Mr. President, Alexander Dumas once said, "There are virtues which become crimes by exaggeration." Current political concern for the medical care available to the nation's aged, it seems to me, is now in danger of falling into this category.

An unequivocal recognition of responsibility for the welfare of the incapacitated, whether from causes of age, youth, disease, or misfortune, has long been deemed a distinguishing mark of a truly civilized society. The fulfillment of this responsibility by individuals is a virtue. When exaggerated and distorted by the extreme heat of the political arena, the resultant excesses are not only crimes against society, but barbaric.

The Senate's consideration of proposals for medical benefits for the aged is both ill-timed and premature. It is ill-timed because of the proximity to the presidential election, when the course that best lends itself to a slogan with emotional appeal might well constitute an irresistible temptation to forsake the action dictated by the facts and sound judgment. It is premature because the many facts which will contribute to a knowledgeable decision on this issue will be forthcoming in the White House Conference on the Problems of the Aged to be held next January.

Judging from the discussion of this matter in the press, and debate here on the Senate floor, some obvious misconceptions as to the problems of the aged prevail. The advances in medical science in the past few decades have caused a marked increase in the number of citizens of advanced age in our society. At the same time, the useful and productive portion of life has increased proportionately to the
life span itself. As the average age of the population rises, we must bring ourselves to the realization that the time has come to reappraise upwards our conception of the age at which incapacitation for work and income production becomes prevalent. It would be a serious mistake to assume that the group incapacitated by advanced age has increased disproportionately to the general population.

It would be equally fallacious to assume that all, or even a large proportion, of those who are retired, or within the brackets of what we conceive as the retirement age, are financially unable to provide medical care for themselves. Neither would it be correct to assume that advanced age is accompanied always by an upsurge of illnesses requiring medical care and treatment.

In its proper perspective, the costs of medical care for other than the institutionalized patient are but one element of the cost of living. Undeniably, medical care for the aged, on the average, accounts for a larger percentage of the family or individual budget than it does in the budget of younger persons. This is not due solely to increased illnesses, however, but also to other shifts in need due to changed circumstances. The elderly citizen has usually completed the financial effort that accompanies the raising of a family, and finds interests in activities less expensive than those which appeal to the younger.

The cost of medical care is increasing, as are costs of all services and commodities. Medical costs have risen either more or less than costs of other services and commodities, depending on the base period for which the increase in costs is computed. In the period 1936-1956, the per diem cost of hospital care increased 265 per cent, and from 1956 to September, 1959, another 22 per cent.
Yet there is every indication that the actual service through hospital care has also increased, as is illustrated by the decline in the number of hospital days per patient illness from 12.6 days in the 1928-1943 period to 8.6 days in the 1957-1958 period.

Since medical care is one element of the cost of living, it is prudent to examine, in the initial stages of the approach to this problem, the income of the aged as a group. In doing so, we should be cautious to avoid a common error of accepting statistics for more than they are worth. Repeatedly it has been asserted—and correctly, to the best of my knowledge—that three-fifths of all persons aged 65 and over have money incomes less than $1,000. True as this is, it proves nothing. The wife of an elderly $50,000 per year executive, who has no income of her own, falls into the class of persons over 65 who have income less than $1,000. One would hardly class her, however, as in dire need of funds for medical care or other necessities.

It must also be taken into consideration that a person over 65 has an advantage in disposable income over a younger person with equal income. A young couple with two children and earnings of $4,000 pays approximately $365 in federal income and FICA taxes, while a couple over 65 with $2,000 from Social Security and $2,000 income from other sources would pay no federal taxes on the $4,000 income.

Another factor which bears on any appraisal of income of the aged as a group is their assets. A mortgage-free home releases income for purposes other than housing. Currently, over 70 per cent of Old Age and Survivors Disability Insurance beneficiaries own their own homes, and 87 per cent of these are mortgage-free. In the six years from 1951 to 1957, the median net worth of a retired worker and his wife increased from $5,610 to $9,616 or 71 per cent. In addition, no other/
bracket shows as favorable a liquid asset position as the group aged 65 and over. According to the census figures, the average income for all persons over 65, including those on public assistance, was $2,100 for males and $800 for women.

When considered in the light of a general decrease in several areas of financial responsibility that accompanies retirement, the decreased tax bite of the National Government, and the cushion provided by the increasing existence of substantial assets, these income figures do not justify the picture of gloom and doom that is being pictured to the public, both at home and abroad, on the status of our elder citizens' financial ability to meet their physical needs, including medical care. When considered objectively, the situation is not really so calamitous; and even more encouraging, it is improving.

