at the present time and there is a medical revolution going on all over the country as I see it in the different states. There is an awakening on the part of the medical profession. We haven't yet done what we should do but I think that there is a new day coming and we will be able to save a lot of patients from going into hospitals, not only that but to integrate these individuals because as Browning said, "Youth knows but half,"

and often times the youth individuals of the Nation, the youth of our country, are getting the major part of attention to the neglect of the older population.

We for too long have looked upon our older people as second class citizens and I think unfortunately to a certain extent the attitude of the communities, the cities throughout the Nation and small communities encourages them to a state of dependency that is almost pathological. And when individuals are encouraged to be sick and encouraged to go into the hospital it's a most unfortunate situation so that I believe that what we need is a fair, thorough going nationwide cultural catharsis and a new look at the great potentials that reside in the individual as he goes into the fabulous later years of life.

DOCTOR READER: Thank you, Doctor Bortz. I think at this point we will turn to what you have been eagerly awaiting and you can save other questions you have for Mr. Humphrey after he concludes his remarks.

DOCTOR ZINSSER: We had hoped to have an old and good friend of our former Vice President. I will tell you about him and introduce him. Failing the presence of Senator Williams, it is my proud duty to introduce to you someone who has been a constant visitor in all of our homes for many years now. I wish to make the point that all politicians and physicians seem to have been at somewhat odds over the past twenty-five years. They really have a great deal in common,

both of them have gone into their professions with a deep sense of compassion for other people. All of them have had as a result either individual power over their own patients or power over large segments of the population. They all of them depend on their constituency for their continued success and well-being and employment. And they must have an overwhelming confidence in themselves that they uniquely can present the services to the individual that he needs.

Now, we live in a society where privilege has become right and with rights some expectations, expectations to have one's needs provided for. The stirring that we have at the present time in the United States is not an under-privileged complaint, it's an underprovision and the medical profession more than any other segment in the population is about to face a terrible crisis in providing medical care.

The multiphasic screening programs are going to uncover three times the amount of work that the physician could possibly do. We are going to need large areas of help in the paramedical fields both diagnostically and therapeutically. Our society has been almost alone in seeking to actively work with the Government over many years.

This leads again to problems on which we are counting for your advice in the course of the coming few days.

Now, some of the difficulties of our former Vice President I share. I went to a school many years ago and I have on my

office wall a photograph of a football team. The head in the center of the photograph is young Joe Kennedy. Off on one side to the right is Jack Kennedy, but the fellow in school that we thought was top man and that we all went out to lick was William Bunty -- Bill Bunty was the big man in the school.

Now, a few people in Wisconsin and West Virginia have temporarily denied us the right to have our Vice President as President. But we've had a great Mayor, a great Senator, a great Vice President, a great follower of the liberal tradition which has led to the enforcement of many of these privileges into rights and a great leader whom I hope will help us today. Thank you.

(Applause).

(Thereupon follows the presentation of Hubert H. Humphrey).

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Return to John G. Stewart

THE AMERICAN GERIATRICS SOCIETY

A SEMINAR ON

SOCIAL POLICY ISSUES IN HEALTH CARE OF THE AGING

March 16, 1969

4:00 p.m.

Del Monte Lodge

Pebble Beach, California

THE HONORABLE HUBERT H. HUMPHREY

George G. Reader, M. D.

Seminar Chairman

BRAY & O'DALY
CERTIFIED SHORTHAND REPORTERS
MONTEREY COUNTY
SALINAS, CALIFORNIA

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MR. HUMPHREY: May I say how very happy I am to be in this beautiful State of California, this very lovely Pebble Beach area, and to be here to participate in this Seminar of the American Geriatrics Society.

I want to thank Doctor Reader and Doctor Zinsser. And I surely want to thank Doctor Robertson and Doctor Lorenze who met me at the airport and took themselves away from this meeting in its very lovely surrounding. And I want to thank those whom I have heard speak because I think I have learned more in the last thirty minutes than I have learned in many, many years.

What I have learned is that we really have a pretty good idea what is wrong and what we ought to be doing about it or at least we are willing to approach a problem in the knowledge that there are things that are very wrong.

We are willing to talk outloud about our inadequacies. That's the first sign of good health -- mental health, political health, social health. So I believe that we have set a standard here that you have of approaching the problems of health care of the elderly and the health care of all people.

Now, I want to just say a word or two before I get into my rather what I believe now to be inadequate remarks.

I couldn't help but note how relaxed I felt when somebody got up to talk about Federal Programs and their inadequacies. How I used to twitch and squirm and the blood would rush up to my head and I would figure how am I going to

answer that one!

For the first time in some twenty years I'm neather defending or advocating, I'm just discussing. The word dialogue has come to have real meaning to me. Up until that time I would either have to be fighting for a program or defending one that someone was fighting against and, my, what that can do to your temperment, to your psychiatriac makeup. So I feel that I maybe qualified fully for the geriatrics program. I'm going to live a long time now that I have had days of relaxation -- I said days, not years. I intend to make the most of it.

Last evening I was in Washington, D. C. at the Gridiron Dinner which is one of the great events of the Washington scene. It's the general razzing session for new administrations, old administrations, administrations coming and administrations going, and I made note of something somewhat apropos. I said that I supposed that I was the only man, the only teacher who, having the privilege of teaching on two campuses, could be simultaneously the hostage for two all at one time, that no other Vice President or ex Vice President or teacher could make that claim. But I am pleased that today instead of talking about campus unrest we are going to talk about another group in our population that needs some attention.

I have said for a long time that you judge a society, at least this is my personal evaluation -- you judge the

moral content of a society by what it does for three groups of people: Those who are in the dawn of life, the very little, the young for whom we have as parents and adults responsibility, and those who are in the shadows of life, the handicapped, the mentally or the physically handicapped, and those who are in the twilight of life, the aged or the elderly, the senior citizens.

I have always had a feeling that the others with some reasonable amount of cooperation from the Government and society ought to be able to make it or at least they have a fighting chance and I would stand on that evaluation or that moral judgment for our time, and our Government, and our Country.

How do we treat our very young? Well, we are not going into prenatal and postnatal care here today but I have a few statistics that tells that we could surely do a lot better.

How do we treat our handicapped? Very poorly, very, very poorly. The mentally handicapped? Very badly. The physically, slightly better and yet I think most of us would recognize that they above all others ought to have a claim on our resources, a claim on our time, a claim on our compassion, on our substance.

I have been asking myself many times just as you have today here how do we treat our senior citizens, our elderly? And quite frankly while it has been a blessing

to have Social Security, some people have contented themselves with the thought that now that the Government has Social Security that's enough. I intend to have a word or two about that.

Now, I'm a teacher and I have begun to get a new feeling about young people and about parents and about other teachers. If there is any one weakness in our educational structure today it is that we do not teach social responsibility.

We are perfectly willing to teach how we help ourselves. We have young people today that want things done now for themselves. Some people said it's the Now Generation, the instant remedy.

Now, we have many that want something done for others but I believe that part of the problem today is that there has been such a search for ways and means to improve our own personal condition that we have forgotten that we also have a responsibility for others.

Now, you say to me, well, if you can improve yourself and it all adds up to two hundred million Americans with self-improvement, isn't that the best thing in the world? Yes, if two hundred million have the same chance for self-improvement. If they had even the capacity for it. But you and I know that many of them do not have that chance and you and I know that through no fault of their own many of them do not have the capacity. So really what we need to teach and to impose upon this Nation, a Nation of incredible

wealth which I think has in a sense corrupted it to a degree, of unbelievable power, which has absolutely corrupted it to an even larger degree, what we need to teach our people is service, responsibility. We need to teach them a little bit about helping others and thereby helping themselves. In other words, to put a little more emphasis upon justice as well as upon opportunity, or a little more emphasis upon doing unto others as you would have them do unto you rather than just doing before the other fellow does you or does you in.

Now, I had no intention of really saying all of that in the beginning here but after listening to you I think I got the message and you have taught me something. I doubt that I am going to teach you very much or give you very much information that you don't already have. But possibly what we get out of all this is a sort of redoing of it so that we pick up a thought here and there and maybe we find a thought that we already have.

I have been thinking about this term geriatrics because it's sort of misleading and kind of fools you for a while. And I decided that it was sort of a halfway between medical jargon and a euphemism for old-timer which is variously applied to California gold prospectors, to Mickey Mantel and to any Democratic Politician who can remember back to the National Convention of 1948.

So I say welcome aboard. But I didn't come here

to make a political speech. I resolved after the election in November that I wouldn't make any political statements until the new administration got started. Of course, if they don't get started pretty soon I may have to break that proposition but not today. I'm not going to do it today. Instead I want to share with you what I now see are some common concerns, common concerns for public policy in the broad field of health and health care, not just correction of disease but, as was indicated here, how do we do something about preventive aspects of disease? And I want to raise briefly the issue of our capacity to deal with this problem and to put some particular emphasis upon the health care for the elderly.

Now, when you talk about the elderly and health care for the elderly three or four other matters come in that you simply must put at the top of the page.

Race -- you have to add that; poverty -- you have to add that because more people, about fifty percent of the elderly are the victims of incredible poverty. So all the good things that we say about the elderly will add up to very little unless we have ways and means of meeting this question of their economic needs.

How do they pay for the care that they get or how is the care that they are to get to be paid for? And I think we also have to face the facts that we have a large number of people in what we call the elderly that are in our

minorities, our ethnic minorities, who are very poor. In other words, if you are elderly you are apt to be poor. And if you are elderly and black you are apt to be poorer. And you may very well find that you are elderly and if you are anyone like we speak of the Puerto Ricons, the Mexican Americans and so forth, you are apt to find the problem compounded.

Now, when you speak also of health care I think we have to recognize that even though time doesn't permit us here a full examination of the situation that we have to discuss many factors which bear upon our living environment.

