The Saturday Evening POST

Medicare:

HEADACHE or CURE-ALL?

It was both prayed for and damned, called a panacea and attacked as the ruination of medicine. Now, as Medicare nears the end of its first year of operation, the Post's medical editor examines the hotly controversial program.

By STEVEN M. SPENCER

They had walked a mile or more in the sun, 200 men and women 65 years and older, yet they were in a holiday mood, laughing, chatting and joking with their escort of reporters and policemen. The date was July 1, 1966—the first day of Medicare. The marchers were members of the Golden Ring Council of the Senior Citizens of America, and they were hiking from their headquarters to Mount Sinai Hospital in Manhattan to celebrate the occasion. "You'll be here someday," one of the walkers called happily to a young reporter. "Medicare is for you, too, you know."

One of the gayest men in the crowd was Isidore Duchinsky, a peppery, laughing, white-haired Russian immigrant who is the editor of the newspaper of the Golden Ring Council. "This is what I came to America for," he said. "My children are so happy—now I have security." A reporter wondered what Mr. Duchinsky thought of the opponents of Medicare. "Give 'em hell!" he announced cheerily. Then he thought better of it. "No," he said, "that wasn't a dignified thing to say."

On that day in July hospitals and doctors across the country had braced themselves for an invasion of creaking old men and

Signing up, a woman enters Medicare's maze of red tape.

BENEFITS FOR THE ELDERLY

Created as an amendment to the nation's Social Security Act, and designed to protect more than 19½ million Americans who are 65 and over against the rainy day of illness, Medicare is by far the most expansive and sweeping piece of social legislation to be passed by Congress since Social Security itself back in 1935.

Under Part A of the program, the Government pays all but the first $40 of the hospital bill for the first 60 days of a "spell of illness" and all but $10 of the daily bill for the 61st through the 90th day. To receive these benefits, a subscriber does not have to pay anything into the program. For a premium of $3 a month a subscriber can get insurance for his doctors' bills under Part B of Medicare. The patient has to pay the first $50 of his doctors' bills in any year, but thereafter the program pays 80 percent of the "fair and reasonable" charges. So far, about 17 million Americans have signed up for Part B. Finally, the Medicare umbrella covers outpatient services, convalescent care in approved nursing homes, and a series of home-nursing visits.

women with all manner of real and imaginary ills. But the rush was not up to expectations, partly because the warm months of summer are kind to the elderly. Then, as summer faded into autumn, and winter blew in with its quota of chills, heart attacks and strokes, its rheumatic pains and broken hips, more and more patients crept in under the huge and floppy Medicare umbrella.

As Medicare now approaches the end of its first year of operation, it is obvious that the program is too broad and complex to permit a final assessment. But it is also clear that it is not quite the glorious success its sponsors promised nor the miserable failure its opponents forecast.

The statistics of Medicare are awesome. In its first nine months the plan paid $1.6 billion in hospital bills for more than 3 million persons, and some 9 million doctor bills totaling $346 million. Nursing-home care—limited to the post-hospital period—has been covered only since January 1, but this and a growing demand for all services will make Medicare's second full year of operation far bigger than its first.

The cost of it all is greatly exceeding some earlier forecasts. President Johnson's budget for the fiscal year beginning July 1 calls for $3.9 billion for the program—some $446 million more than the first year is expected to cost. Medicare is also proving to be more complicated and confusing to operate than its sponsors had predicted. Yet even the American Medical Association, which bitterly opposed Medicare as being prohibitively expensive and complex and destructive of the traditional doctor-patient relationship, is willing to admit the program is not as bad as it had expected. The A.M.A.'s moderate president, Dr. Charles L. Hudson of Cleveland, reports, "The doctors, who anticipated a lot of interference with their practice of medicine, have not discovered any real interference. Medicare itself, except for its basic philosophy, is a program with which we can live without a great deal of difficulty."

Nevertheless, the A.M.A. still believes that Medicare is "unwise legislation," Dr. Hudson testified before the House Ways and Means Committee last month. He said it is covering too many people who could pay their own bills, and he urged Congress "not to expand this program."

