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90TH CONGRESS
2d Session

SENATE

REPORT
No. 1098

DEVELOPMENTS IN AGING
1967

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

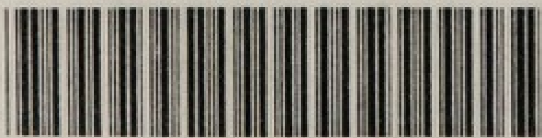
S. RES. 20, FEBRUARY 17, 1967

Resolution Authorizing A Study of the Problems of the Aged and Aging

TOGETHER WITH

MINORITY VIEWS

APRIL 29, 1968.—Ordered to be printed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90TH CONGRESS 2d Session } SENATE { REPORT No. 1098

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LETTER OF TRANSMITTAL

Hon. Hubert Humphrey,
President of the Senate,
Washington, D.C.

Dear Mr. President: I have the honor of submitting to you the report of the Special Committee on Aging in compliance with the requirements of Senate Resolution 20, adopted February 17, 1967.

The committee, charged by that resolution "to make a full and complete study and investigations of any and all matters pertinent to problems and opportunities of older people" initiated several new studies and continued several longstanding inquiries during 1967.

This report reviews the work of the committee and its subcommittees; and it reports on other developments in aging which have occurred since the last committee report, "Developments in Aging," was filed on April 12, 1967.

Senate Resolution 223, which was passed unanimously by the Senate on March 15, 1968, gives the committee new authority to continue its work on matters of direct importance to 19 million Americans now past 65 and the many millions who are nearing that age. Much of that work, as clearly indicated in the following report, is of considerable urgency. The committee will do all in its power to direct public attention to important areas of concern and to make recommendations for action by appropriate congressional units.

Once again, on behalf of the members of the committee and its staff, I should like to extend my thanks to you and the other officers of the Senate for the cooperation and courtesies extended to us.

Sincerely,

Harrison A. Williams, Jr.,
Chairman.

SENATE RESOLUTION 20, 90TH CONGRESS, 1ST SESSION

Resolved, That the Special Committee on Aging, established by Senate Resolution 33, Eighty-seventh Congress, agreed to on February 13, 1961, as amended and supplemented, is hereby extended through January 31, 1968, except that thirteen members of such Committee shall be appointed from the majority party and seven members from the minority party.

SEC. 2. It shall be the duty of such committee to make a full and complete study and investigation of any and all matters pertaining to problems and opportunities of older people, including but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing, and, when necessary, of obtaining care or assistance. No proposed legislation shall be referred to such committee, and such committee shall not have power to report by bill or otherwise have legislative jurisdiction.

SEC. 3. The said committee, or any duly authorized subcommittee thereof, is authorized to sit and act at such places and times during the sessions, recesses, and adjourned periods of the Senate, to require by subpena or otherwise the attendance of such witnesses and the production of such books, papers, and documents, to administer such oaths, to take such testimony, to procure such printing and binding, and to make such expenditures as it deems advisable.

SEC. 4. A majority of the members of the committee or any subcommittee thereof shall constitute a quorum for the transaction of business, except that a lesser number, to be fixed by the committee, shall constitute a quorum for the purpose of taking sworn testimony.

SEC. 5. For purposes of this resolution, the committee is authorized (1) to employ on a temporary basis from February 1, 1967, through January 31, 1968, such technical, clerical, or other assistants, experts, and consultants as it deems advisable: *Provided*, That the minority is authorized to select one person for appointment, and the person so selected shall be appointed and his compensation shall be so fixed that his gross rate shall not be less by more than $2,300 than the highest gross rate paid to any other employee; and (2) with the prior consent of the executive department or agency concerned and the Committee on Rules and Administration, to employ on a reimbursable basis such executive branch personnel as it deems advisable.

SEC. 6. The expenses of the committee, which shall not exceed $200,000 from February 1, 1967, through January 31, 1968, shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee.

SEC. 7. The committee shall report the results of its study and investigation, together with such recommendations as it may deem advisable, to the Senate at the earliest practicable date, but not later than January 31, 1968.[1] The committee shall cease to exist at the close of business on January 31, 1968.

[1] By unanimous consent, the Committee was given additional time in which to file its report.

FOREWORD

One-fifth of the population of the United States is nearing or has passed the traditional retirement age, 65.

To many Americans, advancing years have brought—with release from full-time work—new enjoyment of life.

For many others, however, the aging process has triggered problems that arise even before retirement begins, and intensify soon after.

Those problems, and Federal response to them, are appraised in this annual report by the U.S. Senate Special Committee on Aging. In addition, this document makes suggestions for additional action in areas of emerging or chronic concern.

The following pages tell a story of great progress in 1967, and they provide some measure of work yet needed. A close reading of the report, in fact, leads to an inescapable conclusion: the time has come for a systematic reexamination of many of the public policies and programs that relate in one way or another to the well-being of older Americans, present and future. That reexamination is necessary because:

1. The great breakthroughs of the sixties—medicare, the Older Americans Act of 1965, new advances in housing—necessarily channeled much time and attention away from other issues that now should receive sustained inspection.

   Inadequate retirement income, for example, is by far and away the major problem facing most elderly individuals, but the Congress thus far has considered only parts of the overall problem. A comprehensive view of present and long-range needs is vitally needed. We don't yet have it.

2. New programs should in themselves be evaluated while they are still in their formative years. The Older Americans Act, for one, listed 10 far-reaching objectives. We ought to ask ourselves now, in the early years of that program, how far along we are toward those goals, and whether we are directly on course. The same is true of medicare and other programs now serving our people so well. They are doing much good. But they can probably be made to do more, and this report has suggestions toward that end.

3. Elderly Americans must not be thought of solely as a "problem group," even though for many of them problems are persistent and, too often, overwhelming. The older citizens of this Nation are rich in talent and energies and wisdom. Many ways must be found to free such resources for public good or for private satisfaction. It is wrong to force all Federal efforts on behalf of the elderly into a welfare context. Just as we now regard graduation from high school or

> college as the beginning of a career, so should we recognize that retirement can become the beginning of a rich and rewarding stage in life's development. Many misconceptions must be challenged before that happy state of affairs comes into being, and many critical problems must be solved. But at least we should have a clearer goal in mind when we speak of the elderly and act in their name.

There are many other compelling reasons for a reexamination, and they are discussed further in this document.

A potential mechanism for a thorough reexamination is suggested in a recent proposal for a White House Conference on Aging in 1970. Such a conference, as advocated elsewhere in this report, would assure us of a searching reappraisal not only at the conference itself, but also in the preparatory discussion and meetings in each participating State. The conference could eventually become a symbol, too, of a new determination within this Nation to deal forcefully with the compelling problems that still remain though so much has already been done. Just as the 1961 White House Conference led to major gains during this decade, so could a new conference help this Nation to see more clearly that vital, additional gains are needed.

To help assure that the proposed conference would grapple with issues worthy of national concern this committee will point out, in this report and others to follow, matters that should receive early, widespread consideration. At the end of my first year as chairman of the Senate Committee on Aging, I am pleased to offer this foreword to that report.

HARRISON A. WILLIAMS, Jr.,
Chairman, U.S. Senate Special Committee on Aging.

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A PROFILE OF THE OLDER AMERICAN*

ON NUMBERS. The older population is comprised of 19 million separate individuals whose most commonly shared characteristic is that they have passed their 65th birthday. Its a changing group; in the course of a year, there is a net increase of 300,000 but 1.4 million or 7 percent are newcomers to the age group.

ON AGE. Most older people are under 75, half are under 73, a third are under 70. More than a million are 85 and over.

ON LIFE EXPECTANCY. At birth—70 years, 67 for men but 7 years longer or 74 for women. At age 65—15 years. Men can expect another 13 years but women can expect another 16 years.

ON SEX. Most older people are women, 11 million; men are 8 million. For all those 65+, there are 130 women per 100 men; for 85+, more than 160 women per 100 men.

ON MARITAL STATUS. Most men are husbands; most women are widows. Of married men, more than 40 percent have under-65 wives.

ON EDUCATION. Half never got to high school. Some 3 million or 17 percent are illiterate or functionally illiterate.

ON LIVING ARRANGEMENTS. Ninety percent of the men and 80 percent of the women head up their own households, including some who live alone or have taken nonrelatives into their homes.

ON AGGREGATE INCOME. Forty to forty-five billion dollars a year. Almost half from retirement and welfare programs, almost a third from employment, and about a fifth from investments and contributions.

ON PERSONAL INCOME. Older people have less than half the income of the younger. In 1966 median income of older families was $3,645; median income of older persons living alone or with nonrelatives was $1,443. About 30 percent of older people live below the poverty line; another 10 percent are on the border. Many aged poor are poor primarily because of age.

ON EXPENDITURES. Like most low-income groups, the aged spend proportionately more of their incomes on food, shelter, fuel, and medical care. Aged do not necessarily need so much less, they just can't afford it.

---

*Summarized from a report by Mr. Herman B. Brotman, Chief, Reports and Analysis, Administration on Aging, U.S. Department of Health, Education, and Welfare.

INTRODUCTION AND SUMMARY OF REPORT

Challenges related to aging in our Nation were expressed in 1967 both in declarations of intent and by concrete actions. A year which began with President Johnson's message[1] on older Americans—the second such message issued by a President of the United States—ended with the passage of the social security amendments that provided the largest cash benefit increases ever granted at one time. Federal agencies also demonstrated ingenuity and determination in administering old and new programs. Finally, the Senate Special Committee on Aging and its subcommittees began or continued studies clearly indicating that new problems and new opportunities arise as the population of aging and aged Americans increases every year.

I. THE PRESIDENT'S OBJECTIVES AND THE RESPONSE

President Johnson's message called for:

- A substantial across-the-board increase in social security cash benefits and broadening of other social security and medicare benefits;
- A prohibition against age discrimination in employment;
- Extension of the Older Americans Act of 1965 and an increase in its funding levels;
- Extension of the "Partnership for health" authorization, to improve State and local health planning for the elderly;
- Special attention in the model cities program to the needs of older people in poor housing and decaying neighborhoods.

Congressional Response

By the end of 1967, the President's recommendations had been substantially implemented, by enactment of the following legislation:[2]

1. Public Law 90–248, the "Social Security Amendments of 1967," which provided an increase of at least 13 percent in social security cash benefits, with an increase in minimum benefits from $44 per month to $55, increased the amount of earnings a beneficiary under 72 can have without loss of social security benefits, and provides a number of other liberalizations in social security cash and health benefits;
2. Public Law 90–202, the "Age Discrimination in Employment Act of 1967," which protects individuals 40 to 65 years old from age discrimination by employers, employment agencies, and labor organizations and directs the Secretary of Labor to undertake education and research programs to inform the public concerning the needs and abilities of older workers and their potential for continued employment and contribution to the economy;

[1] Full text of the President's message on p. 165.
[2] Detailed explanations of these new public laws begin on pp. 181, 194, 172, and 221, respectively.

3. Public Law 90–42, the "Older Americans Act Amendments of 1967," which extends the grant programs authorized under the Older Americans Act of 1965 through fiscal year 1972, authorized specific amounts to be appropriated for these programs for the fiscal years 1968 and 1969, and made numerous other substanitve and technical changes in the Older Americans Act of 1965;
4. Public Law 90–174, the "Partnership for Health Amendments of 1967," which extended and expanded the authorizations for grants for comprehensive health planning and services, broadened and improved the authorization for research and demonstrations relating to the delivery of health services, improved the performance of clinical laboratories, and authorized cooperative activities between the Public Health Service hospitals and community facilities.

II. ACTIONS BY FEDERAL AGENCIES

Examples of Federal action to widen or begin programs on behalf of elderly Americans may be found in some abundance in the following pages. Among those worthy of special note are: [3]

1. Voted additional funds by the Congress, the Administration on Aging has begun several new projects, including a research and demonstration program on nutritional needs of the elderly.
2. The Department of Labor has established a pilot older Americans community service program, and is making intensive preparation for implementation of the antidiscrimination law.
3. Rent supplement programs have been proven especially helpful to the elderly, and administrators of the model cities program are receiving suggestions for making that program similarly responsive.
4. The Department of Health, Education, and Welfare is undertaking several studies of proposals intended to make medicare more responsive to actual need.
5. Special projects funded by the Office of Economic Opportunity are continuing to demonstrate the usefulness of the elderly in service programs. The first report on Project FIND shows a clear need for increased "outreach" activity.

III. COMMITTEE AND SUBCOMMITTEE ACTIVITIES

Much of the discussion on the following pages is based on the following hearings conducted in 1967:

Hearings held by—	
Subcommittee on Consumer Interests of the Elderly.	Consumer Interests of the Elderly; Jan. 17, 18; Washington, D.C.
	Consumer Interests of the Elderly; Feb. 3; Tampa, Fla.
Subcommittee on Employment and Retirement Incomes.	Reduction of Retirement Benefits Due to Social Security Increases; Apr. 24, 25; Washington, D.C.
Subcommittee on Retirement and the Individual.	Retirement and the Individual—Survey Hearing; June 7, 8; Washington, D.C.
	Retirement and the Individual—Early Retirement and Related Subjects; July 26; Ann Arbor, Mich.
Subcommittee on Housing for the Elderly.	Rent Supplement Assistance to the Elderly; July 11; Washington, D.C.

[3] Reports by Federal agencies appear on pp. 173–180, 187–188, 196–206, 213–221, 224–244, 252–260, 264–267, and 271–287.