I was surprised by what I heard here about even public construction. When are we ever going to start to build cities so that they are livable? You know, we've had a struggle now with the highway engineers. They know how to build a highway right smack bang through the best building in town if you will let them. And finally we decided that highway construction, like war, is too important to be left either to Generals or Engineers, it has to be left some time or another to people who make public policy.

And I think that we have to face up to the fact that there are very serious pressures that bear upon our liberty, that bear upon our living environment that condition your health. I don't care how many new drugs you have or how many new technicians you have, or how many paramedics you have that when you still have to face up to the problem

of slums, of overcrowding, of smog, of filthy housing, of traffic, of noise, of crime, these are problems that affect the psychic makeup of a person and add to their problems of health more so than any form of bacteria.

So when we at a meeting like this become in a sense interdisciplinary -- I heard a moment ago about how in the medical profession, and this is true in all professions, we are becoming such specialists we are learning more and more about less and less, and it's true, we even have people in Congress that pride themselves upon the fact, and we have reporters that pride themselves upon the fact that there is a Congressman that knows a good deal about the firmament. That's fine, but what about people? What about the problems? Because the firmament Congressman votes on problems that relate to our elderly too.

I happen to believe that experts should be on tap, never on top. You just keep them around and when you need them you run them out through a computer and pick them out but you do not let the computer run the society. You have somebody else that takes care of that.

So when we speak of the health of our elderly I think we would be literally wasting our time and money unless we put it into a broader prospective because you aren't going to have any healthy elderly when they live in filthy tenements in crowded areas and when they are the victims of traffic, and noise, and filth, and smog, and dirt, and air pollution,

and crime, and attack. You can give them all the pills from Humphrey's Drug Store that you can possibly find -- I always get a commercial in -- and it will do you very little or no good.

And as was said here today, what about the poor that are in the world areas? My fellow Americans, I know this is an urbanized society but I must tell you there are more poor people in rural America by far than there are in the cities -- by far. The only difference is you have locked them out. They are hidden away. It's like we used to do with the mentally disturbed or children, we hid them away, we put them out of sight, and we put our poor in the rural areas out of sight.

The poverty that is the shame of America is not in the ghetto, the poverty that's the shame of America is to be found in the shack in the hills and the valleys and down in the delta. In these various areas of rural America where there are no modern facilities and where, mark my word, there are hardly people that care because there are very few welfare workers, very few doctors, very few of the young, bright students want to go there except for a march. They don't want to stay.

If you want to see poor housing, if you want to see poor care, if you want to see people that are wretched and miserable, that are elderly, or whomever they may be, go to rural America. But you have to hunt for them. You see,

that's the difference. In your urban areas they are stacked up for you, they are right there and there are so many of them in one place that you think that that is the majority. But it is not the majority. And yet we have such a time because the press of America is metropolitan. The country news papers are fading out. It's hard to get the people of America to understand that despite the fact that only thirty percent of our people live in rural America over fifty percent of our poor live in rural America and most of our elderly poor live in rural America.

Those are the ones that you are going to have to find if you really want to get at the problem of the health of the elderly.

Now, to say that in a great metropolitan state like California it may be a little out of place, but I don't think so.

Now, how do we start with the health care? Before a child is born? And I happen to believe that geriatrics has something to do also with prenatal care. This is really the preventive type of medical care or of health care that we need. I happen to believe that it may be involved with nutrition. I'm not an expert, this is why I can speak so freely of it, but I am sure that we all know now that we are finding that this rich and affluent America has vast amounts, has far too many people that are the victims not only of hunger, which is a shame, and a disgrace, and a

remedial one may I say, but also we are finding that malnutrition is all too prevalent. And malnutrition takes its toll in all kinds of physical, emotional, and mental problems in the twilight of life. That's when it really blossoms because most of us have enough built in strength in the peak of our lives, in the climax of our lives to overcome even these child deficiencies or these deficiencies of childhood. So I would hope that we consider the health problem while we must put special attention, as this society does, upon the health care of the elderly, that we must remember that the difference in time between a newborn baby and the elderly is but a split second in terms of the life of people or of a society.

Well, we now know that we live at a time when science and technology has given us most of the means that we need to do the things that we have talked about. That's what makes it so very frustrating. And I think this is what upsets young and old alike. It's sort of a nagging paradox. We find that we even take for granted some of the things that seem like miracles: transplants, even TV broadcasts from the moon, vast flying supersonic jets and lifesaving drugs. We get so much that it's hard any longer to impress anybody. But that paradox is that with all that science has brought with it, all of the blessings of science, it has brought with it its own blight, when in fact science is neutral.

It's man that makes the decisions about what science will do. We are interested right now, for example, in missiles, nuclear weaponry. This is the topic of conversation in our country and our concern.

Well, that same science has conceived these weapons of mass destruction. Obviously it can do something else besides that and wants to.

And we have displaced citizens through automation from their jobs. We have mismanaged our national environment until today we are having a crisis, a real national crisis in water, in streams, in lakes, in forests, in the air that we breathe. We created cities filled with beauty to be sure for some but with incredible ugliness for others. And it's out of all of this paradox and out of all of this that I have said that come some of the alienation.

When you talk to young men and women today they say look here, with this great wealth and yet with so many poor, with this massive amount of food, yet so many hungry, with all that we can do to make a space capsule absolutely a perfect, livable environment, and yet we can't seem to do anything at all about the filth of the air that we breathe here on earth.

Now, I know that once you say these things that it seems that you are just giving generalities but these are the things that disturb people and I think that what we are really saying is that the challenge that we have put

to ourselves is how can our improved conceps of governmental responsibility, of our magnificient economic engine -- and we have a magnificient economy -- and our foremost technological systems, systems that would be found in Apollo 8 and Apollo 9, our paramount educational institutions, our gigantic pharmaceutical enterprises, our unprecedented medical research, our massive public and private medical facilities, and, highly trained practitioners, that is the description of what we have. How can these many forces that are here collaborate effectively to deliver good health to the people who make all these enterprises possible? How, in other words, can the most affluent and technologically advanced society in the history of the world meet the basic health needs of all of its citizens and remembering all the time that some of our citizens have liabilities which others do not have.

I heard today, for example, about the poverty programs and I must say that I was impressed when I heard one of the gentlemen say here it may have been better had we not have even started some of these programs if we were not able to keep them up. Rising expectations, my fellow Americans, is not just something for Asians, Africans, or Latin Americans, we have it right here. But I would only add this that the fact that we did prove through some of these programs that we could do something, even if the funds seem now to be cut off, gives us something to work on,

namely, to apply political pressure to see that the funds are not cut off.

One of the problems with many people is that they give up too soon. Surely there's only so much within the national economy that we can divide up. We have to find our priorities which I want to mention to you but I do believe that when something does work we have to be willing to fight for it and not just quietly either but go after it with everything we have.

If I could find a doctor in this room today that could tell me that he had a sure cure for leukemia and he was on a government project but his funds were going to be cut off I want to tell you that I could start any kind of problem in this Nation, any kind of an uprising so to speak to see that you got the money -- political action, not violent political action, effective political action, that action that brings you support.

Well, we saw the war on poverty, we saw that it helped relieve some six million people or lift them out of poverty in the last four years. I think you can say in the last eight or nine years about ten million people have come out of what we call the sickness of poverty. And let me tell you that's a desperate sickness. But we still have twenty-eight, twenty-nine million that are gripped by this disease called poverty, people who need jobs, and education, and food programs, and health care -- twenty-nine

million people who are not receiving the basic necessities of life which they see are available in their one hundred seventy million neighbors and one-half of all the people passed age sixty-five, I must repeat are in poverty. That's who we are dealing with.

So when we see programs that help them we ought to struggle for them.

But I wanted to make it so clear to you that the kind of struggle is what is important, struggle at every level in college, that is, teaching people, city councils, state legislatures, labor unions, chambers of commerce, political action not ridiculous political action but solid, substantive day by day political action. We see something else, you know so well.

With all of our medical competence, the men of twenty countries and the women of eleven countries live longer than American men and women. And I can tell you why because if it were just whites -- we have to face this you see, I don't like to keep mentioning it, but it's a fact -- if it were just whites our rating would be much better. The problem is that if you are black you have so much less chance of living to age seventy. And if you are black you have so much less chance that your baby is going to live.

Therefore the infant mortality rates and the longevity rates, life longevity rates for Americans is

judged by the World Health Organization, taking all kinds of Americans we end up not being too good. We are sixteenth in terms of infant mortality.

We talk about the greatest medical program and the greatest medicine in the world, the richest Nation in the world, the most food of any Nation in the world, the most scientifically advanced Nation in the world and then you add it up and you come out sixteenth on infant mortality.

I think we have to admit that doesn't stand too well in terms of our moral or our political or social values.

I repeat that the non-white mortality rate for babies is fifty-eight percent higher than the whites.

This is part of the problem today, my fellow Americans, this is what young blacks know. This is what the more articulate know, and until we start to do something about it we are going to have lots of trouble. And I want to see something done about it.

Now, while we are all very much concerned about the need to check inflation, and there's a great deal of talk about it, the greatest, single factor in inflation today outside of the rise in the cost of money which they say is the way to check inflaction, is that health costs are increasing at a rate more than double that of the general price levels in our economy.

We were talking about this on the way over here, as we improve the quality of medicine we don't really get

labor saving devices. You take a higher quality of person even to use the devices or the tools that are discovered or designed or fabricated, so health costs go on up. And we find that thirty million Americans have no health insurance at all. There may be more than that. That's a conservative figure, despite the great effort of the insurance industry, private insurance, despite the efforts of the trade unions and all of their fringe benefits, despite the efforts of the Federal Government through Medicare and Medicade programs which all combined have written some form of health insurance for four out of every five citizens. Two-thirds of all personal health care costs remain uninsured.

