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Living Care

SPEECH

OF

HON. JOHN E. FOGARTY

OF RHODE ISLAND

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 23, 1966

Mr. FOGARTY. Mr. Speaker, I rise to introduce H.R. 12976 the Adult Health Protection Act of 1966.

This bill would authorize the Surgeon General of the Public Health Service to make grants to medical schools, community hospitals, health departments, and other public nonprofit agencies to establish and operate adult health protection centers. It would authorize grants for the establishment and operation of these centers for a period of 5 years.

Mr. Speaker, the system envisioned here will do more for preventive medicine and health protection than anything yet proposed. In addition to many other features, it will bring modern instrumentation and computer use to bear on a recognized, growing health problem represented by chronic illness and the increasing scarcity of professional health personnel.

What this act does is to make way for a healthy mutation in our preventive health care practices in this country.

Mr. Speaker, I have often been impressed by the fact that—when the time is ripe—innovations occur independently to a number of people. It is rather noteworthy that last fall, after the passage of the Medicare Act, both Senator WILLIAMS and I were concerned about the aged who were not going to be helped by the medicare system. And, independently, we addressed ourselves to the solution—or solutions—of the problem.

In September 1965 Mr. WILLIAMS reminded the Senate that the increasing numbers of our aged and aging population present a growing problem with special significance for chronic diseases. He pointed out that an estimated 74 million Americans are afflicted by one or more chronic disorders. He went on to cite pertinent statistics on the high incidence among the elderly of a host of cripplers—blindness, deafness, epilepsy, arthritis, rheumatism, glaucoma, and others.

At about the same time last fall I had an opportunity to speak at the dedication of Hall Manor, Cranston's first low-rent housing development for the elderly, in my home State of Rhode Island.

I took the opportunity to remark before that audience:

> I wonder, for instance, how many Americans realize that there now exist more than 2,500,000 elderly people who will actually not benefit from most of our national programs for the aged.
>
> These elderly cannot secure low-rent housing, cannot participate in recreational programs or in vocational rehabilitation projects, will hardly, in fact, benefit at all from the new medicare provisions.

I said that there is, therefore, an urgent need for long-term comprehensive care for the elderly who cannot take care of themselves. I called then for an entire program of services to provide for all the needs of life—in short, for what I called living care.

Finally, I concluded that we need nothing less than full Federal responsibility for maintaining the neglected lives of our 18 million elderly population.

In the measure that Senator WILLIAMS and I are proposing today, this conviction is spelled out in unmistakable terms. We state that "the Congress hereby finds and declares that the Federal Government has a duty to assist the adult population of the United States, particularly the aged and the aging, in protecting, maintaining, and improving their health."

Mr. Speaker, from this premise we propose for the first time to provide Federal assistance in the establishment and operation of regional and community health protection centers for the detection of disease; to provide assistance for the training of personnel to operate such centers; and to provide assistance in the conduct of certain research related to such centers and their operation.

I do not propose to read this bill aloud to you here, but its purpose is to encourage and assist, through grants, in the planning, establishment, and operation of regional health and community protection centers, each of which will provide health appraisal and disease detection services, on a periodic basis, to any adult who requests such services, if he has attained age 50 and resides within the geographic area served by the centers.

These health protection centers would provide a series of basic tests for the detection of abnormalities in the cardiovascular, respiratory, gastrointestinal, genitourinary, and musculoskeletal systems as well as defects in metabolism and organs of special sense.

Specific diseases or conditions to be tested might include hypertension, various forms of cancer, rheumatoid arthritis, respiratory insufficiency, diabetes, kidney disease, obesity, and hearing and vision impairment.

The tests would be administered by technicians, nurses, and medical specialists using automated or semiautomated equipment which has already been proven to give swift, accurate, and reliable results. The results of these tests, along with data provided by the person undergoing the health appraisal, would be fed into a computer. It is estimated that the battery of tests could be administered within 2½ hours.

The results of the tests, summarized by the computer, would be referred to the private physician of the person taking them. In cases where the persons either

did not have a private physician or was medically indigent, the tests would be referred to a physician in accordance with local practice.

The adult health protection centers are intended to provide an efficient means for the detection of abnormalities or indications of disease—but not to replace full examinations. Their purpose is to place in the hands of the examining physician a summary of basic data and to place promptly under a physician's care a person with indications of disease conditions.

The health protection centers would conduct training programs in the operation of technical disease detection procedures and would research and develop new disease detection tests and equipment. Additional grants to the centers would be authorized for operational research and for the establishment of internships to give on-the-job training to physicians, nurses, and technical personnel. The centers would also conduct community education programs on preventive health care.

Finally, a 12-man Advisory Council on Adult Health Protection would be established to advise the Surgeon General of the Public Health Service in the administration of this program. This Council will include men who are leaders in the fields of medicine, public health, public welfare, or representatives of national organizations concerned with the interests of the aging. And it shall include one or more national leaders known for their dedication to the national interest and the welfare of the Nation's citizens.

The basic idea behind the act, put simply, is this: to launch a genuine, nationwide preventive medicine campaign. By making these testing services available to any person age 50 or above, on a voluntary basis, we will encourage men and women approaching retirement to take regular health examinations and we will facilitate the giving of full examinations by practicing physicians.

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Mr. Speaker, the long-range answer to the health problems of the aging is in early identification and control of disease and prevention of illness and disability.

Now, ideally, we would achieve this goal by having periodic health examinations for everyone. Realistically, of course, we know that there are not enough physicians to accomplish a program of this scale.

Fortunately, a way has been found out of this dilemma.

What we are proposing in this act is to take the proven automated testing techniques from an unusual project in California—called Kaiser Permanente—and adapt them for demonstration on a communitywide basis in other areas of the country.

Assisted by a grant from the Division of Chronic Diseases, Public Health Service, the Kaiser Foundation health plan in Oakland has developed a multitest laboratory that is immensely accurate and remarkably economical.

Some 40,000 Kaiser-Permanente health plan beneficiaries are participating in this pilot health program. Their experience will now become the basis for this first nationwide preventive medicine effort, so far as the chronic diseases are concerned—just as, once upon a time, a preventive medicine effort had to be launched against the infectious diseases.

May this new effort be as successful as that campaign proved to be.

Once again I want to repeat what I said at Cranston last fall.

I know well that, hearing this proposal, many voices will cry out—cry out as they did against medicare, and as they did against the heart disease, cancer, and stroke program, and as they cried out against most of the other farsighted public health bills passed by the 89th Congress.

But I say to them, as I said in this House last year, when asked where "this kind of business" will end: that I, for one, intend to keep going and going until we take adequate care of as many people as we possibly can who so badly need better health services, no matter how long it takes.

I promised, in my "Living Care" speech, to introduce legislation to help the elderly. This bill I introduce today is the first piece of such legislation I intend to introduce in this 2d session of the 89th Congress. It is a vital piece of legislation, for only by preventive care can we hope to reduce the staggering load of suffering borne by the elderly in our midst.

As most of you know, I have concerned myself with the problems of the aged for the past decade. In 1956 I supported the President in establishing a Federal Council on Aging, and in 1959 I introduced legislation calling for the White House Conference on Aging that was held in 1961.

In 1963 I introduced the Older Americans Act which finally passed in 1965. I am happy to say that the Aging Administration that it created within the Department of Health, Education, and Welfare is now a going concern.

I am proud of this record and of these successes. Yet it is no exaggeration to say that I believe that the Adult Health Protection Act of 1966 will be the most important single piece of legislation concerning the aging and the aged that I have ever introduced into this House.

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