Hearings held by—Continued

Subcommittee on Health of the Elderly.	Costs and Delivery of Health Services to Older Americans; June 22, 23; Washington, D.C.
	Cost and Delivery of Health Services to Older Americans; Oct. 19; New York, N.Y.
Special Committee on Aging (full committee).	Long-Range Program and Research Needs in Aging and Related Fields; Dec. 5, 6; Washington, D.C.

Summary of Conclusions

The following conclusions are offered by the committee on the basis of the hearings and additional studies:

Chapter I—Income

Despite the increasing complexity and magnitude of the forces that affect retirement income, and despite increasing dependence upon public and private pension systems, and even with introduction of new concepts for a guaranteed minimum income, the Federal Government has as yet no mechanism for sustained, comprehensive attention to the issues and problems involved________________(See p. 13.)

The executive branch should consider the ultimate establishment of an Institute on Retirement Income closely patterned after an institute announced by President Johnson in 1967 to deal with urban problems. Such an institute would be geared for problem solving as well as sustained study_______________________________(See p. 14.)

Legislation providing future social security increases should contain a provision prohibiting reduction of old-age assistance grants due to a social security increase, with exceptions where appropriate. (Additional findings and recommendations on related problems appear on pp. 16 and 17)_____________________________(See p. 16.)

Homeownership gives many older Americans their biggest single, and most important, tangible asset. Attention should be given on a national scale to problems related to homeownership in order to give States and municipalities data helpful to them in formulation of tax policy____(See p. 23.)

Chapter II—Employment and Service

Public Law 90–202 (Age Discrimination in Employment Act) is rich in potential usefulness and it will speed the other changes necessary for full and effective use of older workers in ways that will strengthen the economy and will also reduce the serious loss in happiness and well-being of those now unemployed or underemployed solely because of age__________________________________(See p. 28.)

The committee recommends the broadest possible discussion and exchange of ideas on implementation of the law, and the committee invites suggestions for assuring that the legislation will be far reaching in its effectiveness_______________________________(See p. 28.)

Establishment of two major pilot programs (by the Department of Labor) intended to fulfill several objectives of the proposed older American community service program is a welcome and timely step that can provide great impetus to the next appropriate goal—development of a comprehensive national program using all available resources at the Federal, State, and local levels___________(See p. 37.)

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The committee recommends that appropriate congressional units and Federal agencies keep close watch on the two new demonstration programs, with special attention to such questions as (1) establishment of work relationships with State agencies on aging; (2) effect on existing programs in which unpaid volunteers participate; (3) the role of the Administration on Aging in future development of additional programs; and (4) further refinements of training techniques suitable for older persons preparing for part-time work (similar to techniques already employed in such projects as Operation Medicare Alert and Operation Green Thumb) (See p. 37.)

Chapter III—Health

Medicare and medicaid have already raised some levels of health care and helped dissipate the fear of financial disaster in the case of catastrophic or sustained illness in later years. Nevertheless, the two programs have also had adverse effects that should be eliminated or alleviated; and there is some evidence that some low-income elderly under part B of the medicare program may be paying more now for care than they did in the past (See p. 40.)

The medicare requirement of 3 days of hospitalization as a condition to extended care and home health service benefits under medicare should be eliminated where it is possible to make an objective determination concerning medical justification for assigning a beneficiary to an extended care facility or authorizing home health care services for him, and where such determination has been made (See p. 48.)

Additional educational programs are needed to apprise the elderly of their rights, privileges, and opportunities under medicaid and other health programs for the elderly, of the procedures which must be followed to take advantage of these programs, and of their opportunities for prevention and early detection of illness and ill health in old age (See p. 53.)

In every way possible, the medicare programs should foster greater understanding of the need for health maintenance, concentrating on the prevention of illness, rather than almost solely upon treatment of it (See p. 54.)

Medicare has made hospitalization more accessible for many elderly Americans, but the delivery of other kinds of health services—even through medicaid—is often hindered or made impossible by faulty organization of those services. Low-income elderly are major victims of fragmentation, inaccessibility, or nonexistence of services. Problems in central urban areas, where many elderly reside, seem to be on the increase and have caused a need for new modes of delivery for essential services (See p. 55.)

Neighborhood health centers similar to those now provided through an Office of Economic Opportunity program should be provided on a broader basis, drawing upon other Federal agencies in order to yield widest possible service where most needed (See p. 62.)

Group practice of medicine should be encouraged where needed in every way possible in order to make health services more generally available to the elderly, as well as other age groups (See p. 64.)

Home health services are vitally needed to prevent hospitalization or to provide help upon discharge from hospitals. Present efforts to provide such service are inadequate, and a higher priority should be put on meeting this need (See p. 65.)

Medical manpower shortages are intensifying problems of delivering health services to the elderly, particularly in urban areas. Innovations in training of personnel, including new categories of "paramedical" skills, should be encouraged __________________________ (See p. 65.)

This committee, with the cooperation of the Administration on Aging and other Federal agencies, should prepare several models demonstrating effective programs intended to help institutionalized "geriatric patients" be discharged, as well as those who might be institutionalized in the absence of other forms of help ____ (See p. 66.)

There is a great need for additional efforts to prevent chronic disease on a national scale. Federal legislation should be enacted to establish a multiphasic health screening program on a large scale with eventual expansion nationwide __________________ (See p. 67.)

Chapter IV—Housing and Environment

Now in its second year of operation, the recent supplement program has proven to be a versatile and helpful instrument for providing housing for the elderly and others in a manner that preserves dignity and independence of the renter _______________________ (See p. 72.)

In every way possible, the rent supplement program should be extended to serve additional numbers of Americans who, in any of several ways, stand in special need of its assistance ______ (See p. 72.)

Technical assistance should be provided to help sponsors of projects involving rent supplements ___________________________ (See p. 72.)

Older Americans are among the many individuals who will benefit from the transformation of old, decaying slums into "model neighborhoods" under the recently funded model city program. Their unique problems and special needs—as well as the contributions they can make to the citizen participation aspects of individual projects, should not be overlooked. In this period of intensive preparation, before actual implementation of plans, careful attention should be given to the elderly _____________________________________ (See p. 74.)

Chapter V—Nursing Homes and Other Long-Term Care

Nursing home legislation enacted in 1967 was necessary for correction of the problems and abuses associated with some segments of that industry. However, meaningful and comprehensive progress will not be achieved until the resources of the total health community are utilized to provide the quality and degree of care desired for the elderly in a truly comprehensive "spectrum of facilities." __ (See p. 88.)

Chapter VI—Consumer Interests

(This chapter is primarily a report on major consumer problems of the elderly and activities by Federal agencies to reduce such problems.) (See p. 90.)

Chapter VII—Social Services

The 1967 reorganization plan (by the Department of Health, Education, and Welfare) that resulted in the establishment of the Social and Rehabilitation Service will undoubtedly have far-reaching effects upon the provision of social services for older Americans of

all income groups. Objectives of the reorganization, as expressed when the plans were announced, are laudable. Close attention, however, must be paid to the implementation of the program with special emphasis upon its role in the development of future social services for the elderly ________________________________ (See p. 104.)

There is an obvious, pressing need for organized, comprehensive discussion of the goals and methods of delivering services to older Americans. A White House Conference on Aging—and the State conferences that would be held in preparation—offer ideal opportunities for such discussion ________________________ (See p. 110.)

Chapter VIII—Retirement and the Individual

Agencies of the Federal Government can perform a valuable service by assuming leadership in the development of innovative and varied preretirement training programs that can serve as models for action by other levels of government and by private industry_(See p. 118.)

Legislation should be enacted to provide specific authority and encouragement to establish preretirement programs within Federal agencies ________________________________ (See p. 119.)

The Administration on Aging, in cooperation with Federal agencies and educational institutions, should encourage widespread discussion and the eventual development by Federal agencies of new work-life and study patterns, including phased retirement plans, new kinds of part-time work, and more widespread use of "sabbaticals"_(See p. 119.)

Widespread experimentation in developing new roles for retired Americans while meeting their nonmaterial needs is already underway in programs supported and encouraged by the Administration on Aging, often working in conjunction with the Office of Education and other agencies. Lessons learned from such projects should receive widespread attention and—in the case of educational television, in particular—encouragement from all Federal agencies with a related interest ________________________________ (See p. 126.)

Chapter IX—Other Areas of Concern

A reorganization within the Department of Health, Education, and Welfare in 1967—and its effect upon the role of the Administration on Aging—raises serious questions that should be explored by HEW in extensive consultation with national organizations and knowledgeable individuals at the earliest possible date. In addition, a proposed White House Conference on Aging could serve as a forum for discussion of more fundamental issues related to the coordination of policies and programs within other departments that, in varying degrees, deal with matters related to the elderly __________________ (See p. 133.)

The intent of Congress, as clearly expressed in the 1967 Amendments to the Economic Opportunity Act, is that attention should be paid to the needs of the elderly poor, on a scale large enough to accelerate the noteworthy, but limited, progress already achieved in this area by the Office of Economic Opportunity_____(See p. 136.)

Congressional units and the OEO should remain in close communication on steps needed for full implementation of the amendments. (See p. 136.)

(The chapter also discusses the early phases of committee studies of "Usefulness of Federal Programs to Minority Groups," "Training and Personnel Needs in Aging and Related Fields," and "Federal Support for Research Related to Aging.") ________(See pp. 136-148.)

Chapter X—Long-Range Requirements

The committee supports the proposal calling for a White House Conference on Aging some time in 1970, and it suggests that the Conference, together with all preparations for it, serve as the means of developing comprehensive projections of long-range needs that may be expected as the population of older Americans continues to increase. (See p. 154.)

CHAPTER I

INADEQUATE INCOME—THE MAJOR PROBLEM

Often during the long debate about the 1967 social security amendments, searching questions were raised about fundamental public policies related to all forms of retirement income.

Eventual enactment of a minimum increase of 13 percent in social security benefits [1] late in the year did not end the discussion. If anything, the final congressional action—which scaled down amounts originally sought by President Johnson—seemed to intensify attention to such questions as—

- Shall general revenues be used for partial financing of future social security increases?
- How can automatic cost-of-living increases and rising productivity benefits be built into a public pension system?
- Should a guaranteed annual income be used to supplement social security payments and possibly to supplant inadequate and widely varying State payments to old-age assistance recipients?
- Should retirement income maintenance be tied to a more general plan that would establish minimum incomes throughout the lifetime of all citizens?
- What can be done to provide more adequate private pension coverage to more people?

The year ended with no crystallization of opinion on directions for future action, but the events and debate during 1967 made it clear that income, or the lack of it, is now more than ever the major problem faced by a majority of Americans living in retirement.

I. MAGNITUDE OF THE PROBLEM

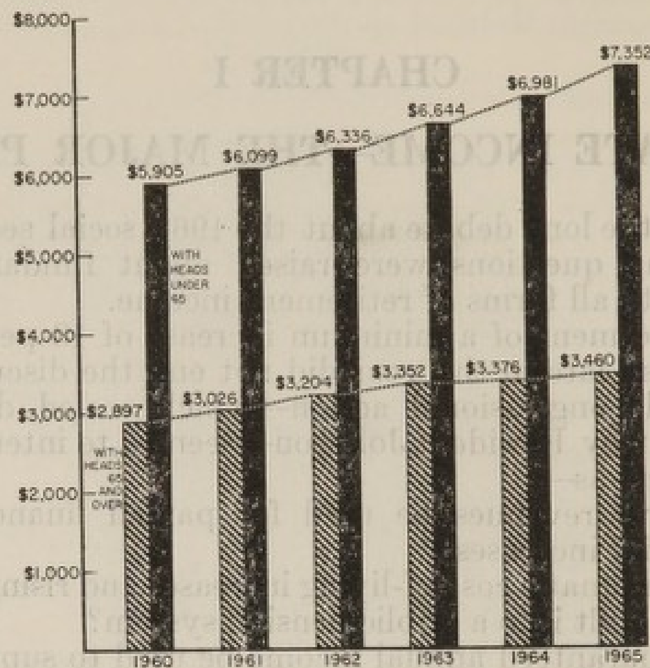
Administration on Aging statistics released last year give the following picture for individuals and families aged 65+ in 1966:

> *Median income.*—$1,443 for older persons living alone or with nonrelatives and $3,645 for families, compared with median income of $4,443 and $7,922, respectively, for their younger counterparts. The median income of older families fell from 50.6 percent of that of younger families in 1962 to 46 percent in 1966. During the same period, the median income of older unrelated individuals dropped from 47.2 percent of that of younger individuals to 41.9 percent. Persons past 65 are, therefore, living on less than half of the income of those younger [2] than they.