As for the patients themselves, Medicare is good, bad or just so-so, depending on their own situation, the extent of their knowledge about the program, and sometimes their political views. To Mrs. Ann Wallace, a petite, Scottish-born woman of 72 who had been remarkably free of illness all of her life, Medicare was something she'd signed up for but didn't believe she'd ever need. Then she fell on the street and broke her ankle and pelvic bone and ended up in Miami's Jackson Memorial Hospital. "My doctor here was wonderful," she said. "He put a steel pin in my bones, and then he sewed me all up so that I have only a very faint red line to show for it. Some doctors don't care if they leave ugly scars on old ladies. They figure, 'What the heck! She's too old to worry about scars.' But not my doctor!"

In a room at the Hospital of the University of Pennsylvania, Mrs. Thomas, a tall, regal woman, sat with her husband as he leaned intently over a large jigsaw puzzle. A teacher for many years in a private prep school, he had undergone four major brain operations and one gall-bladder operation in the past 10 years.

"He has spent a total of thirty-three weeks in hospitals in that time," said his wife, as we walked to a small lounge. "Blue Cross has been most helpful, but he never really approved of Medicare, so when the Medicare insurance application came to us to mark 'yes' or 'no,' we said 'no.' But when we received a letter saying we could no longer be covered by Blue Cross, that worried us, and we signed up for Medicare."

They were glad they did. The plans cover $38 of the $58-per-diem hospital charge and most of the doctor bills. "But I do think Medicare ought to be put on an income basis," she added, "so that people of higher income would pay more. I think such a system would be much fairer."

A wealthy retired man in Pasadena recently underwent a five-day hospitalization for bronchopneumonia and a three-day stay for ear surgery. Using Medicare and a supplemental Blue Cross policy, he had paid only $12.50 to the hospital for the first stay and $8 the second time. In each instance he had been in a private room.

When a visitor suggested he must have been pleased by the arrangement, he said, "I'm an extremely conservative person. I've always held the notion that people should take care of themselves. I can't see this Medicare for people over sixty-five who are able to pay."

"But you used it," his visitor reminded him.

"Oh, sure," he replied. "I have a fixed income, and with taxes as they are I have to take advantage of it. Even so, in principle I don't like it."

Medicare's protection is most warmly appreciated by those who have once had a prolonged illness for which they had no insurance coverage. Mrs. Robinson, a slender, attractive woman in her late 60's, had just undergone a cataract operation in Philadelphia. "I think Medicare is wonderful," she said. "The cost of the operation and the long hospital stay would be prohibitive without it. You see, we still haven't recovered from a heavy blow that hit us thirteen years ago. For a brief interval we had no medical insurance at all, and my husband was hospitalized for a long period. The bills came to ten thousand dollars and took all our savings. We'll probably never get over it. But with Medicare we'll be protected in the future."

The oldsters guard their red-white-and-blue Medicare cards like precious gold pieces. Before a hospital admissions clerk has finished taking information from it, a patient will often ask, "Now, may I have my card back?" And when a patient was asked for his card on entering a Philadelphia hospital, he said, "Oh, it's so valuable I put it in my safe-deposit box." Another, entering the same hospital, said he'd left his card back at his home in Virginia, in a locked trunk.

"We admitted him, of course," explained the gray-haired clerk, "and obtained the card number later." She laughed. "As a matter of fact, I'm of eligible age myself, and I've got my own Medicare card locked away at home in a trunk."

It is hard to determine how many previously unmet needs Medicare is now fulfilling. Certainly the aged suffered more medical neglect in some areas of the country than in others. But bringing in Medicare is not as if some 19 million persons needing care were suddenly getting treatment, observes Dr. Luther Terry, former Surgeon General of the U.S. Public Health Service and now medical vice president of the University of Pennsylvania. "Many had been getting good medical attention all along," Dr. Terry says.

On the whole, older people of slender means are now receiving more services under Medicare because there is now more money to do things for them. In the past, physicians dealing with poor patients often hesitated to prescribe expensive procedures which were not absolutely essential, even though they might have hastened recovery.