We spent six and one-half percent of our gross national product for health care in 1967. We spent a little bit more last year, over fifty billions of dollars yet I think it is fair to say from what I have heard here today thus far without me having any more empirical evidence that we have inadequate health care for millions of our people.

Now, based on minimum standards of qualities set by Medicare -- and I wouldn't say that those were the highest standards -- one-third of all the hospitals in America are not accredited and ten percent of all the hospital patients are admitted to non-accredited hospital beds. And I would like to digress for just a moment to say that I felt a point made in this discussion about the

over use of hospital beds is well taken.

And if there are representatives here from the Federal Government I think we ought to remember those of us who have served in the Federal Government, those of you here serving in the Medicare and Medicade program, the Medicare program has put such a premium upon hospital beds primarily because that's the easiest way for the health services to get paid, if they go through the hospital.

And, of course, there is a good ethical justification that if you are in the hospital you have a chance to get the kind of total care that you may need, the entire physical examination, the kind of professional care that you may need.

But we haven't done very well in this country in developing out-patient clinics, not by a long shot.

Now, these statistics that I have given you know. But what do they tell us? They tell us one thing, they reveal serious deficiencies in the basic planning, design, and operation of our health care system.

ape #2 Now, somebody once said we had the Model T health care system in the space age. Well, I think that may be a little over emphasis but it's a pneumatic editorial emphasis. What it really means is that despite the fact that we spend over fifty billion -- about fifty-five billions of dollars -- we still have according to the testimony right from this floor, and this is not by any means a

full testimony because we were relating to only one segment of the population -- millions of people without proper care.

Now, Abraham Lincoln once told us that the legitimate objective of government is to do for the people, the community of people, whatever they need to have done or cannot do at all or cannot do it all for themselves in their separate or individual capacities. That is the legal justification for government's concern. But I don't happen to think it is just the Federal Government's concern. The time has come to get both our priorities and our systems straightened around and functioning properly.

Historically we have been a Nation of tinkerers, not planners. We like crisis or crises. Then we do something.

We really don't have a National Health Plan. I know that the word "plan" just frightens the living daylights out of some people but I'll guarantee you that every modern corporation has a plan of operations.

That AT&T always amazes me. I have talked to their officers, they plan twenty, twenty-fve years ahead. The communications industry and television, radio are planning for twenty years ahead.

We had, thank goodness, a commission appointed under the chairmanship of Mr. Miller out in Columbus Indiana

that gave us some idea of what we might need for at least hospital plans of the future.

But we as a Nation, if we even want to utilize our resources properly we ought to have some form of National Health Services planned. I don't mean that the government needs to run it but somewhere along the line we ought to look down the road when this population is going to be three hundred million people for sure by the year two thousand, what is your health plan? That's only around the corner.

The young people that we talk about today, they are going to be the ones that are looking to the year two thousand.

What is the plan that you have for them? That's our problem. We are the stewards. If we are critical of our young today because of some of their antics may I suggest that we ought to be equally critical of ourselves that we are not looking down the road as to what the future is going to offer. But we have satisfied ourselves on these crash programs which are costly, less efficient, Jerry-built at best.

For example, we know that the demand for health care both geriatric and general is dangerously outstripping our supply of physicians and you know that we are going to be dangerously short of physicians because we have had an attitude in certain places in this country for a long time that we didn't want more, didn't need more.

We are dangerously short of nurses and paramedical personnel, hospital beds, and related services. And even though your Federal and State Governments are doing much more about it it's sort of coming in after the fact.

We are trying to catch up. No one is thinking about how we can get ahead of the problem -- no one.

We are trying to find out if we can just keep from being overwhelmed with the problem.

Now, I submit that this shortage, and it's a critical one, is largely due to the unplanned, unsophisticated, unresponsive health care system which is unable to use even our existing health resources efficiently and economically, particularly for the poor and the elderly.

How do we justify in the country the failure to have neighborhood health clinics for the needy and the poor? How can we talk about care for the elderly without it?

Now, we can afford it, it's a matter of whether we are willing to pay for it.

I mentioned outpatient clinics mobile units. We sent them all over Latin America.

Now, I think that I wouldn't want our friends in Latin America to think that we were giving them inferior materials because we wouldn't use them here at home.

It's a fact, my dear friends, that the elderly in particular find it difficult to get to the service centers that are set up for some athlete. We make it almost impossible

for a voter to register -- a little matter that I have some concern about on occasion.

Oh, yes, you've got to come down to the City Hall. Of course, if you park your car you get arrested if you park it too long.

We have forty million people in this country that are not registered, mostly because the registration laws make it difficult for them.

Now, what I think we ought to be trying to do is to make these services, whether it's voter registration or whether it's health services readily available.

We don't need to have everything in one place. This concept of bigness has become a curse. We need neighborhoods in America and we need buyable neighborhoods.

One of the problems we are having with unemployed, and I have been very deeply involved in this -- we train workers but frequently they don't have an automobile. Oftentimes they don't have proper public transportation. And oftentimes they have to go twenty-five, thirty miles for a job.

The failure to plan our cities -- and it's been emphasized here by people who are on the job right out here in California and other places.

So I must say that we need to have a service oriented economy and it's so right when we plan these cities in our model cities program that we plan the facilities of

the cities to serve the people. And that doesn't mean that you have to have a forty story building downtown or in the uptown section. You may very well have ten two-story buildings around.

I know these matters, I have studied all this public administration. I used to even teach it. I apologize for it but I did and all my students are entitled to a refund.

They get these charts -- the curse of the administration. They have a centeralized Police Department so you don't have any neighborhood police any more.

My own city where I live in Washington used to have a fourth precinct. Well, we got some experts in there that decided that they were going to close up some of the precinct stations. Of course, we've got more Police Officers than ever before. They closed up the precinct station and the rate of crime has gone up about four hundred percent in that precinct.

Everybody is mobile now, we've got them in cars cruising around. That isn't the way you catch folks that are coming in through the back door. And this is the problem we are beginning to have in America, this idea that we have to centralize things.

I might say that the Geriatrics Society can do one thing and that is to raise cane with those who are planning your city developments. Go down to the City Hall,

go wherever it is, get with the urban coalition, get with the poor and say, "Listen, we would like to have places that we could walk into where we live. We are not trying to see whether or not at age seventy you can walk three miles, five miles, ten miles to get a physical examination." That's good sound medical and social practice and it can be done. And there's no rule against having the medical services come to the people instead of the people coming to the medical services. But you have to arrange it that way.

Now, I wanted to give you a few suggestions as to the economics because I'm not a doctor but I do know something about economics. And I think it's fair to say that most of the economic difficulties today affect two groups of people, the old and the poor. The rest of us are getting along fairly well, particularly those that are on fixed retirement incomes. Inflation is a terrible blow to them.

I have suggested during the time that I was trying to educate the public and seeking some support a few urgent steps that I thought should be taken. And I think this fits into your program. And, by the way, every one of these is feasible. Every one of these is economically possible. Every one of them has been studied, worked out by people who understand actuarial principals and insurance, increasing Social Security benefits by fifty percent across

the board over the next four years.

Now, the fifty percent increase isn't going to amount to too much because their Social Security benefits are still far too low. This would be a minimum Social Security benefit for a couple of one hundred and fifty dollars. How far does that go? When I think of what we spend and what we waste! Making benefits inflation proof after retirement by raising them automatically to reflect the cost of living increases. That's what Government workers want. That's what salaried workers want. That's what Union workers want. When Walter Reuther negotiates a contract with General Motors he has that escalation clause in there that if the cost of living goes up, up comes the wages. They don't have to either negotiate or strike, they just automatically come up. If that's good enough for a forty year old man, it's good enough for grandmother.

I think the Government of the United States ought to set the standard, and this can be done, make it more attractive for the Social Security beneficiary to earn more by liberalizing the provisions which reduce the benefits when a person is employed.

Social Security is depression oriented, like a lot of other things. We had a limitation in the law as to how much you could earn when it was passed in the 1930's because we wanted to spread the work. Today we are looking for good people. What a tragedy it is to deny people a

chance to earn, to have it deducted from their benefits which they have by right and by law under Social Security.

And I think we also have to come to financing part of the increased benefits from general revenues to ease the burden of Social Security contributions.

Now, I wanted to urge too in just a moment here now a few other steps of improving our Medicare Program. And this is something that's in the works but we need your help. I'm not in the Government. I say we need your help, those of us that are interested in these things, we have to put the doctor bill part of Medicare on the same social insurance prepayment basis as the hospital part thereby making it unnecessary for older citizens to pay four dollars a month out of their retirement incomes for medical insurance.

When you say four dollars a month -- to some of us I guess you say,"my goodness, can't they even afford four dollars a month!" But when you're getting eighty-eight dollars a month and have to live on it and you take four dollars out that's a lot of money. And we need to provide protection against the heavy cost of prescription drugs which accounts for about thirty percent of the private expenditures by the aged for health care.

Now, I don't have any magical formula about it but I want to tell you that the cost of prescription drugs today in many countries is very very high. And how cruel it is to deny people those good drugs simply because they

can't afford them, when it's maybe the difference between life or death.

And we need to extend Medicare's protection to the disabled Social Security beneficiaries who like older people have unusually high medical costs at a time when their overall income is sharply reduced.

Tape#3

And I listened today to the problem of retirement homes and the nursing homes. Surely we recognize that there has to be an extension of time which a person can have in a nursing home. And we need many more of them and we need better ones. Some are very good and thank goodness your Government has seen fit to be of help in loans, and grants, and planning funds for nursing homes.

But once again may I appeal to the medical profession to help us get people out of homes into life itself, out of hospital beds into life itself. I remember when I first came to the Senate, I worked with Doctor Magnuson of the Veterans Administration and the effort that we made to get people out of Veterans Hospitals where they had been bed cases for years, and in our own fine Veteran's Hospital affiliated with the Medical School at the University of Minnesota. And that's the best kind of a Veteran's Hospital, one associated with a fine Medical School so it becomes a teaching hospital.