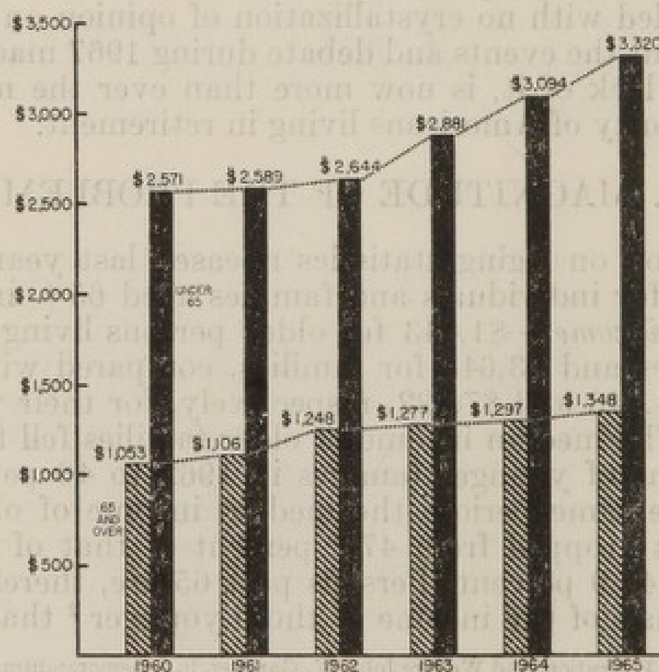
[1] Secretary of Health, Education, and Welfare John W. Gardner, in a memorandum to President Johnson on Jan. 3, 1968, said that the amendments increased social security benefits by the largest dollar amount in the history of the program, and he said that the accomplishments of the three social security laws approved in the prior 30 months "are remarkable in many additional ways." The text of the former Secretary's memorandum is on p. 187. A summary of the 1967 amendments appears on p. 181.

[2] "One's economic needs do not decrease markedly once the magical age of 65 is reached. About the only money need which may be minimized is that involved in going to work, transportation, work clothes, etc. That the older person spends less (as shown in the consumer expenditure studies) results from the fact that he has less income and adjusts his expenditures downward"—from testimony by Dr. A. J. Jaffe, director, manpower and population program, Bureau of Applied Social Research, Columbia University, p. 159, hearing, Subcommittee on Retirement and the Individual, U.S. Senate Special Committee on Aging June 7 and 8, Washington, D.C.

MEDIAN MONEY INCOME OF FAMILIES



MEDIAN MONEY INCOME OF PEOPLE, AGED AND YOUNG, LIVING ALONE OR WITH NONRELATIVES



Poverty.—The number of all poor under age 65 fell from 27,-390,000 in 1965 to 24,285,000 in 1966. But for those age 65 and over, the number in poverty increased from 5,279,000 to 5,372,-000—the only age group whose number in poverty went up.

> (The 1967 social security benefits were expected to lift 800,000 persons past 65 above the poverty line, but even with the increase, average benefits stand at $1,176 a year for an individual and $1,980 for a couple. The minimum benefit: $660 a year.)
>
> *Sources of income.*—Employment, for those able to obtain it, makes a profound difference in the incomes of those who have reached 65. Earnings contribute nearly a third of all such income according to a 1963 social security survey. Among older families, the 15 percent with heads who were year-round, full-time workers had a median income 90 percent higher than did all older families ($6,908 versus $3,745). The 7 percent of all older individuals who were fully employed had a median income more than 2½ times as large as that of all older individuals.

In spite of the importance of earnings, labor force participation by individuals past 65 has shown steady declines for males and only a modest increase for females. The trend is expected to continue through 1980.

II. VITAL ROLE OF SOCIAL SECURITY

OASDHI (old-age, survivors, disability, and health insurance)—or social security as it is known when applied to retirement payments—accounted for approximately one-third of all income in the 65+ age group. The future usefulness of that system is, therefore, of considerable importance to the elderly of today and those in decades to come.

Much discussion of the fiscal soundness [3] of that system occurred during 1967, but a more rewarding field for study was suggested in testimony taken by this committee on a far-reaching question: In the face of continuing economic growth and rising salaries in the labor force, can social security benefits possibly provide adequate income unless fundamental changes are made in present policies?

One answer was given to the committee by James H. Schulz, assistant professor of economics, University of New Hampshire.[4] Discussing all forms of pension income, Professor Schulz put heavy emphasis on social security and said:

> Using a simulation methodology and the assistance of a high-speed electronic computer, distributions of pension income arising out of social security, private, and government pension coverage and assets in retirement were projected for the aged population in the year 1980. These projections were an attempt to investigate the pensions and assets which one could expect to be available to the aged, given the existing institutional pension structure and certain assumptions with regard to changes in these institutional arrangements in the next decade and a half. In general where doubt existed as to the appropriate assumption, the decision was made in favor of being consistently liberal.
>
> The study found that given current trends in retirement income programs, aged poverty would not be eliminated by

[3] An authoritative rebuttal of the most common allegations about instability was made by HEW Under Secretary (now Secretary-Designate) Wilbur Cohen. It appears on p. 288.

[4] P. 261, December 5–6 hearing, in a summary of a paper, "The Future Economic Circumstances of the Aged: A Simulation Projection, 1980," which appeared in Yale Economic Essays, spring 1967. Professor Schulz, at time of this writing, was serving with the U.S. Commission for Cultural Exchange with Iran. See footnote 5.

> 1980. While there will be a sizable shift upward (improvement) in the distribution of pension income for aged persons, the study projected that there would still be a large proportion of aged units with very low pension income in 1980. And, what is most important, the study showed clearly that there would be little or no improvement in the relative income position of the aged population—given the continuing improvement of working population incomes.
>
> If pension systems are to be used to eliminate poverty among retired persons and also to improve their relative economic status in the Nation, the study indicates that significant changes in present U.S. pension systems (and trends) must take place in the future.

Professor Schultz' study also concluded that in 1980 about half the couples and more than four-fifths of the individual retirees will receive $3,000 or less in annual pension income, both public and private.

REASONS FOR THE INCOME SQUEEZE

Difficulties in balancing retirement income with present and future long-range living costs under existing policies in a growing economy [5] were described in some detail to the committee by Dr. Juanita Kreps, professor of economics at Duke University. Her major points:

ONE, the nonworking portion of man's adult life has increased dramatically during this century and is expected to continue to grow rapidly, under the impact of the higher productivity that releases time from work.

TWO, the allocation of greater leisure to man in the form of retirement has been accelerated in recent years by the advent of early retirement schemes, by the lowering of eligibility age for social security benefits, and by the shortening of new job opportunities for older unemployed workers.

THREE, the lengthening retirement span requires a reexamination of the income maintenance arrangements for old age, not only because the levels of income now being provided at retirement are extremely low, but also because the retirement stage of life is now sufficiently long to permit a substantial worsening of that income after retirement.

FOUR, although the impact of inflation on fixed income groups, long recognized as a major threat to the elderly, has often been analyzed, and suggestions frequently made for tying social security benefits to the cost of living, no action of this sort has been taken.[6]

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[5] "Long-range Program and Research Needs in Aging and Related Fields," by U.S. Senate Special Committee on Aging, Dec. 5 and 6, 1967, Washington, D.C., p. 55.

[6] In response to a question from Chairman Williams, Dr. Kreps discussed the common tendency to equate inflation with income increases caused by economic growth:

"Price inflation and economic growth (in the incomes of the active members of the population) are two quite separate matters. Both independently contribute to the worsening of the income position of the retired relative to those still employed.

"If price levels were stable through time so that those retirees on fixed money income suffered no loss of purchasing power through their retirement period, their incomes would still fall steadily behind the incomes of those employed. Persons working will in general continue to enjoy rising money and real incomes as a result of capital accumulation and technological advance. Therefore the relative income position of the retiree would steadily deteriorate in the manner suggested by table 2 of the statement submitted.

"When there is inflation, there is a further tendency for the retiree to suffer a loss in absolute real income during retirement, along with the deterioration of his position relative to those still employed. The inflationary impact is partially offset by periodic increases in social security benefits. But the timelag between the cost-of-living increase and the benefit increase may be significant.

"In discussing the incomes of the aged it is important not to confuse the effects of inflation with the effects of rising real incomes for the employed. Policy measures to deal with the two influences are quite different" (p. 64, hearing cited, footnote 5).

FIVE, even if public policy did in fact keep retirement benefits apace with the cost of living, there would be a gradual worsening of retirement benefits relative to earnings, since earnings grow in accordance with the overall growth of the economy whereas benefits do not reflect such gains from growth.

SIX, the central question comes to be: To what extent (and through what mechanisms) are older people to share in the growth in real national product?

A question of equity: Whose growth is it?—Failure to provide more generous public pensions for retirees in the United States reflects, as Dr. Kreps expressed it:

> A failure to recognize the lengthening retirement period as a new life stage, and in part a belief that each family is in charge of its own financial destiny. Hence, private savings are expected to achieve whatever income smoothing beyond certain minimum pensions are desired.

Saving for retirement while in the work force is extremely difficult, as Dr. Kreps showed in models submitted to the committee. She said:

> Moreover, there is in the present scheme of income allocation, which offers rewards primarily on the basis of productivity, the implicit assumption that the gains from economic growth are due altogether to the efforts of persons who are currently at work. Such an assumption is unwarranted. Increases in the productivity of the employed may have very little to do with their own actions and initiative; they result, rather, from capital accumulation and advances in technology. The growth component of increases in income is largely fortuitous from the standpoint of the individual worker.

Further, Dr. Kreps challenges the common belief that the social security system is like a bank in that retired persons withdraw from the system the same funds they put into it while they were in the work force. She advances the idea that each generation of retirees draws from the funds put into the system by the current work force:

> Public pensions, which in the United States are financed by payroll taxes on the incomes of persons still at work, transfer income claims against the Nation's total output from workers to retirees. It is important to note that the transfer is from workers in 1968 to retirees in 1968, and not from a man who works in 1968 to the same man when he retires in 1988. The retiree of 1988 will have an income claim against the 1988 output, financed by a tax on the worker of that year. Transfers of income claims thus reallocate the annual output between workers and nonworkers (including the young as well as the old).

Dr. Kreps also asked:

> If the incomes of retired persons are to be maintained at levels closer to those of economically active persons, whose earnings are always rising, how should the additional transfer be financed? There are few alternatives: (1) individual

savings; (2) saving through private pension arrangements; and (3) transfers via some taxation-benefit scheme.

Most people agree that they should save more heavily for retirement; most people fail to do so. The private method thus has the advantage of allowing a family to do its own lifetime budgeting and saving for old age; it has also the disadvantage of allowing it to do neither. Indeed, the widespread reliance on public and private pensions rests on the premise that most people make no voluntary systematic provisions for retirement income. And if people generally do not save enough for retirement incomes comparable to their current earnings, how can they be expected to save enough to match their even higher incomes of the future? The reasoning might well be (if the process were thoroughly understood): why depress present consumption levels in order to enjoy higher retirement consumption, when such saving will maintain such a small fraction of earnings?

Private pension arrangements face much the same difficulty, since they also require more saving now for more consumption during retirement. In order to provide future benefits commensurate with future incomes, and further, provide benefits which would rise through the retirement period, private pension schemes would have to exact much heavier contributions from employers and employees than they now require. Unless these larger contributions are made, employers will find it difficult unilaterally to raise pension benefits above the levels financed by past contributions.

Social security benefits will obviously need to rise; debate hinges on the questions of how fast this increase should be, and on the proper direction of tax policy. As to the extent of the increase in benefits, the wide gap between earnings and retirement incomes indicates the range within which income "smoothing" might advantageously occur. But even if benefits are raised to the point where this gap is minimized, the improvement will be temporary unless public policy also deals with the relationship of earnings and benefits through time. Until benefits are in some way tied to the growth in real income, the relative position of the retiree will lag behind earnings.

Further increases in payroll taxes will, of course, be necessary if benefits are to be financed exclusively from this source. Raising the taxable base will help to reduce the regressivity of the payroll tax, but significant increases in the rate may raise again the question of whether we are not taxing heavily one low-income group to raise the incomes of another. Discussion of general-revenue financing for some portion of retirement benefits is long overdue.

Thus, Dr. Kreps indicates that future retirement income from a social security system may have to be bolstered by general revenues. But as she points out, any such step should be preceded by long and careful study.

PROS AND CONS: USE OF GENERAL REVENUES [7]

Arguments in favor:

1. Use of general revenues would be consistent with the original plan for financing social security benefits. It was contemplated that the use of general revenues would begin about 1965.
2. Exclusive reliance on payroll taxes is appropriate for financing the work-related, insurance aspects of social security, such as retirement benefits, but is not appropriate for financing the social objectives of the program, such as dependents' benefits.

   Much of what the social security program attempts to do is "social" or "welfare" in nature; these social or welfare costs ought not to be financed by a payroll tax. A Government contribution would be a recognition of the interest of the Nation as a whole in the welfare of the aged and of widows and children. Such a contribution is particularly appropriate in view of the relief to the general taxpayer which results from the substitution of social insurance for part of public assistance.
3. The payroll tax, as opposed to the Federal income tax, is generally considered a regressive tax, which falls more heavily on lower paid workers.
4. The cost of the social security program includes the cost of paying full benefits to people who had little opportunity to work in covered employment, including those who were approaching retirement age when their work was covered under the program. The cost of paying these benefits—about one-third of the cost of the program—should be considered a social cost that could properly be paid out of general revenues. It is entirely appropriate that the cost of getting into operation a national social security system from which society as a whole benefits, should be borne by the population as a whole.
5. Use of general revenues to pay these benefits would make it possible to increase benefits about 50 percent above present levels or to reduce payroll taxes.
6. Governmental participation (by means of general revenues) in financing of a social insurance program has long been accepted as sound public policy in other nations.
7. Contributions to social security trust funds from general revenues are justified as in lieu of the interest that would have been received if there had been full financing from payroll taxes.
8. There are precedents for general revenue financing. Congress has already recognized the justification of general revenue contributions in the case of (1) social security credits for service in the armed services, (2) medicare benefits for those over 65 who have insufficient quarters to qualify for social security cash benefits, and (3) special payments for those who have reached the age of 72 which were authorized during 1966 by the Prouty amendment.