Today over 19 million workers are covered by private pension plans which have total assets of nearly $40 billion. By 1965, these are expected to have assets of $77 billion. According to Health Insurance Association of America, about 43 per cent of Americans over 65 are now covered by some form of health insurance. Furthermore, it is estimated that the proportion of coverage of those who want and need it will reach 75 per cent by 1965 and 90 per cent by 1970.

This, then, is the other side of the coin picturing the existence of a catastrophic emergency in the form of inability of all persons over 65 to afford medical care. The need for medical care programs at the hand of the government cannot be tied to that non-homogeneous group of persons over 65 referred to as the "aged."

Of the 15.4 million persons in the United States over 65 years of age, about 16 per cent, or 2.5 million, receive some form of public
assistance. Since public assistance programs, in widely varying degrees, are conditioned on need, it is safe to assume that this group of elder citizens is financially incapable of meeting the general cost of living, including costs of medical care, without public assistance. It may also be assumed that there is an additional group with sufficient income to meet normal costs of living, including medical care, that would be financially incapable of meeting a prolonged or catastrophic illness.

Even within the group so defined, the situation is not as desperate as one might be led to believe. Forty States have some form of medical care provisions in their old age assistance plans, and 16 States have direct or money payments for all essential items of medical care. South Carolina's program provides for direct payments for hospital care and nursing home care. These statistics illustrate conclusively that an all-inclusive, compulsory medical care program directed by the government is not needed. They also illustrate that considerable additional information is essential for an objective appraisal of the scope, seriousness, and complexity of the over-all problem. It would be much the better part of wisdom for the Congress to make further determinations of fact before launching from a half-cocked position on a new program.

Although there is too little information available to determine the actual breadth of the problem of lack of means of securing medical care for those within the group aged 65 and over, there is an overabundance of information and facts to illustrate the foolhardiness of any approach to the problem which utilizes the framework of the Old Age and Disability Insurance program.
Mr. President, I cannot escape the conclusion that the overwhelming majority of Americans today suffer from the illusion that the Social Security program is financed along insurance principles. We know, of course, that nothing could be further from the truth. Insurance programs set aside the premiums that are paid by the insured, or at least a substantial portion thereof, in a trust fund or reserve which accumulates interest to provide the funds which will eventually be utilized to pay the benefits guaranteed by the insurance policy. The Old Age and Survivors Disability Insurance program, on the other hand, does not hold intact the contributions of workers and their employers, but on the contrary utilizes these payments in the first priority for payments of benefits of workers already retired in the year in which the contributions are made. In some years, contributions do not even balance benefit payments, much less administrative expenses. For instance, in 1959 total contributions were $8.52 billion, while benefit payments to retirees were $9.84 billion, and administrative expenses were $184 million. Therefore, for the year 1959, there was a deficit of $275 million. Since current contributions are utilized to meet current benefit liabilities, the trust fund remains at a meager level, and the interest on the trust fund is a relatively minor factor in the accrual of financing benefits compared to interest on reserves in a true insurance program.

In 1939, when the OASDI program was inaugurated, the basic concept on which the Congress accepted the program was hinged to the principle that benefits would be payable in fixed dollar amounts. The system was also designed so that it would be workable under conditions of an expanding economy. In other words, the benefits
schedule is so arranged and calculated that there must be an increasing number of salaries on which taxes are levied in order to meet current benefit liabilities. When originally discussed in the Congress, the Social Security program was conceived as one in which the benefits payable through the program would remain constant, as would the rates of contribution as originally established. We are all quite aware that repeatedly Congress has increased the benefits—as was essential if the inflation which we have experienced was to be offset and total impotency of the program to be avoided. These increases in benefits required a compensating increase in contribution rates directly and/or an increase in the salary base on which they were levied.

Contrary to many of the statements made on the 25th Anniversary of the system, the OASDI program has really not yet proved its financial soundness. We know very well that both political and inflationary forces will repeatedly demand further increased benefits. In the absence of complete irresponsibility, additional contributions must be required to meet the increases. At some point, however, we will reach the breaking point, for total contributions are already scheduled to reach 9 per cent of the first $4,800 of wages. Although it is impossible to foretell at just what point the break will come, it is obvious that the cycle of increased benefits and increased contributions must come to a halt, for at some point the wage earners, even if not the politicians, will rebel at further tax levies on wages. This situation could easily become even more crucial should our economy suffer a serious recession or depression for the system is designed to operate successfully only in an expanding economy.