We were able to get about sixty percent of what they called the mental cases back on the job, back into

their homes, back into their neighborhoods so that they no longer were bedridden so to speak or institutionalized. And so much can be done about it and nobody knows more about this than you folks here -- the psychological problems of the aging or of the elderly. That's the biggest problem of all.

I visit nursing homes because my mother is in one and I visit many of them and there are some that are splendid where the people that are in charge have worked out a rounded program. But you know we have done wonders with modern medicine. We have extended their physical life and we have even sometimes helped to extend what you might call their span of mental alertness, but what do they do? Psychological factors are so very important and if they are not in a nursing home where do they live? That's a broad problem and it just affects what I call the health care.

Now, these are short terms, easily taken steps which I think could relieve some of the most immediate needs in the health care field. But I must say these short term advances must not be allowed to blind us to the even more critical necessity, the restructuring of our health care system.

I have read a great deal about this and I am impressed by some of the things I have read. I was pleased to hear today about group practice. I remember when it used to be fought against like it was a mortal sin, and

the group clinic. Well, it has come around now, it's accepted and of course it's accepted and it was needed. This doesn't mean you can't have private practice. It means you should have options, freedom of choice. And I'm impressed by some of the studies that I have read recently.

One was the comprehensive program of principals and action set forth by the Committee for National Health Insurance. I don't know whether everything they have in that program is good but I don't think we ought to reject out of hand when we see what the economics of health care are. The economic problems are so great that we simply have to find a better way of funding health care.

I felt that this program as set forth by the National Health Insurance Group, I believe Doctor DeBakke is associated with it, some of the labor people, and others. This is a thoughtful approach and it takes seriously the vital interests and concerns of all groups in our society that are essential to a successful system of health care service.

But I must say that any health care system will require the concerted and good faith cooperation and planning of the health professions, of Public Health Officials, the private insurance industry, other associations and groups such as the American Geriatrics Society, a restructured health system funded on some form of broadened prepaid insurance.

It may be a mixture of public and private -- I don't claim to be an expert in this -- with emphasis upon taking care of those persons who today seem incapable at least economically of caring for themselves.

That program will have to fit into our own unique American institutions and traditions. It cannot be copied from Great Britain or from European National Health Plans, that won't fit our society but it will have to assure maximum flexability and options for both the consumers and the members of the health professions. And the reason that I mentioned this is that I think that one of the worst things that can happen to this country is for us to get in a battle now, doctors against public officials or one group against another when what we really need to do is to think it out before it's too late.

I think that that kind of cooperative endeavor on the part of all interested parties offers much hope. And I conclude on this note that all of these things are costly. Very few of the things that we have talked about have had very much preplanning. We really don't know where we are going in the health field. We add a hospital here and a hospital there. Yes, I know we have State hospital plans under what we call Hill-Burton. I know that we are going to have regional health centers, medical centers. We are better off than we were some years back but we still haven't projected our medical health facilities, nursing

home requirements, home needs for the next twenty-five years. And yet everybody else in this country that amounts to a hoot is doing it -- private insurance companies are, the Telephone Company is, the automobile companies are, the highway engineers are, even some educators are, they are thinking about how many more classrooms they are going to have to have and how many more teachers -- a broad National Educational Program.

They don't say much about it because then it looks like it must be suspect. But we surely better plan it when it comes to our lives because I know that we have to get our priorities straight.

I have spoken out in recent days on something that I think is at the heart of everything, whether or not we are going to be able to slow down the vast expenditures of this Government and that means of other Governments too in the arms race. Because I have been in Government a long time and I happen to believe that we are at a point in time now in the history of this Nation when we could make a fundamental decision, at least we ought to try it.

This is why I felt, and I say this, I must say it because it's very close to me, that the deployment of a costly antiballistic missile system at this time when there are so many priorities in this country is not a wise policy. I think the deployment that the President suggested was the better of the policies thus far presented. I think

that President Nixon tried and tried very hard to do what was the minimum if you were going to deploy, but I stand on this platform to tell you as a man who was only a few months ago in this Government that we have a margin of safety now so that we do have time to seize the initiative to take bold action to halt the arms race and to do it on our initative as Americans, not to come in after an international propaganda barrage that we are imperialists, which we are not.

I worry that we are going to get ourselves into a position that we are going to spend billions and billions and billions of dollars in armaments which will give us no more security than -- and your're not going to get your plans and your programs for the aged, and for the children, and for the needy. It just isn't going to come because there are a number of myths that have been tettled, namely, that if the war in Vietnam is over next year we'll have a lot of extra money. We won't. We'll have some four or five years down the line but there are built-in costs, my fellow Americans that are going to take a lot of money that you save, and I pray and hope that it will be over tomorrow, this afternoon.

There are other people who say, "Well, we are going to get so much money out of the increase from revenues of the gross national product." That's true, unless the Congress decides that we ought to have a tax reduction

before we meet some of the great needs of this country.

But when you start on the deployment of a vast new weapons system, ladies and gentlemen, you are talking not about five billion dollars, what you are talking about is one hundred billion dollars, maybe two hundred billion dollars. You are talking about figures that people just cannot properly estimate.

My estimate is no more accurate than if a man says it costs ten. All I know is that I have been in Government long enough to know that there has never been a weapons system yet that doesn't cost double or more than what was estimated at the time we started it. Because these systems take time and with time they become more sophisticated, with time and sophistication the price rises. Then there is always the built-in factors of inflation itself. And the next thing you know you're off and your neighborhood health center and your programs of preventive medicine, they take a low priority.

The note that I heard here today was that the poor, I mean the elderly, many of whom are poor, are receiving not top priority in our scheme of things, hardly even second priority. I don't know just where you do put them in the scheme of priorities of your Government in the society but obviously not at the top. And they are going to be further down the ladder if we permit ourselves to get caught up with a costly weapons system before we

try every conceivable way to find an agreement that will give us the same kind or better and more safety and more security than raising the level of danger through expanded weaponry.

This is my view and that's why I said that when we talk about health problems we talk about the total problem of the community. You are talking about a health program in Los Angeles. You cannot talk about the health of people of Los Angeles without talking about the air that they breathe; you talk about a health problem, you talk about the water that we drink; you talk about a health problem, you talk about congestion in our cities; you talk about a health problem, you talk about nutrition for a child; and we talk about a health answer, we talk about resources and while this is a rich country and I know it's going to be richer I hope and pray that it will, there is a limit. What it is I don't know, but I do know that if you dip into the budget of national resources and take out billions more for hardware it soon becomes obsolete -- not hardware for heart surgery, not hardware for kidney transplants, not hardware in terms of building facilities in which people can live but other kinds of hardware, you don't have much left over to do what you want to get done.

Thank you very much.

(Applause).

DOCTOR HOWARD ROSS: Mr. Humphrey, on the plane yesterday

I read your article, "Lift Up Thine Eyes," and I was quite impressed with it and I would like to refer you to a section of Geriatrics dealing with terminal care.

My father lay dying with cancer of the stomach and my mother said unto Him lift up thine eyes. God will take care of you. My father said God is playing hooky today.

And I must remind all of us that there is a problem in geriatrics care where the only hope comes from a Physician who has some elasticity in his brain. And many times you will have to say this is the end of your life. We all have to die, let's die bravely.

There are times when we must be honest and we must be bold and we must face the terminal care of the hopeless person.

Now, one remark about this high cost of medical care, let's take tobacco and liquor and cosmetics, add them together and they exceed the cost of medical care. So let's look to our vanity on one side while we are criticizing our performance on the other.

Besides the expense of the element in the family do not forget that the employees of hospitals throughout this country, the ordinary maid on the floor has for decades been underpaid and some of that expense is trying to get these gals up to their level.

I was quite inspired with your article, by the way.

Now, a remark about dignities. Back here we had a little thought of dignity. There are times when a Social Service worker comes in and though she does not intend it she by her attitudes says to this old person, you are hardly worth my attention. I think that all paramedical people must be taught a great big lesson on human dignity. And if you can't do anything for their pocketbooks, if you can't do anything for their environment, give the man some dignity for God's sake.

Another thing, Ann Arbor Michigan is a town of one hundred thousand. It's something like Carmel. Mrs. Ross and I looked over Carmel this morning for two hours and we looked for the ghetto. We couldn't find a ghetto in Carmel. Let me tell you in the one hundred thousand people of Ann Arbor -- if Doctor McMahon is here he'll call me a baldheaded liar, but in Ann Arbor, Michigan, it's hard to find a ghetto and before July the 1st, 1966, practicing geriatrics my fellow doctor and I made a survey of our elderly people and in Ann Arbor eighty percent of them were not pitiful. You spoke of fifty percent. We do not experience that. And let me say a lot of people here come from other Ann Arbors. They are not out in Podunk and they are not in the heart of stricken cities. So we must think in terms of other communities where there is a more fortunate climate and we must not pick up that fortunate climate and throw it out the window. Rather let's say come to our

fortunate area and let us show you that eighty percent of the old people are not pitiful.

As regards the element of rushing to Washington, here's a man that says it's even best not to have rushed than to rush in vane. We find that many old people are able to perform on the fire within them. They have a burr under their tails and they are performing on their own steam. And I have many old people whose total income is thirty-six hundred a year and they don't even know they are pitiful because they have their garden, they do their stuff in the back yard, they do canning, and they have no notion that they are pitiful until some God-awful person comes in and tells them that they are pitiful.

One more thing about Washington -- we have old people who tell me for God's sake, don't run off to Washington and say, "Oh, Great White Father come and blow my economic nose. I can blow it myself."

Thank you, enjoyed everything.

(Applause).

DOCTOR READER: I think we will dispense with the question and answer period formally because we will have a reception where you will have a chance to speak to Mr. Humphrey again informally and I think that it may be that we should give him a chance --

MR. HUMPHREY: I would like a few questions or comments. I like what Doctor Ross said.