Arguments against:

1. Use of general revenue financing would have an undesirable effect on attitudes of beneficiaries and the general public toward the social security system. There would be a tendency to regard

[7] Summarized from "Historical Review of General Revenue Financing in Social Security," a study by Francis J. Crowly, Library of Congress, Legislative Reference Service, p. 286, hearing cited, p. 4, footnote 5.

social security payments as "charity" or "welfare," in lieu of the present view that social security benefits are received as a matter of earned right.

2. Because employers and employees know that liberalizations of benefits will result in increased payroll taxes that they themselves must pay, the payroll tax serves as a limitation against fiscal irresponsibility and too rapid expansion of the program. This brings home to the participants that there is no magic in social security benefits—that the benefits must be paid for. It is very important that people see clearly that benefit increases necessarily involve increases in costs and contributions.
3. Shifting to general revenues the burden of financing benefits for which inadequate payroll tax contributions have been made would add a huge new general revenue burden, estimated at about $20 billion per annum.
4. Benefits financed by general revenues would not be as dependable as those financed by payroll taxes. If there is ever substantial reliance upon appropriations of general revenues for financing social security benefits, the level of these benefits will depend upon the willingness of Congress to levy sufficient taxes and to make sufficient appropriations. This destroys the dependability of the social security system which now rests upon payroll taxes.

Still another view on the use of general revenues was given by Herbert Striner, director of program development for W. E. Upjohn Institute for Employment Research. Dr. Striner, in an article in 1962 called "The Capacity of the Economy To Support Older People," had advocated an increasing payroll contribution as a means of building an insurance fund capable of sustaining guaranteed retirement incomes. In a 1967 statement to the committee,[8] however, he said he has changed his mind:

> I have come to the conclusion that in order to provide for the income levels necessary to support OASDI recipients more adequately, we must look to funding from general revenues. I have come to this conclusion because history has shown that as long as we continue to tie retirement income to any sort of insurance program, we use the inadequacy of insurance income as a means of curtailing necessary income payments for retirement. In addition, the social security tax is regressive in nature. Low-income groups pay as much as high-income groups. The insurance aspects of this program are such that they are, in reality, a delusion. I believe that we are sufficiently sophisticated by now that we no longer have to lean on the crutch of OASDI being an "insurance program." Indeed, older friends of mine who were involved during the 1930's in the development of this program tell me that the insurance image was designed by President Roosevelt's staff in order to forestall an easy revocation of this program by future, more conservative administrations.
>
> Beyond this, those who have looked at the social security trust fund feel that during the next few years and into the mid-1970's, receipts which exceed benefit payments could

[8] P. 281, hearing cited, p. 4, footnote 5.

exert a depressing effect on the economy. In essence, the present system which seeks to appear as an insurance fund—but really is not—and has the potential for becoming a "fiscal hoarder," is an anachronism. During the past 30 years, receipts have exceeded payments in all but 5 years. At present, there is an accumulation of about $20 billion in the trust fund. Finally, as you are undoubtedly aware, most of the European countries look to general revenues as the support base for social security programs. Although the United States leads as an innovator in hardware technology, we lag in our innovation and commitment in the social problem area.

During the last year, it has become obvious that when we have a real sense of commitment, such as Congress has felt exists in the case of the Vietnam war, we are able to obtain 12, 14, or 15 billions of additional dollars for these types of "emergency" commitments. I feel that the ability of the economy to support a much higher general tax level is such that we should be forced into the funding of necessary retirement programs for our older citizens on the basis of general tax revenues rather than on the basis of earmarked funds coming from OASDI payments tied to a schedule of payroll insurance payments. Since its inception in the 1930's, the OASDI tax has never approached what was contemplated in terms of becoming a sufficient level of support. I see no reason why our experience in the future should change radically from this past experience.

III. OTHER PROPOSALS FOR INCREASING RETIREMENT INCOME

Many suggestions for raising the general level of income in retirement were advanced in 1967, and some received attention from congressional units. The following brief discussion of a few major issues, however, suggests that no simple answer to all retirement income problems is likely to be found.

Private pensions.—Considerable attention was given during 1967 to legislation intended to make pension coverage more universal and more secure for participants.[9]

Usefulness of private pension plans in alleviating pressing income deficiencies, however, is more likely to be long range than immediate. Walter Reuther, president of the United Auto Workers and longtime advocate of higher pensions for the working man, discussed the role of such plans in a paper submitted to the Joint Economic Committee.[10] He said that at the end of 1966 $93.4 billion in assets were being held for the future benefit of more than 27 million employees, and

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[9] The administration's proposed Welfare and Pension Plan Protection Act was introduced early in 1967 by Senator Ralph Yarborough, Democrat, Texas. Among other provisions, it proposed that the Secretary of Labor be given additional investigatory and enforcement powers, that disclosure provisions in present laws be strengthened, and that minimum and uniform fiduciary responsibilities be imposed on persons handling welfare and pension funds. Another comprehensive private pension bill introduced was Senator Jacob Javits', Republican, New York, S. 1103, which proposed the appointment of five-member commission to promote the establishment, extension, and improvement of pension and other employee benefit plans, and to enforce vesting, funding, and reinsurance requirements in the bill. Also introduced were bills proposing studies on attaining portability of private pension plans and proposing systems for reinsuring such plans.

[10] "Old Age Income Assurance," p. 98, pt IV., "Employment Aspects of Pension Plans," Joint Economic Committee, Congress of the United States, December 1967.

that 2.7 million were already retired and drawing more than $3 billion yearly. He further stated:

> Large as these figures are, they must be put in perspective to be properly evaluated.
>
> The 27 million covered persons, including some presently retired, amounted to fewer than 45 percent of the labor force, excluding Government employees. Furthermore, a recent study has shown a serious imbalance in the distribution of this coverage by amount of earnings:
>
> —26 percent of employees earning $3,000 to $5,990 yearly have pension coverage.
>
> —47 percent of employees earning $6,000 to $9,999 yearly have pension coverage.
>
> —52 percent of employees earning $10,000 or more yearly have pension coverage.

In other words, workers most in need of such coverage are least likely to have it.

Shortcomings in private pension plans were succinctly summarized in another paper submitted to the Joint Economic Committee: [11]

> Only about one-fifth of the total number of persons aged 65 and older now receive private pension benefits. By 1980, the proportion will be between a third and two-fifths. Moreover, the benefits paid are, on the whole, small. Many plans are not insured, and many are inadequately financed. Vesting [12] is long delayed, so that job mobility is preserved only at the price of surrendering pension credits. Given the limited coverage of private pension plans, the inadequacy of their benefits for many covered workers, and their other shortcomings, they can hardly be expected to provide sufficient protection in old age for more than a minority of the work force for many years to come.

Professor Schulz, calling for continued and thorough investigation of the extent of private pension coverage and the level of benefits actually paid to workers now and in the future, warned that an unfortunate long-range trend in pension coverage appears to be taking shape:

> Initial studies indicate that private pension coverage cannot and/or will not be extended to a very large proportion of the labor force.[13] If these studies are correct, a serious problem is developing for the future; the labor force is dividing into two groups—workers with both private and public pension coverage (generally adequate for retirement provision) and workers with only public pension coverage (generally inadequate for retirement provision). More analysis is needed as to whether our present mixed pension system is compatible with retirement income adequacy and equity for all workers.

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[11] "The Objectives of Social Security," by Joseph A. Pechman, Henry J. Aaron, and Michael Taussig, "Old Age Income Assurance, Pt. III," pp. 5–28.

[12] Provision for a participant to receive retirement benefits upon reaching retirement age, even though he is no longer working for that employer when he reaches that age.

[13] P. 261, hearing cited p. 4, footnote 5.

A guaranteed minimum income.—Essentially, all versions of this concept call for whatever supplement is needed to bring low income to a level regarded as socially and economically desirable.

Two examples of such programs already underway in other nations were given to this committee by Prof. George F. Rohrlich, of the Department of Economics of Temple University.[14] In 1966, the British Parliament enacted a new supplementary benefits scheme for men over 65 and women over 60, the purpose of which was stated to "provide a form of guaranteed income for those who require such a benefit over a long period." Incomes below the guaranteed amount are supplemented up to the guaranteed level. The other example is Canada, which recently instituted a guaranteed minimum income supplement for those currently reaching pension age whose income falls below a stated level. At present the guaranteed total income is $105 monthly, which is subject to index-linked automatic increases in the future.

Professor Rohrlich believes that significant research should be undertaken in the United States to explore "the feasibility of a simplified and dignified minimum income guarantee for the aged." The fact that the professor asked for substantial exploration before any such plan is adopted suggests that potential pitfalls are numerous. Substance for that caveat was provided in another paper received by this committee.[15] Dr. Margaret S. Gordon, associate director for the Institute of Industrial Relations of the University of California, questioned the arguments of those who believe that the retirement income problem can be resolved in one all-encompassing minimum income plan:

> 1. It is likely to be a long time before we adopt a negative income tax or a minimum income guarantee, and, even if we were eventually to adopt some such system, there would still be a need for maintaining and strengthening our social insurance programs. As I have argued in a paper to be published by the Joint Economic Committee,[16] negative income tax proposals are designed to provide for transfers to the poor at a given point in time, whereas earnings-related social insurance programs are designed to protect the stability of income over the life cycle. There is room for both approaches in an affluent society, and a need for retention of the social insurance approach if we are to prevent the ill, the disabled, the aging, and the unemployed from falling into poverty as well as to aid the existing poor.
>
> 2. The usual negative income tax proposal is not, in my opinion, particularly well adapted to the needs of the aging and disabled. One of the best negative income tax proposals I have seen is that of Prof. James Tobin, who would exempt OASDHI recipients of cash benefits from his scheme.[17] Careful consideration should be given to a different approach to providing a minimum floor of income for the elderly, i.e., a modest universal old-age pension for persons aged 65 and over, which would provide a minimum floor of income to

[14] Pp. 284 and 285. Hearing cited in footnote 5, p. 4.

[15] P. 256. Hearing cited in footnote 5, p. 4.

[16] Margaret S. Gordon, "The Case for Earnings-Related Social Security Benefits Restated: With a Review of Foreign Trends Toward Dual Income Maintenance Approaches" (to be published by the Joint Economic Committee, U.S. Congress, in pt. 2 of a series of volumes relating to problems of income maintenance for the aged).

[17] James Tobin, "On Improving the Economic Status of the Negro," Daedalus, fall 1965.

which earnings-related OASDHI benefits would become supplementary. Such a scheme would do much to overcome the adverse effects of reduced early retirement benefits on the income status of the 65 and over group. Moreover, it should be financed either through general revenue or a combination of an earmarked flat percent on the income tax rate and general revenue, as in Sweden, in order to stem the tide of increases in the regressive contributory OASDHI taxes. If a universal pension proved to be unacceptable, in view of our deeply entrenched national prejudice against "handouts," a modest income-conditioned pension system for the elderly whose OASDHI benefits and other sources of income are seriously inadequate might be considered.

However, as contrasted with a universal pension, an income-conditioned pension would probably discourage saving for old age, at least to some extent, and encourage persons approaching retirement age to turn over assets to adult children. Of course, an income-conditioned pension system can be structured like a negative income tax, so that an individual would always benefit from other income, e.g., income from assets. But any such approach is somewhat incompatible with the goal of a flexible policy toward the age of retirement and with the existing retirement test under OASDHI. I would suggest that a very logical role for an income-conditioned pension is exemplified in New Zealand, where a universal old-age pension is provided from age 65 on, and an income-conditioned pension is available for needy persons age 60 to 64.[18] We have seen that most elderly men who are awarded early retirement benefits under OASDHI are coping with problems of ill health or unemployment and tend to have a low education. Their saving capacity is likely to have been minimal, and thus an income-conditioned pension would not be likely, in the case of such men, to reduce saving.

3. One of the arguments advanced by proponents of a negative income tax has to do with the administrative simplicity of providing transfer payments to the poor through the income tax system. Thus, those who advocate replacing our existing social security programs by a negative income tax are implicitly, and sometimes quite explicitly, advocating the separation of income maintenance from the provision of social services, such as counseling, placement, rehabilitation, and retraining. If the negative income tax were simply designed to supplement existing income maintenance programs, it would not, of course, have this effect. I believe that the development of social insurance in such countries as West Germany indicates that there are great advantages in an intimate relationship between the provision of income maintenance and the social services. The nature of these advantages has been indicated above in connection with industrial injuries insurance in the Canadian provinces. Some will say that this view is paternalistic, but I would argue (1) that the

[18] The income-conditioned pension is also available from age 55 on in the case of unmarried women who are unable to work.

marriage between social insurance and the social services should, in general, be such as to provide incentives for rehabilitation, retraining, etc., rather than compulsion, and (2) that all of the relevant survey research has demonstrated that large percentages of the persons who could benefit from social services do not know about their availability. Thus the complete divorce of income maintenance and the social services would, I believe, make it immensely more difficult to reach the people who need social services.

The foregoing discussion is not offered as an exhaustive analysis of present deficiencies and future outlook on retirement income. Rather, it is meant merely as a preface to the conclusions offered here:

Despite the increasing complexity and magnitude of the forces that affect retirement income, and despite increasing dependence upon public and private pension systems, and even with introduction of new concepts for a guaranteed minimum income, the Federal Government has as yet no mechanism for sustained, comprehensive attention to the issues and problems involved.

