FARMERS UNION

Testimony of

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on

THE HEALTH CARE CRISIS IN AMERICA

before the

Subcommittee on Health
Senate Committee on Labor and Public Welfare

March 31, 1971

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Mr. Chairman, Members of the Committee:

I am Tony T. Dechant, President of the National Farmers Union. I am gratified at the opportunity to testify before this distinguished Committee in regard to the Health Care Crisis in America.

The National Farmers Union is deeply concerned with the need to replace the existing health care situation in the United States with a more workable system for financing and delivering health services. The Committee of One-Hundred for National Health Insurance, on which I am proud to serve, has worked hard to formulate legislation that is required to do this and to inform the public on the meaning and crucial need for such legislation.

About a month ago, February 24-27, Farmers Union held its 1971 National Convention here in Washington, D. C. We included a plenary session on health as a part of that convention; the health session was designed to explore in a bipartisan manner some of the vital issues involved in the health crisis. Our membership heard alternative approaches to the health problem discussed by Leonard Woodcock, Roger O. Egeberg, and other spokesmen.

As a part of National Farmers Union's "Legislative Target Program" for 1971, the voting delegates at the February 24-27 National Convention called for:

> "Enactment of national health insurance legislation, with provision for expanding manpower and facilities as required for effective delivery of health services to rural areas."

There is no better time than now to superimpose a more systematic and functional national health financing and delivery policy upon the existing patchwork of Federal-state-local-private arrangements that now exist.

Present arrangements in the health field have proven woefully inadequate--especially in controlling escalating costs of health services and in providing effective delivery of care to those who are ill. Furthermore, preventive health care is virtually non-existent for the overwhelming majority of Americans.

What is direly needed today is comprehensive national legislation setting forth a health security policy for the United States--comparable in scope to the Employment Act of 1946. Just as the Employment Act provides the framework within which the Nation strives to help all those seeking work to secure meaningful employment, a national health security policy should spell out the right of all Americans to health care (including preventive, dental and psychiatric care), and authorize the network of policies and programs necessary to achieve the objective of good health care for all Americans.

Mr. Chairman, the Health Security Act of 1971 (S. 3; H. R. 4124), introduced by you and other members of the Senate and House of Representatives, contains essential provisions for a national health policy. Your bill provides comprehensive benefits, virtually universal coverage, and financing under Social Security supplemented by general revenue. Its procedural requirement--through which payments for services by the health security program would be made directly to providers of such services rather than to individual recipients of services--is realistically designed to bring the runaway costs of medical care under control.

Furthermore, in at least two ways S. 3 goes beyond the problem of health care financing and facilitates the delivery of health services to those in relatively greatest need:

1. By placing health purchasing power into the hands of all Americans--thus enabling them to demand health services when in need--S. 3 can serve as a powerful inducement toward the acquisition and proper geographical distribution of manpower and other resources that are necessary for an effective health-delivery system; and

2. By creating a permanent Resources Development Fund to improve and strengthen health facilities, manpower, and planning, S. 3 can directly strengthen and improve the health delivery system.

Mr. Chairman, the National Farmers Union intends strongly to urge favorable action on S. 3 and H. R. 4124 by committees with legislative jurisdiction over these bills, and by the full House and Senate. At the same time, we will probably recommend certain amendments--including an amendment designed to achieve a proper balance between rural and urban areas in the allocation of monies from the Resources Development Fund.

The National Farmers Union feels a special responsibility to speak to the health needs of rural people, although our membership is concerned that no American, whether he or she lives in a remote rural place or a congested urban area, is prevented for any reason from receiving good health care. Consequently, we would urge this distinguished Subcommittee on Health to do the following in order to serve rural health needs.

1. In its field hearings on the Health Care Crisis in America, we urge the Committee to go into the small towns and rural communities and hear extensive testimony by farm and other rural people on their health situation and the unique requirements of getting health care to them when they need it; and

2. We urge the Committee to use its jurisdiction and influence to extend and fund existing Federal programs, and to facilitate enactment of additional programs that can give special aid to rural and other areas that exhibit a relative scarcity of health planning, manpower and facilities.

For the remainder of my statement, Mr. Chairman, I will sketch out the health situation in rural America and then suggest some programs and policies for health delivery that can help rural America to catch up with the rest of the Nation.

The Rural Health Situation

As previous witnesses before this Committee have pointed out, health care in the United States compares unfavorably with many other "advanced" nations of the world. Within the United States, the health condition of rural people and the health services available to them are clearly inferior to urban residents and to U. S. citizens generally.

The President's National Advisory Commission on Rural Poverty highlighted the rural dimension of the U. S. health problem in its 1967 report, "The People Left Behind." The Commission pointed out that, although as of 1962-63 about 30 percent of our population still lived in rural areas, only 12 percent of our physicians, 18 percent of nurses, 14 percent of pharmacists, 8 percent of pediatricians, and less than four percent of psychiatrists are located in rural areas.