DOCTOR ROSS: I heard you in Ann Arbor when you were a Senator. You were quite hot then too.

MR. HUMPHREY: You're doing all right too.

A VOICE: I am a citizen of the Monterey Peninsula and we have a very fortunate situation here, having a beautiful climate and a beautiful area to live in and an enormous number of doctors.

Now, we are fortunate to have this situation but at the same time when I hear about these areas in which nobody cares and nobody takes care, is there any way of encouraging doctors to go to the rural communities that are presently unserved? Do the doctors themselves have any ideas about it?

DOCTOR READER: Doctors like good living conditions I think is part of the answer to that question.

Are there other questions?

MR. HUMPHREY: Let me share a thought with her. I surely if I were a young man that spent the years that they have to spend to become a doctor, I would want to go some place where I thought I was going to have a good place in which to work, that I would have a chance for a good practice, where I could be associated with a first class hospital, where I could have reasonably modern facilities, I mean, if I had my choice. I think you would have to expect young people that have to put in many years to get this professional training to want that kind of professional environment in

which to work. And it's quite obvious that in some places where the countryside has been less than prosperous or where there has been a falling of income, or departure of people that it's very difficult to get that kind of medical personnel.

Now, what can you do about it? Well, you can't force people. I hope you wouldn't do that. I hope you just don't go around assigning people. You can possibly make it somewhat attractive by the various programs that you have both public and private of putting up group facilities that are modern, up-to-date, and have all the modern medical equipment, and a broad enough economic base either through a group plan or through some type of insurance program as well as the private practice to give an economic base for a young doctor that wishes to or a group of doctors that wish to practice. We really haven't found an answer to it I must say and I think the medical profession itself recognizes that this is one of its most serious concerns.

Now, we have helped a little bit by these regional hospitals under the old Hill-Burton Act and I know many times we say, "Well, if you have only got a fifty bed hospital well it isn't very economic or very efficient." That may be true but it may be very necessary.

Now, I know that in certain rural areas of my State of Minnesota, I live in a rural county and I know that we have a little rural hospital and because we have a good

hospital we have some good doctors. If we didn't have a good hospital where they could practice their medicine I don't think we would have the same number of good doctors. And it's a way to try to entice people by opportunity as well as service into an area.

I want to make it quite clear I don't happen to believe that you just go to Washington for everything. However, I think Washington has a role to play. What I was really trying to get here today was for us to talk about our needs on a local, state and federal basis and may I just say across the country without even reference to government. I think if we don't do that we are going to end up in many areas with very serious problems.

One little factor, when we come out here we see it so beautiful, this is the way it looks in the place where I live in Minnesota, it's very pretty in summer time. It doesn't look this good right now, however, I try to tell the people in that little village where I live what it's like in some other places.

Let me give you a figure, you could put the entire population of the United States in the other four boroughs of New York City if all of them had the same density as the population of Harlem. When you look at one apartment house in Harlem you are looking at Jackson, Mississippi -- the whole town. You know, that's hard to get people to understand that you look at two and you're looking at

Rochester, Minnesota -- the whole town. Thousands of people are in these apartment houses, tenement houses.

When I go up there I hear them say, "Well, we give them lots of garbage collection." I have, for example, gone around and I say they don't collect the garbage. And somebody says, "Well, these people are dirty." I say, "Well, that could be because many people are rather sloppy." I have that problem according to my wife on occasion, and I always figure our boys have it even worse. The more college education they get the less they ever pick up their shirts and socks and things. I guess that comes later after marriage. But I wonder if we ever stopped to think that equal sanitary services for an area that's densly populated -- I don't mean that you pick up the garbage every Tuesday and Thursday just like you do in a suburban area. When you start to send a garbage truck through half of these places in Chicago, Philadelphia, and New York City where they have these hugh skyscraper tenements your're picking up as much garbage as they have in a whole town in South Dakota where the largest town they ever had in that whole State is twenty-two thousand people, which is the entire population of one apartment house in Brooklyn.

I remember one time I told one municipal official, I said, "How many garbage trucks do you have in this city?" And he told me. I said, "Well, now, that's what you ought

to have for that apartment house that I was near or made a little talk outside."

So we have to get our mind focused on that other fellow's living conditions and I think that's what must be emphasized here. I don't want us to think that this country is all bad because we couldn't have gone as far as we have if it were all bad. The strength of this country is in the fact that it wants to do better and there is a great voluntary spirit in this Nation. I want us to encourage it and I think the place to encourage it is in the areas that we are talking about here only you have a Geriatrics Society. What you are really talking about is care for many people who through no fault of their own some times cannot care for themselves.

You are also talking about a number of people that have great dignity who want to be treated with the kind of dignity that was mentioned here a moment ago. So it is a sensitive problem. But the fact of the matter is that we've got a lot to do and we haven't as yet put ourselves fully to getting it done.

You know, my family, we have some other problems -- I have a tendency to personalize these things -- everybody today has a cause. We've got all kinds of demonstrators, my goodness, don't we. And uh -- we've got five million families in this country that have mentally retarded children. What do they do for them? I want to tell you it's pathetic.

It is pathetic when you talk about the money spent on whiskey and cosmetics and commercial recreation, and whatever else there is. You know, my father was a wonderful man. He never ever told me what time to go to bed. He just told me what time to get up. The later I would stay out the earlier I would have to get up.

I have quit telling people what they ought to do about their habits because I find out that they think that you are either a reformer, or you are not with it, or something else. So I say,"look, you do as all those other things that you want to do but would you mind also putting a little money in the plate for this and for that and so on and so forth," -- and that generally works a little better than telling them not to do the other things. Then they have to make a decision somewhere along the line what they wanted to do.

Anybody else?

MR. JOHN DUFFY, JR: Mr. Chairman and Mr. Humphrey. I hope what I say will be taken in good faith.

MR. HUMPHREY: I am sure it will be.

MR. DUFFY: The subject I am talking about doesn't lend itself very much to humor. I am a little bit concerned here about what does this social problem mean to the involvement of medical people? What are we trying to do here? Are we going to talk in vague generalities or are the doctors and the medical people going to say, "We are going

to be committed not just to specialists but as citizens."

What is our citizen's responsibility? We can talk forever about the specialist's responsibility but what are we going to do as citizens?

Now, for example, we know what to do to some extent about arteriosclerosis but what do we do about the arteriosclerosis of bureaucracy? In our cities, and in our Federal Government, and in our State Government the veins are clogged. What are we as medical men doing about this?

Pretty soon in San Francisco they will be taking before the Board of Supervisors the budget. Last year I attended the budget hearing. Only two or three of us general citizens were there. All the rest were office holders. What will the Medical Society, the medical profession, what will they say about the makeup of this budget? Is it a healthy budget? Does it reflect mental health, and physical health, and social health? Or are we going to sit off on the side and let all these decisions be made and the pipeline get clogged again and the city become sick and here we are with all this know-how and we don't use it or the city doesn't use it.

Now, many years ago, Mr. Humphrey, if you will forgive a personal reference, I had the privilege of sitting down with Herb Waters and you in your office around 1949. Herb Waters is a personal friend of mine and I know he has

been a very good helper to you.

MR. HUMPHREY: Yes, he has.

MR. DUFFY: One of the things we talked about was how to take the idea of the old Civilian Conservation Corps and commit and mobilize and motivate the youth of America on a broader scale to give themselves to their Nation. You took this idea over the years and expanded on it and one time in San Francisco Jack Kennedy announced it as the Peace Corps. And I think commitment is one of the most important things that is needed in the lives of professional people. And somehow or other I sense it is missing. Maybe I'm wrong.

MR. HUMPHREY: I want to thank you for your statement. I must say that I have found great commitment on the part of many of the leaders -- I think you would be pleased to know that -- of our medical profession, our scientific profession. Obviously people have a professional interest and thank goodness they do because we need professional standards.

I believe we are now at a time where we can say that many of the people who have these professional responsibilities also feel a great citizen responsibility and that's really what we are talking about here.

I gather here today that there was a much broader view being expressed than just the particular expert's point of view and in the exchange of ideas here it adds up

to a rather substantial citizen commitment and I'm happy to see you again, Sir.

DOCTOR BROCK BRUSH: I have enjoyed the program very much but I think there are a couple of things here that need a little clarification, for instance, this infant mortality. This has been properly analyzed in many places and the trouble with the infant mortality where it is very high is when the patients come into the doctor when they are in labor.

Tape#4

MR. HUMPHREY: Right.

DOCTOR BRUSH: And they don't have the motivation and the education to get these people in to the doctor before they start to deliver.

One other point is about the rising cost of medical care, of course, which are known to be higher and getting higher unfortunately but part of this problem is also motivating the people in trying to get the people to leave the hospitals when they should. You do surgery and when the person has had an adequate lapse of time after the operation, they are in good shape, you say, "You can go home tomorrow." And the patient most often says, "Well now, couldn't I stay another few days?" And then the children call up in rotation about every three hours and say, "Couldn't you keep my father or my mother there another week?" We say that the convalescent home is beautiful. They can go to a convalescent home, they can

go to a nursing home, but the patients like the care, the supervision, the protection, and the feeling that they get in the hospital. These are some problems so it isn't all education or commitment of the doctors. It's largely a commitment and an education on the part of the patients and of those who are guiding the programs.

I think it's good we're pointing these out to point out all of the facts.

MR. HUMPHREY: I wasn't critical of the costs and I just simply said it's difficult to pay it. All I talked about was prescription drugs and I happen to own a drug store and I know what the cost of prescription drugs are and I also know a little bit about the wholesale and the retail and the markup. I'm very familiar with it and I happen to believe in the profit system. I'm not a socialist, I like the profit system but what I would like to say is that we have to find ways and means of handling these problems without just handouts.