Discussion.—Executive branch units with jurisdiction over programs related to retirement income are numerous, and the task of coordination is complex. Here is only a partial listing:

AGENCY AND RESPONSIBILITY

President's Council on Aging: Government-wide surveillance over and coordination of aging programs, including those relating to incomes in old age.

Social Security Administration, Department of Health, Education, and Welfare: Administers social insurance program.

Social and Rehabilitation Service, Department of Health, Education, and Welfare: Administers public assistance programs which provide income in old age, such as old-age assistance, aid for the blind, and aid for the permanently and totally disabled. Its Administration on Aging maintains general surveillance over incomes in old age, makes research and demonstration grants, and administers the foster grandparents program under contract with the Office of Economic Opportunity.

Veterans' Administration: Administers pension and compensation programs for elderly veterans and their elderly dependents or survivors.

Civil Service Commission: Administers civil service retirement system.

Department of Defense: Administers armed services retirement system.

Office of Economic Opportunity: Administers programs to enhance incomes of the elderly poor.

Department of the Treasury: Administers tax laws affecting establishment and operation of private pension systems.

Department of Labor: Administers laws requiring registration and disclosure of pension and welfare plans. Cooperates with Office of Economic Opportunity on programs to provide employment and service opportunities for the elderly poor. Administers various programs to assist older workers to qualify for and find employment.

A new President's Commission.—As President Johnson signed the Social Security Amendments of 1967 into law, he also announced that he was establishing a Commission on Income Maintenance which will apparently make retirement income one part of a major study on the need for far-reaching changes in the present public welfare system.[19] In correspondence with Chairman Williams of this committee, the Commission Chairman, Mr. Ben Heineman, has said that the Commission will take an active interest in some areas related to retirement income.

The Commission has a major responsibility, and the Senate Special Committee on Aging will cooperate in every way to advance studies of unique problems of growing population of retired Americans who face income pressures that may ultimately force many of them to become reluctant welfare recipients living well below poverty levels.

The committee welcomes the establishment of the Commission but believes that additional action may be necessary to implement the following recommendation:

The committee recommends that the executive branch consider the ultimate establishment of an Institute on Retirement Income closely patterned after an institute announced by President Johnson in 1967 to deal with urban problems. Such an institute would be geared for problem solving as well as sustained study.

Discussion.—The Institute on Urban Development, as described by President Johnson in an announcement on December 7, is intended to provide answers to problems that now beset major cities and metropolitan areas. A nonprofit corporation, the Institute will be organized by a six-man panel, and organize a staff of about 100. Initial funds will come from the $10 million research fund of the Department of Housing and Urban Development. Foundation grants later may be accepted. One unique aspect of the Institute was described by Urban Renewal Expert Edward Logue: "The special qualification of the 'think tank' is in problem solving while the urban studies in universities are mainly research." [20]

A New York Times article of December 11, 1967, suggested that the Institute might also have a clearinghouse function in that it "might provide an answer that universities have needed in their own urban studies. There is a lot of research 'ongoing' as the professors say, but virtually no communication between any of these urban studies groups."

Responses to informal inquiries from this committee suggest that economists, sociologists, and others in aging and related fields believe that the institute mechanism might well be applied to the field of retirement income, or perhaps to the more general subject of income maintenance throughout life.

The need for concentrated attention to such subjects was suggested also by the Joint Economic Committee in a letter of transmittal accompanying its five-part study of old-age income assurance. That study is an impressive, helpful collection of essays from leading authorities in the field, but the letter expressed a strong desire for additional action:

[19] Text of the President's remarks on p. 188.
[20] NAHRO letter, Dec. 15, published by National Association of Housing and Redevelopment Officials.

> The compendium confirms the fact that programs to aid older people have grown in number, size, and complexity; and that *the coordination of these programs and their combined impact on the income of older people have received very little attention. Clearly, public policy issues exist with respect to coordinating these programs, appraising their effects on the economy, and improving their equity.* [Emphasis added.]

The very complexity of the issues involved, as described in the summation above and in statements to this committee, suggest that the Institute, or "think tank" approach might well be considered by the executive branch, or possibly by the Congress, as one means of providing the overview so vitally needed on the far-ranging programs, social forces, and problems related to retirement income.

IV. ADDITIONAL ISSUES RELATED TO RETIREMENT INCOME

Attention to other, more specific problem areas related to retirement income was provided during 1967 by both the Congress and the administration. The four most urgent issues: Reductions in retirement income linked to increases in social security, continuing concern about low old-age assistance levels, the impact of taxes upon homeownership, and the increase in the number of individuals who receive reduced social security payments because of retirement at ages earlier than 65.

A. Social Security-Linked Reduction of Other Retirement Benefits

Each time Congress increases Social Security cash benefits, there are some recipients who, because of the increase, suffer equal or greater reductions in other benefits including Old Age Assistance in some States and veterans pensions. In these cases, the social security increase which was voted to increase retirement incomes can have the opposite effect of reducing them.

In an effort to find and recommend wise and sound solutions to this problem, this committee's Subcommittee on Employment and Retirement Incomes held hearings [21] which led to a report issued by the subcommittee on August 21. The subcommittee chairman, Senator Jennings Randolph, in opening the hearings, said:

> I am convinced, * * * that there need not be a repetition of the disappointment experienced by too many older Americans in the past. These persons have eagerly anticipated social security increases only to discover that when they were enacted some other retirement benefit was reduced, leaving them in no better financial circumstance or, worse still, in even more impoverished circumstances.

As the hearings opened, it had become obvious that top priority consideration would be given during 1967 to legislation to increase social security cash benefits. The President had sent to Congress a proposal to increase such benefits, and the House Ways and Means Committee had held extensive hearings on the proposed increase.

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[21] "Reduction of Retirement Benefits Due to Social Security Increases," hearings before the Subcommittee on Employment and Retirement Incomes (Senator Jennings Randolph, chairman), Senate Special Committee on Aging, first sess., 90th Cong. (Apr. 24-25, 1967).

In the introduction to its report, the subcommittee said:[22]

> While total retirement incomes of the vast majority of older Americans would be augmented by the proposed increase, there is a substantial minority of social security beneficiaries whose total retirement incomes, as a result, either will remain the same or will actually shrink. These are our older compatriots who receive, in addition to social security, incomes from Federal, local, or private programs whose amounts depend upon the size of their social security entitlements.
>
> Benefits of this type which have been reduced in the past whenever social security was increased include old-age assistance in some States, veterans' non-service-connected pensions, and some pension plans of private concerns and of State and local governments.
>
> The subcommittee undertook this study convinced that Congress must do better than it has before to protect these older Americans from reductions in retirement benefits due to social security increases. Our studies and hearings on this subject have confirmed us in our conviction that such reductions need not be the inevitable consequence of social security increases * * *.
>
> * * * * *
>
> The subcommittee has concluded that it is most in keeping with the purposes of the Social Security Act and the intentions of Congress in voting social security increases to assure that such increases will improve the total incomes of senior citizens, or, at least, that their total incomes will not suffer as a consequence.

The subcommittee also made the following findings and recommendations:

1. Old-age assistance

Finding: The subcommittee has found that few States have taken advantage of the 1965 permissive disregard provision to avoid reduction in old-age assistance benefits due to the 1965 social security increases.

Recommendation: The subcommittee recommends that legislation providing future social security increases contain a provision prohibiting reduction of old-age assistance grants due to a social security increase, but giving the Secretary of Health, Education, and Welfare or his deputy power to permit such reductions in whole or in part for States which can prove to his satisfaction that (1) the funds saved by such reductions will be used to enrich public assistance programs for the elderly; or (2) the State's old-age assistance program provides cash payments sufficient for minimum subsistence needs.

2. Veterans' benefits

Finding: The subcommittee finds that there was no way whereby a veteran or his widow whose income was slightly below income limits before the 1965 increase could have protected himself or herself from loss of pension as a result of that increase.

[22] P. 1, hearing as cited in footnote 21.

Conclusion: The subcommittee concludes that if Congress waits until after another social security increase is voted to address itself to this problem, it runs the risk that the increase will again produce disproportionate veterans' pension reductions, at least temporarily.

Finding: The subcommittee finds that the basic reason why some veterans and their survivors lose more in pension incomes than they gain in social security increases is that there are so few steps in the schedule of income limits that this result is inevitable; there appears to be no logical reason why there could not be established a sufficient number of steps that this result could be prevented.

Recommendation: The subcommittee recommends enactment of a refined schedule of income limits as the best long-range solution to the problem of losses of veterans' pensions due to social security increases.

Recommendation: The subcommittee recommends, as an emergency solution, amending H.R. 5710 to permit waiver of all or any part of a beneficiary's social security entitlement, and prohibiting the counting of the benefit so waived as income for purposes of veterans' pensions.

3. Private pensions

Recommendation: The subcommittee recommends that all social security beneficiaries, including those who also receive private pension benefits, be given the privilege of waiving all or any portion of their social security benefits, and of rescinding or modifying their waivers at any time.

4. State and local government pensions

Recommendation: The subcommittee believes the waiver privilege which it recommended earlier in this report would help to take away the incentives for State and local governments to include in their pension plans provisions permitting or requiring reduction of their pensions due to social security increases.

PROGRESS ON PUBLIC ASSISTANCE

Strenuous efforts were made to implement the recommendations in the report. As finally enacted, the Social Security Amendments of 1967 contains a section which expands the provision enacted in 1965 allowing States to exempt up to $5 a month of any type of income in determining eligibility and the amount of public assistance for the aged, blind, and disabled. It does so by increasing the amount which may be so exempt from $5 to $7.50 a month.

PROGRESS ON VETERANS' BENEFITS

As a result of the year-long discussion of the effect of social security increases upon veterans' non-service-connected pensions, H.R. 12555 was introduced on August 23, passed the House on December 15, 1967, and the Senate on March 11, 1968, and was signed into law (Public Law 90-275) on March 28. This new public law carries out the subcommittee's recommendation that there be a refinement of income limits for purposes of pension benefits for veterans and

their survivors. This is illustrated by the following table, which appears in the House committee report on the bill: [23]

Income increment	Veteran alone		Veteran with dependent		Widow alone		Widow with 1 child [1]	
	Existing law	H.R. 12555	Existing law	H.R. 12555	Existing law	H.R. 12555	Existing law	H.R. 12655
$100	$104	$110	[2] $109	[2] $120	$70	$74	$86	$90
$200	104	110	[2] 109	[2] 120	70	74	86	90
$300	104	110	[2] 109	[2] 120	70	74	86	90
$400	104	108	[2] 109	[2] 120	70	73	86	90
$500	104	106	[2] 109	[2] 120	70	72	86	90
$600	104	104	[2] 109	[2] 118	70	70	86	90
$700	79	100	[2] 109	[2] 116	51	67	86	89
$800	79	96	[2] 109	[2] 114	51	64	86	88
$900	79	92	[2] 109	[2] 112	51	61	86	87
$1,000	79	88	[2] 109	[2] 109	51	58	86	86
$1,100	79	84	84	107	51	55	67	85
$1,200	79	79	84	105	51	51	67	83
$1,300	45	75	84	103	29	48	67	81
$1,400	45	69	84	101	29	45	67	79
$1,500	45	63	84	99	29	41	67	77
$1,600	45	57	84	96	29	37	67	75
$1,700	45	51	84	93	29	33	67	73
$1,800	45	45	84	90	29	29	67	71
$1,900		37	84	87		23	67	69
$2,000		29	84	84		17	67	67
$2,100			50	81			45	65
$2,200			50	78			45	63
$2,300			50	75			45	61
$2,400			50	72			45	59
$2,500			50	69			45	57
$2,600			50	66			45	55
$2,700			50	62			45	53
$2,800			50	58			45	51
$2,900			50	54			45	48
$3,000			50	50			45	45
$3,100				42				43

[1] Plus $16 for each additional child.
[2] Add $5 for 2 dependents or $10 for 3 or more dependents.

B. Increased Early Retirement Under Social Security

A long-range adverse effect upon retirement incomes is foreseen as a result of recent increases in the numbers of social security beneficiaries who retire before age 65 and as a result receive actuarially reduced benefits.

Statistics compiled by the Social Security Administration [24] show that over half the regular social security awards to men are actuarially reduced awards because of early retirement.

Commenting on early retirements, Dr. Margaret S. Gordon, associate director, Institute of Industrial Relations, University of California, advised the committee: [25]

[23] P. 6, House Report 1039, 90th Congress, 1st session (1967).
[24] "Another Dimension to Measuring Early Retirements." Research and Statistics Note No. 20, Office of Research and Statistics, Social Security Administration (Nov. 7, 1967).
[25] Hearings cited p. 4, footnote 5, pp. 243-247.

Changes in the labor force participation patterns of men and women approaching retirement age may be expected to have important effects on the future income status of the aged. * * *

The early retirees appear to fall into two rather distinct groups, consisting of a relatively well-off minority and a comparatively impoverished majority who leave the labor force or shift to part-time work because of ill health or unemployment problems. * * * The major factor appears to have been the lowering of the male retirement age for OASDHI benefits to 62 in 1961, so that men aged 62 to 64 could receive old-age benefits on an actuarially reduced basis. This interpretation of what has been happening is supported by various types of data.

For one thing, the number of men who have taken advantage of the availability of early retirement benefits under OASDHI is large.