Although the aging sick have not swamped all hospitals—the nationwide increase in admissions

Helping them, getting them
to make progress—there's an art
to treating old people.

To strengthen his arms, a Medicare patient works with a heavy weight in a rehabilitation center in Chicago.

in this group is five percent—they have certainly helped to create a shortage of hospital beds in some areas. New York's Montefiore Hospital, for example, reports the waiting time for nonemergency cases has increased from 2 to 3 weeks a year ago to 6 to 10 today. Even many persons with "urgent" though not "emergency" conditions, such as gall bladder or congestive heart disease, have been subjected to what doctors call medically serious delays.

Before Medicare, nearly one third of all hospital care was devoted to patients who were 65 or over, even though they made up only 10 percent of the population. Since Medicare, there are signs that elderly patients are staying in the hospital even longer. A survey of several Catholic hospitals in New York City showed that older patients were staying twice as long as they did before Medicare was passed.

To prevent unnecessarily prolonged hospital stays, Medicare requires each hospital and accredited nursing home to set up a committee to review case records and to interview patients and physicians to determine whether continued hospitalization is medically justified.

"Usually the committee agrees with the physician," explained the chief of staff of an Arizona hospital. "Occasionally the doctor may feel the patient is ready for discharge but is being pressured by the family to keep the patient in. He now gets support from the committee and can tell the family, 'Well, the committee has decided that further hospital care isn't necessary. You'll have to take Grandma home or pay her bills yourself.' This tends to get Grandma home."

Getting Grandma home is only a small part of the tons of Medicare paperwork that have flattened many a hospital administrator and doctor and have proved to be one of the greatest drawbacks of the program.

"If all of us, including the best minds in the health-insurance business, were to sit down for a year and do our best to draw up a complicated system, we couldn't devise one as complex as Medicare," says Fred Higginbotham, a Dallas Blue Cross official.

Medicare's intricate billing procedures have added millions of dollars to hospital overhead. Manhattan's Mount Sinai, typical of the nation's larger and better hospitals, had to hire 41 new clerks when Medicare began. This new task force is obviously one reason for the startling rise of 16.5 percent in hospital costs last year, after a 6 percent yearly rise from 1960 through 1965. (The main reason, however, was that hospital wages were being forced up by the pressure of strikes from traditionally underpaid employees.)

In a sense, organized medicine is to blame for some of the paperwork that it now condemns. Certain specialty groups insisted that doctors' services should be billed separately from hospital charges, even if performed in a hospital with hospital-owned equipment. The cost of an X ray, for example, is divided into two fees: one for the use of the machine and for the technician who takes the picture, and one for the M.D. radiologist who reads and interprets the films.

The doctors held out for separate billing because they thought it would maintain a clearer picture of the physician's own services and help create a better doctor-patient relationship. But the problem of apportioning costs is turning out to be overwhelming, and in some cases it is ludicrous. During the first four months of Medicare, for example, outpatient claims in Syracuse, N.Y., averaged only $1.81 for the hospitals and $2.91 for the doctors. The actual cost of processing the outpatient and inpatient claims ran as high as nine dollars apiece.

Much of the Medicare paperwork is even more wasteful. About 60 percent of the one million outpatient claims processed during the first seven months of Medicare resulted, because of deductions, in no payments at all.

Although Congress is responsible for writing the complex Medicare Law, it was subjected to pressures from many groups, notably, of course, the American Medical Association. It is now privately admitted even at the A.M.A. headquarters in Chicago that the organization could have guided the

'I've got my Medicare card right in my pocketbook. It's nice to know I can pay my way.'

program along smoother paths if it had begun its cooperation earlier instead of carrying on a last-ditch battle against the entire concept.

Since Medicare became law, however, Social Security Commissioner Robert M. Ball has found the A.M.A. to be quite cooperative. "Without exception," said Mr. Ball, "the A.M.A. leadership took the good-citizenship position that 'now that Medicare is law we will work with the Government and try to be helpful.'"

One official in Washington who now has some nice things to say about the A.M.A., somewhat to his own surprise, is Wilbur J. Cohen, the doughty Under Secretary of Health, Education and Welfare and a principal planner of Medicare.