Even so, under a high cost estimate, the Old Age and Survivors/insurance
trust fund will decrease from a maximum of about $55 billion in 20 to 25 years from now until it is exhausted in 1997.

Mr. President, millions of Americans have placed their complete confidence in the Old Age and Survivors Insurance system to provide them with funds for retirement in their latter years. In reliance on this system, not only have they neglected to establish retirement plans in private sources, but, indeed, they have had no choice but to place such funds as they earn for this purpose in the Old Age and Survivors Insurance program. A failure in the program would literally mean the economic destruction of millions of Americans. Although the soundness of the program, in my opinion, yet remains to be proved, we should at the very least treat the program in the manner best calculated to insure its continued solvency.

The medical care proposals which would utilize the framework of Social Security are not only unneeded, but, if enacted, would materially decrease the probability of continued solvency of the system. The proposal for medical care benefits within the OASDI program to which, for lack of a better name, I shall refer to as the Forand proposal since apparently it was first introduced by Congressman Forand, would completely change the original concept of the OASDI program from one guaranteeing fixed dollar benefits to one which guarantees specified services. The fixed dollar benefit concept has the advantage of being resistant to inflation, although we must admit that in times of inflation there is a likelihood that it will not provide the resources in purchasing power for which it was originally intended. The guaranteeing of services, as contrasted to fixed dollar benefits, will not withstand the ravages of inflation, but would be marked by increasing costs of benefits as the cost of services themselves increase, and would tremendously increase the
pressures for additional contributions to keep the fund solvent. Such a change in concept would materially hasten the day when the point of rebellion at further increased contributions is reached. Whereas the present system, based on fixed dollar benefits, might be impaired by a relatively serious depression in the economy, the Forand-type concept would subject the fund to bankruptcy from possibly even a mild, extended recession of the economy.

Mr. President, we have no right to jeopardize the OASDI program by grafting on this new concept of guaranteeing services in addition to dollar benefits. Rather than weakening this program, we should concentrate on checking the inflation which nullifies the purchasing power of fixed dollar benefits, in order that the confidence of the millions of contributors to the system might not be betrayed.

I cannot comment on this Forand proposal, Mr. President, without restating that it is socialized medicine, for it seeks to provide, not the funds with which to obtain medical care, but, on the contrary, it seeks to provide medical service itself. In any approach of this sort, the federal government must control the disbursement of funds. It must decide the benefits to be provided. It must set the rates of compensation for hospitals, nursing homes, dentists and doctors. It must audit and control government expenditures to hospitals, nursing homes and patients. It must establish and enforce standards of hospital care and medical care. These are but the basic and usual safeguards that accompany the spending of tax funds. Is anyone so naive as to believe that the national government could exercise these responsibilities without affecting the quality of medical care received? The government and not the patient and physician will determine the quality and extent of medical care under the Forand
proposal, and this is socialized medicine.

The disadvantages of socialized medicine are not merely reprehensible because there is a bad connotation placed on the word "socialized". The evil lies in the deterioration of the quality of service which inevitably results, to the detriment of the patient, from the government's efforts to standardize a service which is by its very nature a personal service, and must so remain if it is to be of a high quality.

Mr. President, in this discussion of the proposals before us, I have refrained from utilizing either the Constitutional or philosophical approach, and have attempted to discuss the various plans from the standpoint of sound judgment, need and practicality. I realize, of course, that my approach to the problem is conservative—as is my philosophy—and consequently, I have sought to examine the problem in the light of the facts, removed from the Utopian dreamworld of radical thought that appears to be prevalent in our political society. I could also just as well have adopted a Constitutional approach, for I am convinced that the Forand proposal is repugnant to the intent and spirit of the Constitution.

In speaking at all, I am fully aware that I am joining in what we all know is an exercise in futility, for regardless of the outcome of the Senate's votes on the various proposals, there is very little likelihood that we will create more than a political issue, if that. Perhaps it is optimism on my part to harbor a sincere hope that the Senate of the United States will at least reject the Forand proposal, if it will not take the even wiser course of postponing any action on this subject until a more objective and better informed consideration can be obtained. Our actions and discussions in this fish bowl
arena are more than ever in the eyes of the entire public, both American and foreign, and I cannot conceive that our actions and debate on this political, as contrasted to legislative, issue are well designed to promote respect and high regard for this parliamentary body.

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