Why do so many men in this age group apply for early retirement benefits, even though they will receive substantially reduced benefits for the rest of their lives in most cases? In the last 4 months of 1965, for example, after the benefit increases incorporated in the 1965 social security amendments had come into effect, average retirement benefits awarded to men at age 62 to 64 amounted to $79.52 a month or only 70 percent of the average award of $111.13 a month for men aged 65. These figures indicate, as do other data, that men retiring at ages 62 to 64 tend to have lower average earnings than men retiring at age 65, for the actuarial reduction amounts to 6⅔ percent of the benefit amount a year, or to 20 percent for the 62 year olds, 13⅓ percent for the 63 year olds, and 6⅔ percent for the 64 year olds.

The answer appears to be that the great majority of the men who apply for early retirement benefits are coping with problems of ill health or unemployment * * *. Ill health figured even more prominently as a reason for retirement for men aged 62 to 64 in the 1963 survey than in the case of the men aged 65 and over, accounting for more than half of the cases, while "laid off or job discontinued" accounted for nearly a fifth. Only 11 percent of the 62 to 64 age group responded that they "preferred leisure" * * *.

As further evidence of the role of ill health in bringing on early retirement, 60 percent of the male beneficiaries aged 62 to 64 who were not at work in the survey week reported that they did not plan to work in 1963 because they were "not well enough." Only 36 percent of the male beneficiaries aged 62 to 64 were in the labor force, and among these only half were employed, as compared with 88 percent of male nonbeneficiaries in this age group. Thirty-one percent were unemployed, while 17 percent indicated that they had a job but were not at work.

A recent Bureau of Labor Statistics study showed that the 1962–65 decline in participation for men aged 55 to 64 was almost entirely among those with the lowest educational attainment * * *.

Low earning capacity among early retirees is apparently frequently associated with ill health, judging from the large proportions who report that they retired because of ill health. No doubt in some cases this reported ill health is subjective, but it is probable that, even when there are no objective indications of ill health, there may often be a sense of debilitation and a feeling that continuing to work has become a strain. In this connection, it is well to recall the Steiner-Dorfman finding that, among men 65 and over, the proportion not well enough to work tended to be high in occupations that make heavy physical demands (e.g., farming, laboring) and low in sedentary occupations (e.g., professional work, selling) without any marked relationship to the income levels of the various categories. They concluded that "this circumstance lends support to the belief that the classification 'not well enough to work' has a substantial objective foundation and is not a mere rationalization for being out of the labor force."

C. Concern About Old-Age Assistance Levels

A report [26] released during May, 1967, gave new evidence about the living conditions endured by the approximately 2 million older Americans who are dependent upon old-age assistance support provided by States with Federal assistance. The report's major findings:

—Forty percent of the recipients reported major defects in their housing;

—Sixteen percent of the recipients live in houses without running water, and 41 percent were in homes not completely heated in the winter;

—OAA money payments averaged $62.92 a month, and income other than assistance averaged $26.89 (including $22.50 in OASDI benefits);

—The average unmet need, [27] under State standards, came to $2.60 a month. Nine percent of the recipients had unmet needs exceeding $10 a month.

This committee, which has received many statements in support of a uniform nationwide floor, or minimum level [28] on OAA payments, received similar statements in 1967. Typical was the comment of Professor Morris of Brandeis University, who said that low payments lead to at least one contradiction between the stated purposes of our old-age assistance program and the reality of this program. He said: [29]

> The purpose of public assistance is to permit older persons to live with minimum security and to live their remaining years in minimum decency. Unfortunately * * * standards of old-age assistance in most States make it impossible for older persons to maintain a telephone or to purchase clothing suitable for any socializing, or to pay for transportation in

[26] "Characteristics of Old-Age Assistance Recipients: Highlights of Findings of the 1965 Study," Welfare Administration, Department of Health, Education, and Welfare (May, 1967).

[27] "Unmet need" of a recipient of old-age assistance is the difference between his total income, including his Old-Age Assistance, and his need for total income under the standard of need established by his State.

[28] See, in particular, pp. 21, 59, 77, 79 and 86 of "Services to the Elderly on Public Assistance," hearings before the Subcommittee on Federal, State, and Community Services (Senator Edward M. Kennedy, Chairman), Senate Special Committee on Aging, 1st sess., 89th Cong. (1965).

[29] Pp. 31 and 32 of the hearings cited on p. 4, footnote 5.

> order to meet with friends and colleagues. Above all, levels of assistance do not permit the payment of rentals in decent housing suitable to the health condition and the more feeble state of many older persons. While we want older persons, even those on old-age assistance, to maintain their social contacts and to remain a part of their communities, we make this impossible by withdrawing all means of keeping up communication. The absence of a national minimum standard is a major contributing factor.

In its June 1966 report,[30] the Advisory Council on Public Welfare recommended:

> A minimum standard for public assistance payments below which no State may fall.

Here is another component of the retirement income picture that should receive careful study in a coordinated effort.

D. Financial Implications of Home Ownership

Among problems of income maintenance in old age which were brought to the committee's attention during 1967 are those related to steadily rising real property taxes on homes owned by this age group. In testimony before the committee, Mr. Milton Shapp, Chairman of Public Policy for the National Council on the Aging, said:[31]

> Since so many people over 65 are homeowners, attention must be drawn to another inflationary trend, in the form of local and State real estate taxes. This committee may want to look into the effects on the income of older people of the total tax burden, including various State and local taxes, which vary so widely from place to place * * * the older people have no chance of getting any other income; they are completely locked in, their pension or social security funds are the only sources of revenue they have, whereas a younger person, even though working at a fixed salary, has the opportunity of getting an increase in salary, and has the opportunity of changing jobs or things of this sort. * * *
>
> * * * there is nothing you can do here except consider some kind of a national deferment or abatement. Some of the States are getting into this now. In other words, either a deferment or abatement plan whereby, if there is any increase in local taxes in order to support the needs of a local community, these people on fixed income are not forced to pay an ever-increasing percentage of their funds to meet the local taxes and therefore sink down lower into the poverty level.

In a statement submitted at the same hearings, a dim view of special real estate tax concessions for the elderly was taken by Dr. Yung Ping Chen, department of economics, University of California, Los Angeles, who said:[32]

> Any tax concession is an act of tax discrimination * * *.

[30] P. 15, "Having the Power, We Have the Duty," report to the Secretary of Health, Education, and Welfare of the Advisory Council on Public Welfare, appointed pursuant to sec. 1114 of the Social Security Act, as amended in 1962.

[31] Pp. 14–16, hearings cited on p. 4, footnote 5.

[32] Pp. 279–280, hearings cited on p. 4, footnote 5.

Tax favors to the aged mean tax disfavors to younger persons, assuming that a given level of tax revenues is raised. Tax concessions are, in effect, subsidies. The case of tax favors must, therefore, rest ultimately upon the economic circumstances of the aged vis-a-vis those of the nonaged.

Several major arguments have been advanced for special tax consideration in behalf of the aged, all of which are somewhat related, only some of which apply to any specific measure. It is said that many of the aged have fixed or declining incomes, which, due to retirement, have little chance of being offset by higher future incomes. Further, it is said that they tend to incur higher living costs because of medical and drug expenses and expenses for personal care. Moreover, it is pointed out that older persons tend to spend a larger proportion of their incomes for housing, thus bearing a special burden from a tax on housing. Also it is argued that the aged do not benefit directly from certain property taxes which primarily support Government expenditures for schools. These arguments, when considered separately, may seem to provide a persuasive case for the aged. However, such arguments deal only with certain specific income and expenditure items, but fail to consider that the taxpaying ability of a person, young or old, must be judged according to his total budget requirements and wealth status, in addition to his income.

Dr. Chen went on to advocate measures to increase incomes of older Americans, to enable them to bear increasing property taxes more easily.

That there are financial advantages, as well as disadvantages, of homeownership by older Americans was brought out in a statement submitted by Dr. Sidney Goldstein of Brown University, based upon an investigation carried out with a grant from the National Institute of Child Health and Human Development. He advised the committee: [33]

Because home equity plays such an important role in the asset position of aged persons, considerable attention has been given to its relevance for the economic welfare of the aged. One such analysis by James H. Schulz (1967), tried to estimate for 1960 "imputed" rental income emanating from homeownership by the aged. His findings suggest that "inclusion of imputed rent in the income of low-income aged families would shift the measured distribution of income upward considerably."

* * * * *

Among older units represented in the survey, 68 percent of (families) headed by persons 65–74 years of age and 65 percent of those in the 75-and-over age category reported owning their own homes.

* * * * *

Would these owners be better off if they disposed of their homes and used the cash income from increased investments

[33] Pp. 269, 270, 278, Hearings cited p. 4, footnote 5.

for other purposes? On the average, the median market value of the owner-occupied housing of aged units was $9,858 for those in the 65 to 74 age group and $8,805 for those age 75 years and over. The amount of actual equity in these homes is not available. If it is assumed that equity was 80 percent, and that income received from a reinvestment of funds would be 5 percent per year, the average annual money income would be increased by approximately $400 and $350 for the two aged groups, respectively. These are, of course, only average figures and will vary considerably in individual cases.[34] Moreover, since the market value of owner-occupied housing varies directly with income level, the income gains for the lowest income groups will be considerably less. For example, among the aged 65 to 74 with incomes $1 to $1,999, the market value is $6,893 and the estimated annual income for reinvestment would therefore only approximate $275. The average amounts of added income are, however, greater than the differentials between the housing costs of owners and renters. This suggests, that, providing they find housing at rental values equal to those paid by renters, the owners would be able to use the added income to cover the higher costs of housing and still, on the average, have some additional income available for other purposes.

All other things being equal, this argues in favor of the aged selling their homes and moving to rented quarters. It overlooks, however, both the significant noneconomic factors involved, including the social-psychological value of continuing to live in one's own home, and the whole question of the physical quality of the owned versus the rented housing. Without additional information on these considerations, especially in view of the fact that the average net gain in income would be only several hundred dollars, a realistic appraisal of the relative merits of retention or sale cannot be offered. The data do suggest that, compared to those who rent, aged homeowners are economically in a better position; they might be in a still better one if they sold their homes and used the income from investment for rent and also for raising their level of living by spending more on other categories of goods and services. But then again, the costs, in noneconomic terms, may be too high.

Homeownership gives many older Americans their biggest single, and most important, tangible asset. Attention should be given on a national scale to problems related to homeownership in order to give States and municipalities data helpful to them in formulation of tax policy. This committee will encourage and assist all efforts to generate such attention.

[34] "It would also be possible to estimate the distribution of the principal over the remaining years of the units' lives so that the assets would be exhausted by the end of that period. This would increase the annua average income by a considerably greater factor. (See, for example, Epstein and Murray, 1967.)"

CHAPTER II

EMPLOYMENT AND SERVICE OPPORTUNITIES

Older workers are classified by the Department of Labor as those who are "having difficulty in getting or keeping a job principally because of age, or of characteristics ordinarily associated with age." For statistical reporting purposes, the age of 45 years and over has been used for this employee group.

Within recent years, older workers have received considerable attention, not only because of their numbers—they comprise two-fifths of the total labor force—but also because their problems are so severe:

- Their labor force participation rates fall consistently, increasing rapidly as age advances. (And yet, the average 55-year-old man has 12 additional years of work ahead of him, or more than one-fourth of the average entire work-life expectancy.)
- Median income steadily declines after age 45.
- Once unemployed, older workers remain unemployed substantially longer than younger workers; some may never find a job again.[1]

Important breakthroughs to cope with such problems made 1967 a remarkable year of accomplishment. A landmark bill to ban age discrimination became law.[2] The Department of Labor renewed emphasis on older worker programs and established Operation Mainstream, which has enlisted considerable numbers of individuals past 45 in Project Green Thumb and other significant projects. The foster grandparent program received widespread praise and broadened its scope of operations. An Institute of Industrial Gerontology was established, and there was increasing acceptance of the need for an older Americans community service program.

I. THE ANTIDISCRIMINATION BILL

Purposes of this legislation[3] were emphatically expressed by President Johnson in his message to Congress on aid for the aged:

> Hundreds of thousands not yet old, not yet voluntarily retired, find themselves jobless because of arbitrary age discrimination. Despite our present low rate of unemployment, there has been a persistent average of 850,000 people aged 45 and over who are unemployed. In 1965, the Secretary of Labor reported to the Congress and to the President that approximately half of all private job openings were barred to applicants over 55; a quarter were closed to applicants over 45.

[1] Additional details on "Factors Affecting Labor Force Participation of Older Workers," a study prepared by the Bureau of Labor Statistics, are given on p. 203 of this report.

[2] Introduced on Feb. 3 by Senator Ralph Yarborough with 9 cosponsors; signed by President Johnson Dec. 15, 1967, Public Law 90–202.

[3] Summary of major provisions appears on p. 194.

> In economic terms, this is a serious—and senseless—loss to a nation on the move. But the greater loss is the cruel sacrifice in happiness and well-being which joblessness imposes on these citizens and their families. Opportunity must be opened to the many Americans past 65 who are qualified * * *. Though 23 States have already enacted laws to prohibit discriminatory practices, the problem is one of national concern and magnitude.

Testimony taken during 1967 made a strong case for enactment of the antidiscrimination laws. Among the major points made: [4]

1. Economic loss caused by age discrimination includes more than three-quarters of a billion dollars a year in unemployment insurance.