I think Medicare is one of the ways that it is helped a good deal. I think the group insurance programs that we have have done a great deal of good. I happen to belong to some of them for years and they have surely eased the cost. But I also know that a man can go into a hospital and spend a day and he'll pay fifty dollars for a room and they say it's a single. They'll say it's a private room and he ends up finding out that he's got two

or three partners.

And I am just as well aware of the fact that a poor girl working in the hospital a few years ago didn't get much money. And I happen to be one that thinks that they are entitled to a living wage. I happen to believe that there are programs under way to improve the administration of our hospitals. I know, for example, that some of the hospitals -- I happen to know of a hospital group of twelve or fourteen hospitals that was losing money a few years ago that was taken over by a private company, a private corporation, and they made four million dollars last year and they didn't raise the rates.

I know that there are ways that you can improve. I know that at Rochester, Minnesota, we have an experimental hospital, we are trying to find out how you can get equal or better service with no more personnel and still cut down hospital administrative costs. This is what I'm talking about.

I think these are problems that are not a matter now of accusing anybody. Goodness me, I wouldn't want to accuse a nurse, I don't think nurses are over paid. I don't think doctors are over paid. When you are sick you need help and I would like to think that our drug store performs the service. I just know that all of this stuff costs money. It costs money to get a martini too as was indicated here a while ago. And I was just trying to

point out what are our priorities?

The worst thing that can happen to us, and I'm out of Government and I can sure tell you more about bureaucracy than you have heard here today, the worst thing that can happen would be for those persons in this room that are concerned about how you give better health care to any group is to get into an argument and be at loggerheads so to speak with the medical profession over whose fault it is that it isn't being done or whether or not somebody's got a proposal that is accused of being socialistic or something.

We don't need to call each other names any more. We've gotten out of that field. We are all over that I hope. But here we are now at a point where we are in a position to recognize a problem, to analyze it as has been said here like infant mortality, you are so right. This is why there is a great need in this country for the kind of education that you spoke of and the kind of neighborhood health care, the kind of outpatient care, the prenatal care, and teach people to use prenatal care and postnatal care.

We don't need to scold anybody, it's just that we haven't done it right yet and we are going to find a way of doing it. I happen to believe that there's a lot of goodwill in this Nation, a tremendous amount of it and I also know that there are a large number of people that are willing to give of themselves, of their valuable time

to find some answers. And we are not going to get into a shouting contest or into an argument, we're going to try to find a way to work out a partnership here to improve the economics of the situation.

You've got to live it, you've got to know how we do it, how we pay for it, how we spread it out, how we distribute it.

DOCTOR READER: Doctor Dorman --

DOCTOR GERALD D. DORMAN: Yes, I'm Doctor Dorman from New York. I just wanted to speak to the rural health problem because the American Medical Association is holding its two day conference on rural health in Philadelphia this Friday and Saturday.

The problems of having the doctors go to the rural areas are not only a question of financial support, the Sears Roebuck Foundation has been very helpful in placing doctors in rural areas, but unfortunately there are other problems with the doctors, one is the wives. They don't all want to go out to the rural areas. Another is the education of the children. Sometimes they don't feel that they get as well educated children in the rural areas.

These are only some of the problems. Now, the answers to them have been many and are being studied. Down in Oklahoma, for example, the State University is sending out teams into the country where they stay for short periods of time and Doctor Wilbur was down opening up the

center in Washita there this fall which is a rural center for treating the rural health area but connected with the University.

There are some of our mountain states where there are large sheepherding groups around the country and there's a problem in getting the care up to the sheepherders. And there they are using the helicopter service and the tie-in of having some of the people that are not actual doctors but trained in some of the paramedical work, the assistant physicians who are able to spot the trouble where a case needs to be referred in to the main University Hospital.

These people are trained in our Armed Services. We have had them serving with our troops in the Army and the Navy as various trained medical personnel. These people can go on and serve in that way so that there is a lot being done. It's being shaped and has to be shaped to the area that you are covering but there are problems in it.

Thank you.

DOCTOR READER: Mr. Hess.

ARTHUR HESS: My name is Arthur Hess, Social Security Administration. As one of the few live bureaucrats in captivity here this afternoon I'd like to make an observation or two and see if Mr. Humphrey would respond.

He spoke of a massive need and I think we all recognize there is going to have to be more money spent, more gross national product spent. But he also pointed

out the tremenous amount of money, the fifty billion or more that we are already spending and the fact has been emphasized over and over this afternoon what we know better how to do. We know so much better how to do what we need to do than we are doing.

I think it is obvious that services follow the dollar. That was your answer, sir, to the question about the lady about doctors and while Doctor Dorman pointed out it is not all the dollar our mutual experience in the Medicare certainly was that when you say how are you willing to spend your money, you can say what the standards are, what the qualifications are, where it is going to be spent, and how it is going to be spent and it wasn't until we as a Nation decided that we were going to say that we were going to put some money into home health services and some money into extended care and set a pattern that we demonstrated within just two years that you could raise up a massive improvement of standards and qualifications and get programs going all over the place.

Now, if we could get this kind of a mutual understanding with private health insurance so that as we have a concensus of the medical profession the insurances and the public programs of where and how and under what qualifications money will be spent this isn't regulation. This is saying what you want for the buck and how do you see, sir, getting this interaction, this concession?

We all know what to do now. We all know we ought to get patients out of hospital beds and into other programs, and there's a lot of money going into hospital care. How do we get this specification and this understanding?

MR. HUMPHREY: Well, I think meetings like this are very helpful. By the way, you could have put in a little plug for the low administrative cost of the Social Security system. And since you are speaking of bureaucracy it's a marvelous structure for efficiency. I've forgotten how many cases, insurance files they have, about eighty million or more insurance files and the administrative cost is much less than it is in most private companies despite the fact that it is the Government and it isn't so bad. It works pretty good. I know some of these Government agencies get a little loused up but if you've ever placed a mail order with some of these private companies you will see what I mean.

First of all you can't get the mail through sometimes. And that's part of the Government.

Let's take a look at one of the points mentioned here on overutilization of hospitals. Now, this is a fact-- I've forgotten which one of the gentlemen brought this to our attention -- why is there an overutilization of hospitals? Well, we have to take a look into how the Medicare program itself works. Does the Medicare program lend itself to hospitalization rather than outpatient care? I think the fact is it does. Now, if that's the case then we must put

together a kind of advisory board, consulting boards to try to come up with some standards and hopefully some suggestions to the medical profession, to hospital administrators, and to the recipients, and to the Social Security beneficaries themselves about less use of the hospital room, the hospital bed for cases that do not need hospitalization.

I don't think we are going to find any sure cure for it but I can say we can reduce it and I think they are beginning to now. I think there is some evidence that this fact has become so obvious that there is a tendency now on the part of the doctors and hospital administrators to try to minimize this, and they have to do it, as was indicated here, over the complaints of the children and the families who want their mother or their father or somebody else to be left in the hospital when in fact the person really shouldn't even be there.

What else can we do? Well, you can pass laws and it's the cost by way of Medicaid and Medicare are much more than what you estimated it's primarily due to the number of people that are using it and to the fact that services are more costly, without being critical, they are just more costly for many reasons. And we are possibly going to have to take another good hard look in the Congress. I imagine they will do so this year as to what kind of rules and regulations you ought to have under Medicare and Medicaid

to prevent what you would call the abuses of the system. But the best way to do it is for the professional people along with the interested citizen groups to talk it up until we begin to get a consensus. And then when we get that you can translate that into effective rules and regulations.

I believe that that is one of the prices we have to pay in this country because a rigid rule of where you try to tell a doctor how long he can keep a patient in, or tell a family how long that patient can stay in is going to get you into an awful lot of trouble. I would prefer to pay the price of a little extra cost and maintain some flexibility rather than to have a rigid prescription on some of these matters which we now see could be improved.

I don't think I have much more to offer than that. I do think it is fair to say that Medicare has shown us what can be done under prepaid insurance programs. I don't think there's a doctor in America that's worse off for it. I know the hospitals aren't, and I think that most of the people that have had the benefit of Medicare are the better for it.

Now, let's build from that. That isn't to say that it's good enough and the people in the Geriatrics Society and its affiliates, all of those here associated can help so much if you can get your discussion in to the proper authorities. And you say, "Who are the proper

authorities?" Well, I have a little knowledge about this. With all the brilliance of the executive branch of the Government, let me tell you that your Congressmen and your Senators are interested in you and your thoughts. You may not think so but they are and many of them have very creative minds and capable staffs and they are fully dedicated people, the most of them are. And I would hope that even out of a meeting like this after you analyze your two or three day Seminar and you come to some observations and some recommendations and conclusions that you won't let it just be a published document for yourselves but that you would see that it gets to every responsible authority, local, state, federal, and the societies, the professional organizations, and the less than professional organizations that are related to the care of our elderly.

Spread the message and it has a way of building up its own base of imformation and therefore its own self discipline.

I may become more patient as the years have gone on because I have found out that's the way it works the best.

(Applause).

DOCTOR READER: Thank you, Mr. Humphrey, for a very fine afternoon.

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ADDRESS BY

HUBERT H. HUMPHREY

Before the

American Geriatrics Society

Pebble Beach, California
March 16, 1969

"HUMANISM IN A TECHNOLOGICAL SOCIETY:
THE IMPENDING HEALTH CARE DISASTER"

Dr. Zinsser, Senator Williams, and my fellow participants in this important seminar.

I am delighted to participate in this Dialogue with such an august body of distinguished experts in the field of geriatrics -- And I want you all to know, before I go any farther, that I'm not a bit fooled by that term. "Geriatrics" is half way between medical jargon and a euphemism for "old timer" which, in turn, is a description variously applied to California gold prospectors, Mickey Mantle, and any Democratic politician who can remember back to the Korean War.

And after today, I expect some of my young friends to accuse me of being a practitioner of the "geriatric left."