"Thirty years ago people who wanted reform couldn't even have a dialogue with the medical profession," he remembers. "Doctors who wished only to study the problem were isolated or attacked by others in their profession. Now there is a breath of fresh air, and even though there isn't always total agreement all the time, we have a completely open dialogue."

On occasion, however, the dialogue takes a wry turn. The story is told of a physician who once approached Mr. Cohen and said, "You know, Mr. Cohen, if you ever need a doctor I'd be happy to take care of you." Mr. Cohen smiled, said he was well satisfied with his regular doctor but appreciated the offer. "Well, I mean it," the doctor persisted. He moved closer, tapping Mr. Cohen's chest with his forefinger. "As a matter of fact," he said, "I'm a surgeon, and I'd just love to cut you open from here to here."

One aspect of Medicare that irks many doctors is the frequent report that they are somehow getting rich from the program. A Department of Health, Education and Welfare report on medical-care prices did show that physicians' fees rose 7.8 percent in 1966, after increasing only two or three percent a year from 1960 through 1965. But the rise was less than half that occurring in hospital charges, and the H.E.W. report said "there is no evidence that Medicare was a major factor" in it. H.E.W. also noted that most physicians did not raise their fees, although some were getting more income because they were seeing more patients.

In all the arguments over Medicare, the A.M.A. was less concerned about how much the doctors would be paid than with how the bills were to be handled. The program allows the doctor to send a patient's bill to Medicare through Blue Shield or some other designated intermediary. The doctor is then paid, after weeks and sometimes months, for his "customary and reasonable" charges.

But the doctor also has the option of billing the patient directly, as before. The patient pays him and sends the receipted bill to Medicare for reimbursement. This arrangement is obviously simpler for the doctor but more complicated for the patient, who is now the one who waits for payment.

Delegates to the A.M.A.'s 1966 convention were so determined to have as little as possible to do with the machinery of Medicare that they urged all doctors to practice direct billing almost exclusively. Of the medical claims processed by Medicare headquarters in late March, about half were from patients who had been billed directly. Practices vary in different parts of the country, but most doctors don't bill directly those who would find it hard to wait for reimbursement.

The relatively few physicians who are still adamant in their opposition to Medicare use direct billing as their main weapon against the system. Many of these same doctors argued in 1965 that physicians should combat Medicare by simply refusing to participate in any program that Congress passed. Indeed, some of these doctors leave the impression that they are still clinging to the "nonparticipation" policy. Said an employee of Social Security's New York office, "People come in here and ask us what doctors they can go to. They'll say, 'My doctor doesn't want to belong.'"

Paradoxically, old people living on borderline incomes often find that they are now worse off with Medicare than they were without it. Take, for example, a woman in a southwestern state whom we shall call Lola Jones. Mrs. Jones is 76, a retired domestic. By frugal management and occasional help from a former employer, she manages to stretch her $60 monthly Social Security and $37 state old-age assistance checks to cover rent, food, clothing and incidentals. Last year she signed up for Medicare insurance, and $3 a month is now deducted from her Social Security payment. But Medicare won't pay any of her doctor bills until she herself has paid the first $50 — the deductible amount. So she must pay her $36 premium, plus the $50 deductible, or a total of $86, before Medicare begins to help her meet her bills. And even then she must pay 20 percent of the balance.

What puzzles Mrs. Jones, and many like her, is that she is now paying more a year for insurance than she used to pay to her doctor. In most years his bills have totaled only $15 or $20, and in one bad year, "when he had to do quite a lot for me while I was in the hospital with my heart attack," it came to $40.

Mrs. Jones had, of course, been the beneficiary of the doctor's traditional discounting of fees for the lower-income patient. Although he is a specialist in internal medicine, he charged her only $2 or $3 for an office visit, $4 or $5 for a house call.

"Now with the advent of federally financed medical care for those in straitened circumstances, the medical profession is faced with a dilemma," Mrs. Jones's doctor declares. "Should the doctors continue to charge a greatly reduced fee, or should they charge a standard fee and make the patient pay fifty dollars a year in doctor bills that he can't afford? Some doctors will prefer to take care of them for nothing. They've been taking care of them for *next* to nothing for a long time."