2. Many of the most common reasons given for refusal to hire older workers are based on false premises.

The National Association of Manufacturers,[5] for example, submitted reports showing that: contrary to widespread belief, pension plan costs are not markedly increased when older workers are hired; mature workers generally maintain better attendance records than younger employees, and are also superior in their attitude toward work; many new job opportunities for mature people are opening up with the growth of service industry and the increase in automatic machinery that reduces the need for physical strength. The NAM also gave its official statement of policy on employment practices for employment without undue regard to advancing age:

> Older workers represent countless years of rich and seasoned experience, judgment, and stability, and constitute an immensely valuable asset in the Nation's work force. Employers are urged to observe voluntary hiring practices which give consideration to skill and abilities rather than to any arbitrary age factor.

3. Erroneous attitudes about the effects of age on work performance can have insidious results. Secretary of Labor Willard Wirtz said, for example:

> There is increasing evidence that in a large number of cases in which reduced productivity appears—say between ages of 55 and 65—it results from the individual's reaction to the prevailing practices and attitudes regarding the effects of age, rather than from the individual's age itself.[6]

Experience from the manpower development and training program, said the Secretary, shows:

> That while younger trainees perform better "on the average", 40 percent of the older trainees are also "above the average".
>
> That while younger trainees do better in the shorter training courses, especially where perceptual-motor skills are involved, the older trainees often average higher than those who are younger where the courses are longer and involve larger judgment factors, and

[4] See "Age Discrimination in Employment," hearings before the Subcommittee on Labor (Senator Ralph Yarborough, chairman), Committee on Labor and Public Welfare, U.S. Senate, March 15, 16, and 17, 1967. Hearings on H.R. 13054, the House companion bill, were held before the House Education and Labor Committee on Aug. 1, 2, 15, 16, and 17, and the bill was reported from that committee on Oct. 23.

[5] P. 323, hearing cited, footnote 4.

[6] P. 38, hearing cited footnote 4.

> There are infinite possibilities of job redesign which would permit the use of older workers' skills with substantial net advantage to employers.

EDUCATION AS WELL AS ENFORCEMENT

Penalties against discrimination, however vigorously applied, will have potent, but not total, effectiveness in reducing older workers' problems. To combat misconceptions that cause such problems, the new law also calls for education, research, and information programs. The vital need for such activity was described by Andrew J. Biemiller, legislative director of the American Federation of Labor and the Congress of Industrial Organizations:

> Since one of the biggest needs in eliminating discrimination in employment is getting rid of attitudes about older workers which are not substantiated by the facts and in making employers and other persons understand the capacities and potentialities of older workers, these provisions are of great importance in aiding the substantive provisions of the bill. We are glad to see them * * *.[7]

With passage of the law, attention now turns to implementation Secretary Wirtz, well aware of the difficulties inherent in any program to ban bias—which can effectively be disguised in a large number of ways—acknowledged at the hearing that many administrative difficulties can be expected, including coordination gaps with States that already have enacted antidiscrimination laws.

Dr. Harold L. Sheppard, social scientist at the Upjohn Institute for Employment Research, described other areas of concern in testimony before the Senate Special Committee on Aging. If the antidiscrimination law is to open new employment opportunities, he said in effect, it becomes all the more important to develop appropriate retraining resources for those workers. Asking for more flexible techniques as well as intensified efforts, Dr. Sheppard said:

> I think we are going to be seeing an increasing need in the years to come for people in the labor force to be less narrowly specialized in their skill than in the past. I said "need." I don't know about recognition of need. Those are two different things. It is the task of educators—and here I have a broad definition of education: legislators, it is a function of this committee to educate—there is an increasing urgency to get people to recognize this need.
>
> There will be an increasing need for people not to be overly specialized during their work years. *At least, they should be better prepared to exercise a variety of occupational skills, to be prepared three times or four times to acquire new kinds of skills through formal education or through on-the-job training during their adult working lives.* [Emphasis added.]
>
> Now, the question is, Who is doing what and doing it now to cope with these emerging needs? Is our educational system doing it? Are our vocational educational systems doing it? Are our employers doing it? Are the unions doing it? Are the various governmental programs doing it? I have many doubts about this * * *.

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[7] P. 96, hearing cited p. 25, footnote 4.

I think the dynamics of our labor market in the 1970's, 1980's, and 1990's will be such that technology will be changing, requiring new skills and different skills of people affected by technological change. I think we will continue to see as a symptom or a concomitant of a dynamic economy, plant shutdown, plant movings affecting, usually, for the most part, older workers. And those older workers affected by shutdowns, whether we are talking about the Packard plant or the Studebaker plant, those we know about more dramatically, those older workers who have been trained in and know only one skill are going to be at the greatest disadvantage in the labor market.

We have not created the institutions to make it possible for them to be acquiring more than one skill. This is going to be very important as the years come before them.

He added:

We don't have the right manpower to train older workers. We are going to have to be training new people in these special techniques, not merely stealing present teachers and trainers in order to work with the older-worker problem, because then you get into the fight about scarce resources.

Again, what is the Government doing, what are the universities doing, the other schools doing, to train a new cadre of specialists in older-worker training?

I am sure the answer is zero on this except for one or two so-called experiments which are very often publicized, giving me the feeling that we have been brainwashed so that we believe the country as a whole is doing this on a wide scale.

I think that the use of television by different agencies and programs could publicize the potentials and the actualities of older workers to the general public and to employers.

Also, we are going to be needing a number of regional workshops with personnel people and supervisors, and so on, to really make this law effective.

Finally, we can't merely start this program, pass this law and maybe appropriate x million dollars and expect automatically that the Labor Department or HEW or what have you, is going to hire people who automatically are prepared to implement the law. They are going to need orientation and reorientation.

Right now our efforts in the field of older worker specialists in this country are very meager. They still haven't been basically mandated throughout our manpower system. I think this new law will provide an opportunity for it. It certainly creates a mandate for it.[8]

Turning his attention to research programs authorized by the antidiscrimination law, Dr. Sheppard said:

I am sure that the Department of Labor * * * will want to do some intensive multiple classification of data that they probably already have holding several things constant at once.

[8] "Long-Range Program and Research Needs in Aging and Related Fields," hearings before the U.S. Senate Special Committee on Aging, Washington, D.C., December 5-6, 1967, p. 107.

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The trouble with so much of the information we have about this field as well as others, is that we will be given tables talking about just occupation of older workers versus young, just industry or just region. But we are going to need tables that show all three of these simultaneously so that you can zero in and pinpoint what industries, which industries in which occupations in which regions of the country have low proportions of older workers compared to other industry-occupation-region categories—low relative to what we know about the supply of older people in those same regions. That is the critical point.

More pinpointedly, we need to be getting analysis of the new hires by employers, their age distribution.

The other is that we are going to be needing programs to help employers train older workers either on the job or in vestibule training prior to any kind of employment similar to MDTA * * *.

The committee finds that Public Law 90–202 (Age Discrimination in Employment Act) is rich in potential usefulness and that it will speed the other changes necessary for full and effective use of older workers in ways that will strengthen the economy and that will also reduce the serious loss in happiness and well-being of those now unemployed or underemployed solely because of age.

The committee recommends the broadest possible discussion and exchange of ideas on implementation of the law, and the committee invites suggestions for assuring that the legislation will be far-reaching in its effectiveness.

II. DEPARTMENTAL EMPHASIS ON OLDER WORKER PROGRAMS

A Department of Labor report [9] to this committee describes "renewed emphasis" on the Department's older worker programs. Widespread reevaluation of individual programs is underway. Operation Mainstream, the name given to several work programs for chronically unemployed adults of all ages, provided 7,991 job opportunities by June 30, and 58.3 percent of the participants were aged 45 and over. Not the least of the developments was the establishment of a new position, that of Special Assistant for Older Workers. In addition, the U.S. Employment Service issued a contract to the National Council on the Aging for the founding of a National Institute of Industrial Gerontology.

The institute has a potentially far-reaching assignment. It is expected to:

- Develop curriculum components for training of employment service counselors and other responsible personnel, at whatever level desired and/or required in serving older worker applicants.
- Develop research relationship between selected State employment service agencies, researchers, and universities in the States.

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[9] Text on p. 196ff of this report.

- Conduct a seminar on industrial gerontology for selected State employment personnel and labor and industry specialists responsible for developing older worker services.
- Develop plans for an ongoing National Institute of Industrial Gerontology program relationship between the Federal Bureau of Employment Security and State agencies.

III. OLDER AMERICAN COMMUNITY SERVICE

Long advocated by this committee, the concept of an older Americans community service program gained increased recognition during 1967. Legislation to enlist the elderly in service programs received considerable support at hearings late in the year, but the major step forward was taken administratively by the Department of Labor in its plans for establishment of a program intended to fulfill, at least on a broad demonstration basis, several fundamental purposes of the legislation.

A. The Legislation

Major purposes and provisions of Senate bill 276 [10] were described by its chief sponsor at hearings conducted on September 17 and 18: [11]

> S. 276 has a dual intent.
>
> It is intended to encourage local sponsors to organize entirely new service programs enlisting the services of older Americans, and it is intended to support existing private or public service programs that are already serving community needs by mobilizing the talents and energies of the elderly.[12]

To achieve both purposes, the program would work in the following way:

> On the local level, potential sponsors of service programs—and the sponsors could be public agencies or nonprofit private organizations—would study the service needs of their communities, and they would undoubtedly find that there is much that could and should be done.
>
> Once the high-priority needs of a community have been identified, the potential sponsor would be in a position to plan the organization of a work force, which would be open to persons of age 60 and over.
>
> The sponsor may decide that a small force of older persons should be given short-term training and be paid a modest sum. The bill makes it possible to pay up to $1,500 a year for each participant. This amount would keep all individuals within the present social security maximum,[13] yet allow sponsors the flexibility to pay varying rates of pay, if circumstances warrant.
>
> In some communities, a private organization may well be the logical sponsor of a service program. Several senior citizens corps programs are, in fact, already underway in cities of widely varying populations. Directors of such programs

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[10] Introduced by Senator Harrison A. Williams (Democrat, New Jersey) together with 18 cosponsors; 47 Members of the House of Representatives have introduced identical or similar bills.

[11] Conducted by the Special Subcommittee on Aging (Senator Edward M. Kennedy, chairman), U.S. Senate Committee on Labor and Public Welfare.

[12] P. 205, hearings cited, footnote 11.

[13] Maximum earnings limit raised to $1,680 by 1967 Social Security amendments.

have discovered that their very worthy activities often face a fundamental difficulty—the participants find that it costs them money to give service. Bus fare, for example, can be a burden to a person who lives on a tight budget. Perhaps clothing requirements and other expenses cause problems.

Private organizations often find, too, that the directors of such programs begin on a part-time basis but often find themselves working around the clock. Even a small infusion of funds would help keep such programs going and growing; but usually there is no help to be found.

The bill introduced today would make it possible to provide some help for private organizations when their objectives meet the specifications of the older Americans community service program.

Sponsors, public or private, would submit their proposals to the State agency responsible for formulating State plans for the elderly as provided in the Older Americans Act of 1965. Upon approval by the designated State agency, the proposal would be submitted to the Administration on Aging in HEW.

Among the criteria that would be considered by the Administration on Aging in considering proposals would be the following:

First. Close coordination, wherever appropriate, with the Department of Labor, the Office of Economic Opportunity, and all other relevant Federal and State programs, and there must be efficient use of the experience and programs of these agencies.

Second. The program must include whatever short-term training—no long-range job training projects are contemplated—necessary for effective use of skills and talents of participants.

Third. The programs would be developed, conducted, and administered with maximum feasible participation of persons of age 60 or over.

Nine million dollars would be authorized for the first fiscal year and $15 million for the second. Local sponsors would have to make a 10 percent matching payment in the second year.

Service opportunities.—Community Service needs were described as legion. The following examples were given:

Aides, receptionists, and visitors in hospitals and nursing homes, especially in those for the long-term ill.

Aides in health-screening programs and to the aged and others returning to the community from mental hospitals.

Assistants in day care centers for children and for the aged.

Classroom assistants in schoolrooms, particuarly to help potential school dropouts.

Teachers of functionally illiterate adults.

Workers in central meal services for older people and information-referral centers.

Companions and visitors to homebound elderly persons, assistants in libraries extending their services to older people.

Organizers and workers in community improvement programs.

National organizations—including the Adult Education Association, National Education Association, the American Library Association, the National Recreation and Park Association, the American Nursing Home Association—sent spokesmen to testify on service deficiencies in their areas of responsibility. Their conclusion was that the

elderly would play an important role in providing such services. The very existence of a new Federal program would undoubtedly stimulate additional suggestions. As Eone Harger, president of the National Association of State Units on Aging, expressed it:

> When a source of help becomes known, unimagined possibilities for service evolve.[14]

ADMINISTRATION ON AGING EXAMPLES

Additional examples of service by elders were given by AOA Commissioner Bechill[15] in an account of several AOA-assisted projects. Among them:

> NASHVILLE, TENN.—A title III project * * * is including older citizens in the activities of Outlook Nashville—a volunteer organization which involves the lay community in the social rehabilitation of their handicapped neighbors. Older persons and teenagers are being recruited and trained to serve as lookouts to the aged, handicapped and as partners in a grandparent-PAL team. Friendly visiting services to aged and handicapped individuals will be stressed. The grandparent-PAL team approach is unique in that it enables an older person and a young person to provide a service by working together which neither could offer alone. Thus, the grandparent assumes responsibility while the PAL does the "leg work." While their work together has as a primary goal benefits for a third person, a valuable byproduct is expected to be a better understanding and acceptance between the older and younger generations. The program hopes to attract persons who can afford to volunteer their time as well as those needing to supplement their income; persons who have limited services to offer in a protected setting and those who might find satisfaction from providing a limited professional service.
>
> LOS ANGELES.—A senior volunteer service program * * * under a title III grant is training older persons who are willing to serve as volunteers in the provision of a variety of needed social services in the community. These older persons conduct art classes and supervise social functions for needy children, provide library services in hospitals, and act as ward aides in a local veterans hospital. The program represents a concerted effort to give due recognition to the talents of senior volunteers in working with civic, education, cultural, recreational, health, and welfare groups.
>
> PORTLAND, OREG.—A project at Lewis & Clark College is developing and demonstrating a new service employment role for older persons. Fifty senior citizens are performing as replacement supervisors on public school playgrounds and in lunchrooms. The identification of this new role in the community provides added meaning to the lives of older persons themselves while broadening the definition of the potential

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[14] Hearings on S. 2877 (an earlier version of the Williams' bill) and S. 3326 (a "Talented American Senior Corps" introduced by Senator George Smathers), before Special Subcommittee on Aging, U.S. Senate Committee on Labor and Public Welfare, May 24, 25, and June 15, 1966; p. 77.