In a February 1970 report, "Rurality, Poverty and Health," the Department of Agriculture's Economic Research Service used a five-group classification of U. S. counties to document rural-urban differences in manpower and facilities. The county groups ranged from the most urban and densely populated (group 1) to the most isolated and sparsely populated (group 5):

Medical Personnel and Hospital Facilities Per 100,000 Population, 1966

	GP's	Dentists	Active Nurses	Specialists	Hospitals	Hospital Beds	Specialists Plus Hospital-Based Physicians Per 100 Beds
Metropolitan Counties (1 million or more)	34	70	328	137	1.8	401	34.2
Metropolitan Counties (50,000 to 1 million)	28	52	340	95	1.9	381	25.0
Counties next to Metro areas	35	39	254	38	4.0	323	11.8
Semirural Counties (at least 1 township with 2,500)	36	39	243	45	5.3	412	11.1
Isolated Rural Counties	33	27	126	8	6.3	209	3.8

The ratio of specialist physicians, dentists, and nurses declines sharply as rurality increases. Only for general practioners

is the ratio between medical personnel and population roughly identical in urban and rural areas. Rural counties have more hospitals than urban counties in relation to population but the rural hospitals are usually smaller, more often inadequately staffed, poorly equipped and lacking out-patient and extended care facilities.

Furthermore, even when allowances are made for the greater proportion of older persons living in rural areas, the incidence of activity-limiting chronic health conditions is greater in rural than urban areas. The February 1970 report of the Department of Agriculture reported the following:

Percentage of Persons with Activity-limiting Chronic Health Conditions, 1/ by Place of Residence, 1963-65

Residence	Unadjusted for age	Age adjusted 2/
	Percent	Percent
Large metropolitan areas	9.8	9.8
Other SMSA	11.4	11.9
Outside of SMSA		
Nonfarm	14.6	14.1
Farm	16.5	15.4

1/ Includes heart conditions, arthritis or rheumatism, mental and nervous conditions, high blood pressure, visual impairments, and some orthopedic impairments.

2/ Age adjusted means that the effects of uneven age distribution among residences have been removed.

In addition to the greater incidence of health impairments in rural areas, the danger of these and other health impairments is compounded by the relative paucity in rural areas of transportation facilities by which either the ill can be rapidly taken to a treatment center, or effective treatment can be brought to the residence of those in need.

Rural people, moreover, are less prepared financially to cope with ill health. Only about 40 percent of farm workers are covered by any type of health insurance compared with coverage of 80 percent for the population as a whole. Further, relatively few rural residents have sick pay or other income maintenance benefits.

In sum, rural America, as compared with urban areas and the U. S. generally, is deficient in professional medical personnel, physical health care facilities, and ability to afford the financial costs of illness. Rural areas are "ahead" only in sickness and the ill health of its people. Clearly, catch-up programs of health and services to rural people are required.

Catch-Up Policies and Programs for Scarcity Areas

Mr. Chairman, I know that some of the proposals that I am going to mention are covered in bills now before this Committee, and that you will hold separate hearings on many of them later this year. However, I want to touch upon them briefly at this time, since they can make important contributions to the delivery of health services in rural areas.

Both the Health Manpower Act of 1968 and the Nurse Training Act of 1964 would expire at the end of June of this year. Bills to extend both statutes are pending before your Committee.

The Health Manpower Act and the Nurse Training Act contain provisions for forgiveness of repayment of federal loans made to medical students and students of nursing, provided that after graduation they practice in areas of health manpower shortage. These forgiveness provisions--and especially the one for physicians --have not been very effective as inducements to practice in rural areas. We think that the provisions should be extended and strengthened, by providing a much larger and somewhat faster forgiveness of loans for physicians and nurses. Doctors, for example, must be allowed to cancel several thousand dollars during the first year of practice in a rural area, to make the inducement truly effective.

In addition to physicians and nurses, the forgiveness feature might be extended to para-medics, assistant physicians, and medical technicians.

The Emergency Health Personnel Act, enacted by the Congress last year, provided that the Public Health Service of the Department of Health, Education and Welfare may recruit medical doctors and allied medical professionals for service in rural and other scarcity areas. Personnel for this program could be recruited from among the 30,000 military medical corpsmen, trained as medical sub-professionals, who leave the armed services each year. The Public Health Service is also authorized by the Act to deploy some members of its Commissioned Officers Corps--a force of nearly 6,000 doctors and other professionals--to serve in scarcity areas. The Act authorized the expenditure of $10 million for Fiscal Year 1971, $20 million for FY 1972, and $30 million for FY 1973. Unfortunately, to this date the 1970 Emergency Health Personnel Act has not been funded and gotten underway.