In about half of the states, individuals like Lola Jones are being helped by a program called Medicaid, which takes up where Medicare leaves off. Set up under another Social Security amendment, Medicaid provides funds to pay all medical, hospital and dental expenses of families below certain income levels. But Medicaid, which is funded by both the state and Federal Government, is administered by the state-welfare departments, and many of the older people are too proud to accept anything with a "welfare" label.

A side effect of Medicare, which angers many patients, is the fact that Blue Cross and Blue Shield are canceling subscribers' policies as they reach the age of 65 and become eligible for the federal program. The "Blues" officials don't like the word "cancellation" and point out that they offered all their old subscribers, as well as new ones, "senior-care" policies which fill in or supplement Medicare coverage. At roughly half the premium rates, these policies meet the $40 deductible on the hospital bill, pay for hospitalization beyond the Medicare limitation of 90 days and cover the 20 percent co-pay on the doctor bills.

But many of the long-time "Blues" subscribers, who had been dutifully contributing to the program for years in anticipation of full protection when they became ill in their old age, argue that the "senior-care" policies don't give them enough for their money. Moreover, many people feel that Blue Cross is benefiting so much by Medicare's assumption of hospital bills that they should reduce the scale of premium rates they charge everyone.

One Blue Cross spokesman admitted last year that cancellation of policies held by persons 65 and over was saving Blue Cross about $150 million a year in payments. But this age group had been receiving in benefits much more than it was paying in premiums. "We were already making significant subsidies to the older subscribers out of receipts from those under sixty-five," a Blue Cross Association executive in Chicago explained. "A few percentage points might now be taken off as a result of not having the over-sixty-five's on board. But rising costs of hospital operation, the thirty or forty percent increase in nurses' salaries, for example, counteract this. Many Blue Cross plans have just been able to hold their own as a result of Medicare. Without it they would have had to raise rates."

Another disturbing "side effect" of Medicare and Medicaid, which has received little public notice, is the restraints they impose on the training of tomorrow's physicians and surgeons, especially the surgeons. Traditionally the "ward patient," admitted free or at a reduced rate, was the "teaching patient." He knew that his care would be mainly in the hands of interns and residents, who would be supervised by experienced staff members. Today, under Medicare and Medicaid, everyone is entitled to choose a private physician and a semiprivate room. The "charity" or "ward patient" has all but disappeared.

If every patient insists that all his medical care be administered only by his private physician, interns and residents will get no practical experience. "You can't learn to drive a car just by watching someone else," a New York surgeon remarked. "It's the same thing with removing a gall bladder or a lung. There are technical skills that can be learned only by doing."

Teaching surgeons are now seeking ways to change the Medicare rules to ease this situation. In the meantime, the major hospitals are finding ways to solve their own problems. At Manhattan's Columbia-Presbyterian Medical Center, a special unit of 110 beds has been set aside for surgical patients who are operated on by experienced residents in training, supervised by staff surgeons. Patients are told of the team approach before admission to the unit, and so far only one in five has refused to accept the arrangement.

Even in the nonsurgical branches of medicine the student cannot learn just by watching but must eventually make judgments on his own. "One of our jobs as teachers is to have interns and residents learn to recognize the point at which they need the help of more experienced people, and then to ask for it," says Dr. James B. Wyngaarden, the young head of the University of Pennsylvania's department of medicine.

In the Hospital of the University of Pennsylvania, as in other university hospitals across the country, many Medicare patients are now freely agreeing to act as subjects for the training of interns and residents. If they aren't too sick they enjoy trying to stump a young intern on an obscure diagnosis.

Troublesome as certain parts of Medicare may be—and legislative changes are expected to smooth out many of the worst wrinkles—one encouraging side effect is the prospect that the program will improve the nation's sadly neglected system of nursing homes. Since January 1, Medicare has covered patients who have been in a regular hospital for a specific illness and who have been transferred for further treatment to an accredited nursing home or "extended care facility." (Medicare does not pay for the custodial care of old

people.) Under the program, Medicare pays for the full bill for the first 20 days, and all but $5 a day for the remainder of a required stay, up to 80 days.