Actually, I have not come here to make a political speech. In fact, to do so would require me to break a promise I made to myself last November when I resolved to make no political statements until after the Nixon Administration got started. If they don't get started pretty soon, I may have to break that promise, but not today.

Today, I want to share with you some of my concerns

for public policy in the field of health care. I am concerned that we face impending disaster as a nation if this problem continues unsolved.

In this technological age in which we live, we are learning to view and solve problems as they relate to a broader and more complex system. In this "systems approach" sense, I view health care, and health care for the aged, as part of a broader system of providing ways and means of improving the quality of life of our citizens.

In an even broader sense, this subject engages an issue which has challenged me, almost daily, for the past decade: It is the issue of "Two Cultures" which C.P. Snow wrote of -- the role of humanism in our technological society.

In this age of technology, science has been good for this country. It is an essential driving force to our expanding economy, generating the highest living standard in the world.

Science and engineering have placed within reach of all men the prospect of freedom from superstitution and tyranny; freedom from hunger and the toil of simply raising food. They have offered man a longer life, free of disability and disease. In fact, we find the contributions from science and technology so commonplace today that we take for granted the miracles of heart transplants, tv broadcasts from the Moon, supersonic transport, life saving drugs.

Science and technology make it possible for our private enterprise to be the most productive in the world -- and for

our Government -- which is the people's enterprise -- to meet its responsibilities.

But here we have a nagging paradox. While the power of scientific discovery has been employed for positive social purposes, we have not done nearly well enough. In a word, science has been a blight as well as a blessing to society. It has been both supportive and destructive of humanistic goals.

We have invented weapons which could wipe out humanity.

We have displaced some of our citizens from their jobs through automation.

We have mismanaged our natural environment and permitted pollution of our air, our streams and our landscapes.

We have an implosion of rural migration to cities unprepared to absorb urban concentration. We have created traffic jams, unsightly cities, slums, smog, noise and frustration at all the mechanical gadgets that stop working at the most embarrassing moments.

Looking ahead, we face either the abyss or the threshhold of new developments -- genetic manipulation, home broadcast satellites, sonic booms, artificial organs, birth contol methods which may help to check the world hunger and population explosion cycle -- a subtle world time bomb which, if unchecked, threatens the survival of mankind on this planet just as surely as the hydrogen bomb. All of these developments will challenge our social, governmental and ethical values.

The applications of science and technology do not depend on scientists and technicians alone. In fact, the most

challenging and most awesome applications depend upon decisions made by you and me, the people, and our political leaders. Such decisions must be based not only on what is technologically feasible, but also what is socially desireable.

Our early statesmen -- Washington, Adams, Jefferson, Madison and Franklin -- saw and understood the mutually re-enforcing benefits of science and government. In their vision, they recognized how science and technology expand the dimensions of freedom: provided new options for each individual -- widening choices as to where he would live, at what he would work, when he would travel, the extent of his education, and the opportunities to enjoy the fruits of his labors and of others.

John Kennedy, one month before he died, said this to the National Academy of Sciences:

> "In the last hundred years science has emerged from a peripheral concern of Government to an active partner. The instrumentalities devised in recent times have given this partnership continuity and force. The question in all our minds today is how science can best continue its service to the Nation, to the people, to the world, in the years to come."

I think that is still the question.. So let us explore one aspect of that question today. Namely, how have our improved concepts of governmental responsibility, our magnificent economic engine, our foremost technological systems, our paramount educational institutions, our gigantic pharmaceu-

tical enterprises, our unprecedented medical research, our massive public and private medical facilities and our highly trained practitioners -- all combined their forces to deliver good health to the people who make all these enterprises possible? How, in other words, is the most affluent and technological society in the history of the world doing by way of caring for the health needs of its citizens? Let's consider the following:

Item: Although the War on Poverty has raised 6 million people out of poverty in the last four years, we still have 29 million poor people in affluent America -- 29 million people who need jobs, education, food programs, and health care which they can afford and can get to conveniently; 29 million people who are not receiving, and whose children and grandchildren are not receiving, the most basic necessities of life which they see available to their 170 million neighbors.

Item: With all our affluence and medical competence, the men of 20 countries, and the women of 11 countries, live longer than American men and women.

Item: Where do we rank among the nations of the world in terms of infant mortality? 16th.

Before we let that statistic slide by, let's remember what that means in human terms: It means that, compared to Sweden, for instance, the failures of our medical and health system needlessly killed 50,000 American babies last year.

Item: While we are all concerned with the problem of checking inflation, our health costs today are increasing at a rate more than double that of general price levels in our economy.

Item: 30 million Americans have no health insurance at all. And despite the great efforts of the insurance industry, supplemented by Medicare and Medicaid programs, which, all combined, have written some form of health insurance for 4 out of every 5 citizens, the fact is that two-thirds of all personal health care costs remain uninsured.

Item: Based on minimum standards of quality set by Medicare, one-third of all hospitals are not accredited, and 10% of all hospital patients are admitted to non-accredited hospital beds.

These few statistical items are well known to almost everyone in this room. They are common knowledge; not revelations. They are, in fact, the fever thermometer of a dangerously, if not mortally, sick system.

Do they spell neglect? Unfortunately, I think perhaps not -- at least not in conventional terms. It is difficult to say that a nation which spends $53 billion -- 6.5% of its gross national produc t -- for health care is in a state of neglect. I say "unfortunately" because simple neglect is a relatively easy problem to understand and overcome.

However, I am afraid that these statistics, and the hundreds more which I could recite, spell incompetance rather

than simple neglect -- massive, almost universal incompetance in the planning and design of our health system. And the needed complete overhauling of such a system -- or "non-system" as some have called it -- is not a simple task at all.

The "systems approach" to problem solving is a new development. It is a child of the computer and has been applied most effectively to the design of hardware systems in the fields of defense and space. We have only recently begun to apply this methodology to human systems, and we have a lot to learn.

One of the major advantages of systems design is that it forces planners and designers of systems to look at causes as well as effects; to ends as well as means; to the disease as well as the symptoms. In other words, it identifies and oils the whole system rather than merely some of its squeakier parts. In the field of health care, we need a whole new machine, not an oil can.

Historically, we have been a nation of tinkerers, not planners. The results have thus been a long series of remedial, crash programs which are inevitably more expensive and less efficient than doing the job right the first time.

In the forties we had a baby boom, but we waited until the sixties to respond to the inevitable and predictable population crisis in our schools and colleges. The question is, will we now wait until the year 2000 to deal with the issues of a dramatically expanded golden age group?

The statistics which I have cited show that we have let

our demand for health care -- both geriatric and general -- dangerously outstrip our supply of physicians and hospital beds. In addition, medical manpower specialists have been alerting us for ten years to the expanding need for medical technicians and other paramedical personnel. Today, late as always, we are beginning to plan training programs for this so-called new and emerging cluster of careers.

The chances are we will need costly crash programs to train more doctors, nurses, paramedical technicians, and to build more hospitals, neighborhood clinics, and residential facilities for the aged and the chronically ill. To a great extent, however, this will be no more than tinkering some more with the symptoms of the problem.

But the disease, the real enemy, is an unplanned, unsophisticated, unresponsive health care system which is so deficient,in terms of the needs of our population in general and our elderly citizens in particular, as to be no system at all.

The fact is that a well conceived and coordinated system of health care, which deployed doctors and hospital beds rationally, and which provided universal health care, could probably be provided without increasing the number of physicians and without even replacing the sub-standard hospitals which should be abolished. And it could probably be provided, through a redistribution of funds, at no greater cost than we now pay.

Our health care crisis hits hardest the poor and the aged on fixed retirement and social security benefits. While

we are talking about improving the fundamental system, we will need immediately to do some tinkering, inefficient though that may be.

We will need to increase Social Security benefits across the board.

We must improve upon Medicare.

We must put medical payments on the same insurance pre-payment financing basis as the hospital part, thus relieving older citizens from the $4 per month drain on their retirement income.

And We must work into the program some protection against the high costs of prescription drugs.

I must stress, however, that while some additional, stop-gap tinkering with symptoms may be necessary, it is the basic inadequacy of our entire system of delivering and providing health care to all our citizens which is the root cause of our impending health care disaster. The solution, then, is inescapable. We must overhaul the system and thus avoid the future expenditure of funds designed merely to compensate for its failures. We must cure the disease, not just prescribe for the symptoms.

I am not going to detail the specifics of such a system today. To be workable, any health care system will require the concerted, good faith planning of the health professions, public health officials, the insurance industry, and many other interested organizations which represent the vital interest of the affected public.

I think certain fundamental propositions are nonetheless clear. The system must be designed to provide every American with access to the full range of high quality health care, including medical, dental and psychiatric. The cornerstone will have to be some form of universal, prepaid insurance which is substantially comprehensive.

The system will have to be designed to fit our unique, American forms and institutions. It can not be copied from prototype British or European National Health Plans. It will have to assure maximum flexibility and options both for the consumers and the doctors.

Finally, let me say a word to our traditional naysayers in the medical and insurance communities. I hope and trust that the lessons of Medicare and "Black Lung" have not been lost on you. The days of citizen aquiescence in expensive, inferior and selective medical care are numbered. A new, relevant, responsive health care system for America is coming. All those of good faith will have the opportunity to help shape the model. But help or hinder, the medical profession and the insurance industry will be vitally affected by the ultimate system. I hope they will help. I think the public interest demands that they do.

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These few statistics are common knowledge, not revelations, to the people in this room.

What do these statistics tell us? They reveal ~~massive, almost universal incompetance~~ serious deficiencies in the basic and operational planning, ~~and~~ design of our health-care system.

And they reveal further, a failure of our society to establish the national priorities ~~in the expenditure of our national wealth~~ which are necessary to provide ~~is essential to produce~~ humane and ~~comprehensive health-care system~~ full access to humane & comprehensive health care. for every citizen.

The time has come in this country to get both our priorities and our systems straightened around and functioning properly.