The delay is tragic, for this program offers real promise of expanding health manpower in rural areas. There is reason to believe that indirect financial inducements such as forgiveness of educational loans are insufficient--that we are not going to really get additional health professionals into rural and other scarcity areas unless we have some sort of <u>government</u> corps that can be assigned for a duration of time to these areas. In any event, this approach is one that ought to be included among our programs that are directed to the problem.

Mr. Chairman, we urge you and this Committee to use your influence to work for immediate implementation of the Emergency Health Personnel Act of 1970 at a level of funding approximating the authorized figure. Funds for FY 1971 could be included in the Second Supplemental Appropriations Bill, and further monies should be carried in the regular HEW Appropriations Bill for FY 1972. Clearly, this program could begin to make inroads to solving the health delivery crisis in rural America, and we cannot afford to delay its implementation.

Mr. Chairman, one thing that we have learned from the Peace Corps, VISTA, and other essentially voluntary programs is that <u>humanitarian</u> incentives can be more powerful than financial inducements in motivating people to carry out neglected and badly-needed tasks and programs. This experience should now be applied in the health field. We clearly need a National Health Service Corps of the kind that was proposed in several bills introduced in the 91st Congress, and that have been reintroduced in the 92nd Congress.

A National Health Service Corps would provide a framework within which the idealism and social commitment of our young health professionals and medical school students could be put to work, serving the most disadvantaged people in our Nation. Furthermore, because such a Corps probably would be made up in large part of unmarried young men and women as well as young married couples, the Corps approach would be able to get around one of the real problems of getting and keeping physicians in small towns and rural places: the unwillingness of the wives of physicians to forego certain apparent amenities of living in larger urban communities.

As a means of strengthening the facilities component of rural health deliver, I strongly endorse the proposal for establishment of area health education centers that was made by the Carnegie Commission on Higher Education in its October 1970 Report. The Carnegie Commission called for 126 new area health education centers, which could be geographically distributed so as to bring essential health services within one hour of driving time for over 95 percent of all Americans.

According to the Carnegie Commission's suggestion, one or more health education centers would be located in each of the states. Because of their dispersion throughout rural America, in many cases such a center could go beyond strictly educational functions and serve as the hub around which a network of health delivery services could be developed. The health centers could experiment with helicopters, cooperative ambulance operations, and other means of improving transportation facilities to serve the health care needs of surrounding rural areas. The center could emphasize preventive medicine, and home and outreach services.

The Resources Development Fund, as provided in the Health Security Act of 1971 (S. 3) could serve as a source of funds for these and other activities operated out of area health education centers.

To place rural health delivery and outreach programs into operation, for the most part we need not move into untested activities that may result in inefficient expenditures. For many outreach programs, pilot projects are in operation in various parts of the Nation that afford experience on which we can now draw.

One such project, operated under the auspices of the Arkansas Farmers Union under contract with the Department of Health, Education and Welfare, is the Community Activities for Senior Arkansas (C. A. S. A.) Among other health outreach projects, CASA has operated a mobile medical unit to conduct medical examinations in rural areas in the vicinity of Little Rock, Arkansas. Since its inception two years ago, this mobile unit has completed several thousand examinations, with a referral rate of about 40 percent. Clearly, many of these people who were found direly in need of medical care would not have received this check-up and referral in the absence of the CASA outreach program. The project demonstrates not only that in this way the health of large numbers of medically-deprived people can be measurably improved. It also shows that this can be done <u>inexpensively</u>. The CASA mobile unit was constructed in a school bus and equipped at relatively little expense.

Other rural health delivery programs are being tested by the Appalachian Regional Commission, from which this Committee will hear testimony later today.

Mr. Chairman, many of the recommendations that I have made for the strengthening of rural health delivery are, I will frankly acknowledge, rather ad hoc and stopgap in nature. They do not add up to a coordinated "system" of delivery services--although I think that the Carnegie proposal for area health education centers, if implemented and elaborated to its full potential, could provide a foundation on which a more systematic structure of services could be built.

Indeed, the health problems of migrant farm workers are so massive and unique as to defy any attempt to treat them as part of an integrated rural health care delivery system.

In a real sense, however, a coordinated system of rural health care services will have to await the <u>general</u> redevelopment of rural areas and communities. Only as we revitalize and rebuild our smaller communities and rural areas will we overcome the

cultural, social, technical, and economic factors that impede the natural flow of health services throughout the countryside areas of the Nation.

But we cannot await the "greening" of rural America generally before we supply essential health care to people who happen presently to live in rural regions. We must employ stopgap measures of health delivery today, while we work for more fundamental and long-range adjustments.

Mr. Chairman, we commend you and this Committee for your leadership in combating the crisis in health care financing in America. We look to you also for continued leadership in delivering good health care to the American people, regardless of where they live and reside in the United States.