The advantages of Medicare for a private nursing home are great: a steady supply of patients and a guaranteed payment plan. But to become eligible for this program, the homes have to meet Medicare requirements of skilled nursing around the clock and a registered nurse in charge. To date, only about 4,500 of the country's 12,700 nursing homes have managed to meet these requirements, but many of the facilities are in the process of upgrading themselves.

Dr. G. Clayton Kyle, chief of the diabetes clinic at the Hospital of the University of Pennsylvania and a medical-insurance expert, says that 75 percent of the patients now in general hospitals are suffering from chronic conditions which could be cared for in qualified nursing homes.

"When the taxpayers become sophisticated enough to know they are paying fifty dollars a day for care that could be given at a cost of twenty dollars a day, they will demand more of these convalescent or extended-care facilities," says Dr. Kyle. "Otherwise Medicare is going to cost ten times as much as was originally estimated."

Another important plan to help the elderly is home-health care, under which a patient can obtain payment for as many as 100 visits a year by a trained or practical nurse, a physiotherapist, a speech therapist or a "home-health aide." The program of visits must be prescribed by a doctor, and to date far too few physicians have recognized the value of this type of service. "Home environment is more conducive to rehabilitation, provided the patient has the proper supporting services," says Dorothy Rusby, director of the Visiting Nurse Association of Cleveland. "Our nurses and therapists have often gotten a patient back on his feet after a doctor had considered the situation almost hopeless."

Success of all three phases of Medicare's program—general hospital, nursing home and home health service—will depend largely on the availability of good nurses. And it isn't easy, I was told, to recruit nurses to work with older people, who are often more demanding and difficult to care for than young patients.

"Nurses find the routine care of older patients depressing," observes Mrs. Betty Gross, nursing supervisor of Provident Hospital, a small Negro institution in Chicago. "One of my nurses resigned after thirty years because she was having to care for so many older terminal patients."

If the full potential of health care is to be realized, whether under Government or private auspices, the physician, as well as the nurse and therapist, must be attuned to the whims, the quirky demands, the slower tempo of the older patients. Says Dr. Martin R. Steinberg, the perceptive director of New York's Mount Sinai Hospital, "There's an art to getting old people to eat, making them comfortable, avoiding bedsores, giving them the kind of things they need simply because they are feeble."

In a recent talk to a group of hospital workers, Dr. Steinberg recalled a situation that epitomizes the problems that face those caring for the aged. He described one hospital where many of the patients were elderly immigrants.

"They felt medicine was a sort of black magic. The greatest compliment they could pay a doctor was, 'He guessed me well.' They knew nothing about this magic and didn't like to disturb it. So getting a history would go something like this:

"'You'd say, 'Mrs. Shapiro, what's the matter with you?' She would look at you with half scorn and half pity and say, 'You're the doctor.' You'd say, 'Yes, but why did you come to the hospital?' She'd think about that a minute and answer, 'Because my doctor sent me.' 'Well, why did he send you?' She'd wrestle with that a minute and say, 'You'll have to ask him.' And finally you'd say to her, 'All right, Mrs. Shapiro, what hurts?' That you knew she couldn't parry. She would think awhile and then it came: 'What doesn't hurt?'

"All of this took time," Dr. Steinberg observed, "and it became a sort of dialogue, which was pleasant and showed our love. That was the important thing. And we were successful with them, which was terribly important. But ours was a one-to-one relationship, and that's difficult to achieve in a big, modern hospital. I'm almost afraid it is gone for good. But if we try hard enough, we may be able to recapture it.

"The most important thing we have learned about the aged is the necessity to give them the shortest possible period 'down,' the longest period 'up.' When a patient is 'up' he is a citizen, an individual. When he is 'down,' he and his doctor are in trouble. This overrides every other consideration. 'Down' is bad; 'up' is life." □

Recovering from surgery, Mrs. Ethel Daniels, 79, feels well enough to sit up—and to put on her earrings.