Historically, we have been a nation of tinkerers, not planners. And we have been satisfied with a long series of remedial, crash programs which inevitably are more expensive and less efficient than doing the job right in the first place.

For example, we know that ~~Today~~, the demand for health care -- both geriatric and general -- dangerously outstrips our supply of physicians, nurses, paramedical personnel, hospital beds and related health services.

But A major factor in this critical shortage is a largely unplanned, unsophisiticated, unresponsive health-care system which ~~is grevously deficient in meeting the needs of our population in general and our elderly citizens in particular.~~ is unable to use our existing health resources and poor efficiently and economically.

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and to raise briefly the issue of how our capacity to deal with this problem, as well as many others, ultimately depends on the priorities we set for ourselves as a democratic society.

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our Government -- which is the people's enterprise -- to meet its responsibilities.

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We have mismanaged our natural environment and permitted pollution of our air, our streams and our landscapes.

We have an implosion of rural migration to cities unprepared to absorb urban concentration. We have created traffic jams, unsightly cities, slums, smog, noise and frustration at all the mechanical gadgets that stop working at the most embarrassing moments.

Looking ahead, we face either the abyss or the threshhold of new developments -- genetic manipulation, home broadcast satellites, sonic booms, artificial organs, birth contol methods which may help to check the world hunger and population explosion cycle -- a subtle world time bomb which, if unchecked, threatens the survival of mankind on this planet just as surely as the hydrogen bomb. All of these developments will challenge our social, governmental and ethical values.

The applications of science and technology -- for good or ill -- do not depend solely on the decisions of scientists and technicians, alone. In fact, the most

challenging and most awesome applications depend upon decisions by we, the people, and our political leaders. Such decisions must be based not only on what is technologically feasible, but also what is socially desireable.

Our early statesmen -- Washington, Adams, Jefferson, Madison and Franklin -- saw and understood the mutually re-enforcing benefits of science and government. In their vision, they recognized how science and technology expand the dimensions of freedom: provided new options for each individual -- widening choices as to where he would live, at what he would work, when he would travel, the extent of his education, and the opportunities to enjoy the fruits of his labors and of others.

John Kennedy, one month before he died, said this to the National Academy of Sciences:

> "In the last hundred years science has emerged from a peripheral concern of Government to an active partner. The instrumentalities devised in recent times have given this partnership continuity and force. The question in all our minds today is how science can best continue its service to the Nation, to the people, to the world, in the years to come."

I think that is still the question. So let us explore one aspect of that question today. Namely, how have our improved concepts of governmental responsibility, our magnificent economic engine, our foremost technological systems, our paramount educational institutions, our gigantic pharmaceu-

tical enterprises, our unprecedented medical research, our massive public and private medical facilities and our highly trained practitioners -- how can these many combined their forces to deliver good health to the people who make all these enterprises possible? How, in other words, can the most affluent and technological society in the history of the world meet the health needs of all its citizens? Let's consider the following:

Item: Although the War on Poverty has raised 6 million people out of poverty in the last four years, we still have 29 million poor people in affluent America -- 29 million people who need jobs, education, food programs, and health care which they can afford and can get to conveniently; 29 million people who are not receiving, and whose children and grandchildren are not receiving, the most basic necessities of life which they see are available to their 170 million neighbors.

Item: With all our affluence and medical competence, the men of 20 countries, and the women of 11 countries, live longer than American men and women.

Item: Where do we rank among the nations of the world, the United States ranks sixteenth in terms of infant mortality? 16th.

What does this mean in Before we let that statistic slide by, let's remember what that means in human terms? It means that, compared to Sweden, for instance, the failures of our medical and health system needlessly killed 50,000 American babies last year.

Item: While we are all concerned with the problem of checking inflation, our health costs today are increasing at a rate more than double that of general price levels in our economy.

Item: 30 million Americans have no health insurance at all. And despite the great efforts of the insurance industry, supplemented by Medicare and Medicaid programs, which have written some form of health insurance for 4 out of every 5 citizens, the fact is that two-thirds of all personal health care costs remain uninsured.

Item: Based on minimum standards of quality set by Medicare, one-third of all hospitals are not accredited, and 10% of all hospital patients are admitted to non-accredited hospital beds.

These few statistical items are well known to almost everyone in this room. They are common knowledge, not revelations. They are, in fact, the fever thermometer of a dangerously, if not mortally, sick system.

Do they spell neglect? Unfortunately, I think perhaps not -- at least not in conventional terms. It is difficult to say that a nation which spends $53 billion -- 6.5% of its gross national product -- for health care is in a state of neglect. I say "unfortunately" because simple neglect is a relatively easy problem to understand and overcome.

However, I am afraid that these statistics, and the hundreds more which I could recite, spell incompetance rather

What do these statistics tell us? They reveal primarily a ~~than simple neglect~~ massive, almost universal, incompetance in the planning and design of our health care system. And the needed complete overhauling of such a system -- or "non-system" as some have called it -- is not a simple task at all.

The "systems approach" to problem solving is a new development. It is a child of the computer and has been applied most effectively to the design of hardware systems in the fields of defense and space. We have only recently begun to apply this methodology to human systems, and we have a lot to learn.

One of the major advantages of systems design is that it forces planners and designers of systems to look at causes as well as effects; to ends as well as means; to the disease as well as the symptoms. In other words, it identifies and oils the whole system rather than merely some of its squeakier parts. In the field of healthcare, we need a whole new machine, not an oil can.

Historically, we have been a nation of tinkerers, not planners. And we have been satisfied with The results have thus been a long series of remedial, crash programs which are inevitably more expensive and less efficient than doing the job right the first time place.

In the forties we had a baby boom, but we waited until the sixties to respond to the inevitable and predictable population crisis in our schools and colleges. The question is, will we now wait until the year 2000 to deal with the issues of a dramatically expanded golden age group?

The statistics which I have cited show that we have let

INSERT OVER

(And they reveal further a failure of our society to establish the priorities in the expenditure of our national wealth which is essential to produce a humane + compassionate health-care system for every citizen.)

8)

Today the demand for health care -- both geriatric and general -- dangerously outstrips our supply of physicians, nurses, paramedical personnel, and hospital beds and related health services. In addition, medical manpower specialists have been alerting us for ten years to the expanding need for medical technicians and other paramedical personnel. Today, late as always, we are beginning to plan training programs for this so-called new and emerging cluster of careers.

The chances are we will need costly crash programs to train more doctors, nurses, paramedical technicians, and to build more hospitals, neighborhood clinics, and residential facilities for the aged and the chronically ill. To a great extent, however, this will be no more than tinkering some more with the symptoms of the problem.

A major factor in this critical shortage But the disease, the real enemy, is an unplanned, unsophisticated, unresponsive health care system which is grievously deficient, in meeting the needs of our population in general and our elderly citizens in particular, as to be no system at all.

The fact is that a well conceived and coordinated system of health care, one which deployed doctors and hospital beds rationally, and one which provided universal health care, could probably be achieved without drastically increasing the number of physicians and without even replacing the sub-standard hospitals which nevertheless should be abolished for other reasons. And it could probably be provided, through a redistribution of funds, at no greater cost than we now pay.

Our health care crisis hits hardest the poor and the aged on fixed retirement and social security benefits. While

It is, I repeat, a question of priorities and planning.

9/ * * * *

We must act as promptly as possible to relieve the most immediate injustices in the present system--injustices which afflict most directly the poor and the aged on fixed retirement and social security benefits.

During the Presidential campaign, I suggested a series of urgent steps that should be taken:

--Increasing Social Security benefits by 50 percent across the board in steps over the next four years.

--Making benefits inflation-proof after retirement by raising them automatically to reflect cost-of-living increases.

--Making it more attractive for the Social Security beneficiary to earn more by liberalizing the provisions which reduce benefits when a person is employed

--Financing a part of the increased benefits from general revenues to ease the burden of social security contributions on the workers.

I urged taking the next steps in improving our Medicare program:

--Putting the doctor bill part of Medicare on the same social insurance pre-payment basis as the hospital part, making it unnecessary for

out of their retirement incomes
older citizens to pay $4.00 a ~~xxxx~~ month/for medical insurance.

--Providing protection against the heavy cost of prescription ~~drugsxx~~
by the aged
drugs which account for about 30 percent of private expenditures/for health care.

--Extending Medicare's protection to disabled Social Security beneficiaries who, like olderpeople, have unusually high medical costs at ~~xx~~ a time when their overall income is sharply reduced.

These are short-term, easily-taken steps which would relieve some
more immediate
of the ~~most pressing~~ needs in the health-care field.

to
But we must not permit short-term advances/blind us to the ~~needx~~ even more critical necessity of restructuring our entire health-care system.

In this regard I am ~~greatly~~ impressed by the comprehensive ~~action~~ program of principles and action ~~recommendations~~ set forth by the Committee for National Health Insurance. ~~To be~~ By the same token, ~~workable,~~ any health-care system will require the concerted and good-faith planning of the health professions, public health officials, theinsurance ~~xxx~~ industry, and other interested associations and groups, such as the

This is a balanced and thoughtful approach which takes seriously the vital interests and concerns of all groups in our society that are essential to a successful system of health care reform.

American Geriatrics Society.

A restructured health care system--founded on some form of universal, pre-paid insurance--will have to fit our unique American institutions and traditions.

It cannot be copied from Great Britain or European National Health Plans. It will have to assure maximum flexibility and options both for the consumers and members of the health professions.

And, finally, this kind of health-care system will be possible only in a society which has its priorities straight--a society which has decided to direct its energies from the works of war to the works of peace. That is why I have in recent days spoken out against deployment of the Sentinel anti-ballistic missle system and urged instead the beginning of prompt negotiations with the Soviet Union to seek the reduction of both defensive and offensive strategic nuclear weapons.

It is in this spirit that I am honored to participate in this stimulating dialogue on social policy issues in health care of the aging.

Minnesota
Historical Society

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