[15] Hearings cited, p. 29, footnote 11, p. 14.

resources available to a community with which it can meet its education program requirements.

NEW YORK CITY.—A title IV project operated by the Community Service Society of New York is demonstrating that a group approach to recruitment, placement, and training increases significantly the retention of members of a corps of older volunteers and the satisfaction they find in their work. Many assignments are to institutions for the mentally retarded and handicapped, and other locations in which senior volunteers participate. This project is providing services to institutionalized persons which would not have otherwise been available.

Need for national focus.—Success of scattered individual projects was reported in many other statements received by the subcommittee. A clear need was felt, however, for Federal action that would provide national visibility and a more total sense of national commitment to the concept of community service by elders. For example, Mrs. Fred Weiser[16]—in testimony describing the Senior Service Corps projects sponsored by the National Council of Jewish Women—saw the proposed Federal program as a source of practical help for volunteer programs on a national scale:

> The initial findings of our pilot projects are only a first step. This is one of the special functions that a voluntary organization is best able to perform—it can take the pioneering steps, make the first mistakes; and find out what to do and what not to do. However, to be of national scope, and to have impact in it throughout the country, it is essential that funds be provided for staff, for local administration and promotion for resources of trained professional personnel to work with older adults and the agencies they serve.
>
> We have also abundant documentation that even in a voluntary service program, transportation and out-of-pocket expense must be available to some of the volunteers.

Advocates of programs that would pay elderly participants also saw a need for accelerating the development of similar programs elsewhere with Federal encouragement and assistance.

Still another reason for national focus on the matter is simply the magnitude of manpower resources that could be tapped. Former Secretary of Health, Education, and Welfare John W. Gardner—commenting at a different hearing on the need for a "helping corps," as he called it—made this appraisal:

> To the typical man retiring at 65, retirement means at least 25,000 hours of "extra time" for the balance of his life expectancy. Male retirees alone now number well over 5 million. *The total time freed by this even amounts to over 100 billion hours.*[17] [Emphasis added.]

Mr. Gardner made it clear that he does not expect all retired persons to build a "community service component" into their later years:

[16] Hearings cited, p. 29, footnote 11, p. 185.

[17] "Retirement and the Individual—Survey Hearing" by the Subcommittee on Retirement and the Individual (Senator Walter Mondale, chairman), U.S. Senate Special Committee on Aging, Washington, D.C., p. 6.

* * * Older people, like all others, vary greatly in their desires, interests, and needs; and we should not presume to judge what will be best for them.

Some will want to work until the day they drop; others will want to pitch horseshoes; others will want to watch someone else pitch horseshoes. Some will want to be part of a community; others will want to be alone. Some will want to remain in their hometown; others will want to be footloose. So we must design a society in which older people have choices. And in designing such society, we shall have to work harder on some choices than on others. It's already fairly easy for the older person to be alone; it is often much harder for him to find companionship and friends. It's already easy for him to find a park bench to sit on; it is much harder for him to find useful work.

Making much the same point, John Edelman [18] indicated that the possibilities for an elderly oriented service program are nevertheless enormous:

* * * America is suffering from the absence of skills, talent, and knowledge which exist as a vast reservoir among our older people. Not all the elderly are capable of work after retirement. But there are many—perhaps as many as 2 million or more over 65 and perhaps 5 million over 60—who have time, experience, and an active desire to serve others. But they don't know how or where to begin or they lack the technical assistance and facilities.

(Mr. Edelman's percentage estimates of likely nationwide response are similar to the percentages actually found in one State. A recent Massachusetts study [19] showed that 20 to 30 percent of a sample group of elderly individuals said they would welcome part-time activity.)

Once begun, a truly national program would probably enlist many individuals who would not now even think of participating. Such was the view of Professor Robert Morris of Brandeis University [20] in testimony before this committee:

American communities could easily expand the opportunity for community service activity on the part of retired persons along lines already introduced by the Office of Economic Opportunity and by various nonprofit and voluntary associations in local communities. What is needed, however, is an expansion of these opportunities on a mass basis. Most of these experiments have reached a very small number of persons who would normally gravitate to such activities anyway. They reach the individuals with the highest education, the highest incomes, and the greatest involvement in the same community services during their earlier years. What is needed is the expansion of such opportunities for persons who have seldom, if ever, engaged in such activity and who have less education.

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[18] President, National Council of Senior Citizens, p. 52, hearings cited p. 29, footnote 11.
[19] "New Roles for the Elderly," p. 124, hearings cited on p. 29, footnote 11.
[20] Hearings cited, p. 27, footnote 8, pp. 34-35, 28.

He also said,

> * * * such ideas have been advanced from time to time. They are going to require some kind of agreement about a national policy, to give the direction for action, and that national policy I think is going to have to be backed up with certain kinds of incentives. I don't think that social agencies or business or labor is able to take this initiative by themselves. Without such national policy and incentive, small-scale experiments are unlikely to become widespread.

OTHER ARGUMENTS FOR PROGRAM

1. Income supplement: Though not designed as a vast employment effort, the program would nevertheless provide small salaries in some cases. With approximately one-third of today's older Americans living in poverty, and with many millions of others denying themselves goods or services they need, even modest pay is no small consideration. Monetary reward for work also has an important effect on morale, alleviating, in the words of one witness, "the dread * * * that there is no longer a place for them in the present scheme of things." [21]

2. Practical assistance to volunteers: As testimony from the National Council of Jewish Women and other organizations so forcefully argued, large numbers of volunteers—including many elderly individuals—now perform vitally needed social service without any hope or desire for pay. Senate bill 276, as already reported earlier in this chapter, would give other kinds of practical assistance to volunteer organizations and thus help them to become even more useful than they are now.

3. Strengthening Federal-State-local approach: The Older Americans Act of 1965 was clearly intended by the Congress to speed development of statewide aging programs rooted strongly in community initiative. Senate bill 276 would require close teamwork among Federal, State, and local government with overall leadership from the Federal Administration on Aging. Thus, the proposed program would help fulfill the purposes of the 1965 law. Arguments for this approach were given by a chairman of a State unit on aging, Monsignor Joseph T. Alves of Massachusetts:

> * * * The idea of community planning in the local municipalities on behalf of the elderly cannot be ignored. The Massachusetts Commission on Aging has become an avenue in the Commonwealth for creating and implementing the structures for facilitating that concept known as creative federalism. The proposed service corps would serve to augment the Commission's functions in the realm of community organization and consultative services to local councils for the aging and voluntary agencies.[22]

4. Long-range significance: Monsignor Alves also saw the proposed program as having other important objectives:

> Enactment of this amendment would be another step on the road to dignity for many citizens aged 60 and over. It

[21] Hearings cited, p. 29, footnote 11. Testimony by James C. O'Brien, assistant to the president, National Council of Senior Citizens, p. 51.
[22] Hearings cited, p. 29, footnote 11, p. 124.

should not be necessary to review in depth at this time the values that can accrue to our communities and the Nation as a result of the working participation of our older Americans in public service projects. Specifically, learning about community service organizations and agencies, participating in decisionmaking, and contributing to the comfort and pleasure of others in society *will benefit the elderly and our society as much as the GI bill did a generation ago for the individual veteran and the country.* [Emphasis added.]

* * * * *

The Monsignor's words have even more significance in view of current expectations that longevity will increase, perhaps dramatically, within the next few decades, even as the portion of a lifetime spent in the work force dwindles.[23] Dr. Ewald Busse, president of the Gerontological Society of America and director of the Center for the Study of Aging and Human Development at Duke University, discussed long-range implications:

As health improves and education and the standard of living go up, expectations of life go up. Therefore we must anticipate that as the adults of today move into retirement and the latter years, they will undoubtedly have greater expectations than those of the present and past. I believe that there are many people—and there will be more in the future—who feel that they have a need and a right to continue to contribute to society. These people should have the privilege of making choices as to how to meet those needs.[24]

B. Alternate Proposal by Secretary Wirtz

The Secretary of Labor, testifying on S. 276, applauded its objectives, but asked whether it might not disrupt all chance of developing a comprehensive national manpower program that would serve all age groups. Mr. Wirtz made a counterproposal which, at the time this report was in final preparation, had been implemented on a scale somewhat less than originally planned, but noteworthy nevertheless.

Department of Labor viewpoint.—Mr. Wirtz was emphatic about the need for new service roles for the elderly:

* * * the vitally important fact about S. 276 is that it recognizes that beyond the social security that we have been talking so much about *there is the crying need in people's lives for continuing "social opportunity" and for the need to be useful as well as to be secure.* [Emphasis added.]

There is not much more I can add to my previous efforts to stress * * * the essential importance of work and service opportunity for older people. I don't suppose it is the most pressingly urgent business before our country today. And yet, I think it is entirely likely that we will look back later on our continuing inattention to this particular matter, and to our ironic encouragement of the idea of "retirement" as being a good thing. We will look back later on that as being one of the real marks of our present immaturity as stewards of life's experience.[25]

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[23] Additional discussion of changing retirement patterns appears in ch. VIII of this report.
[24] Hearings cited, p. 29, footnote 11, p. 48.
[25] Hearings cited, p. 29, footnote 11, p. 108.

Further:

> I expect before we are through with this, we are going to find a whole new concept on what people do after age 60 or 65. I don't think we are looking 50 years ahead. I think we are looking 5 or 10 years ahead. I see the emergence, with the development of technology and the affluent society, and all that kind of thing; I see the emergence of a whole new concept of what people do, are supposed to do, and how they are paid for it, how they are compensated for it after they finish what we presently call employment.[26]

The Secretary's misgivings about the bill were based on the premise that the legislative establishment of a new work and service program, to be administered through a set of agreements between Federal and State agencies, would cause duplication of effort and a slowing down on forward motion: [27]

> I admit to a certain sensitivity to the fact that no day passes now and no day has passed I suppose in the last year without there being some criticism, usually responsible criticism, of the complexity and the lack of coordination of the national manpower program. It has become a typical, almost patterned complaint that there are so many different programs—one day they say 10, another 15, another 20—so many different programs administered by so many different Federal, State, and local agencies that their effectiveness is substantially impaired.[28]

Testifying on a similar bill in 1966, the Secretary had proposed that a comprehensive strategy for the older worker should be created by all Federal departments that, under existing authority, had some responsibility in manpower development. A lesser approach, he suggested, could misshape the healthy growth of an interdepartmental program.[29]

A plan for action.—Secretary Wirtz' proposal, made at the 1967 hearing, called for:

ONE: Establishment of the type of program proposed by S. 276 by joint action of the Department of Health, Education, and Welfare; and the Department of Labor; within existing statutory authorizations, within the existing administrative structure, and with reliance upon appropriations already recommended to the Congress for approval.

TWO: A division of responsibility assigning projects involving unpaid volunteers to the Department of Health, Education, and

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[26] Hearings cited, p. 29, footnote 11, p. 113.

[27] Hearings cited, p. 29, footnote 11, p. 108.

[28] The Department of Health, Education, and Welfare expressed similar sentiments the day before Secretary Wirtz testified. William Bechill, Commissioner of the Administration on Aging, said:

"In addition other programs are being established under present provisions in the Economic Opportunity Act and the Manpower Development and Training Act. Government-sponsored programs such as Project Green Thumb, VISTA, and SCORE and privately sponsored programs such as the International Executive Service Corps are providing opportunities for retired individuals to put their know-how to the best use. The Administration on Aging is working with the Department of Labor and the Office of Economic Opportunity on new ways in which funds already appropriated by the Congress can be more effectively used to develop opportunities in the areas of full-time employment, part-time employment, and voluntary services.

"In determining whether a major new national community service program is now needed, these existing programs must be taken into account. While we definitely do have the authority to administer the type of program proposed in S. 276, it is our opinion that at this point in time, in view of existing economic and budgetary considerations, our best course lies in strengthening those programs which have already been established rather than in adding one more to their number." Hearing cited, p. 29, footnote 11, p. 16.

[29] Hearing cited, p. 31, footnote 14, pp. 116–117.

Welfare; and those projects involving training or paid work to the Department of Labor.

Secretary Wirtz said he would seek early implementation, and he assigned his special assistant for older workers to devote full time in working out this project.

President Johnson announces contracts.—Just before work was completed on this report President Johnson awarded contracts that, in effect, establish an Older Worker Community Service on a demonstration basis.[30]

The National Council on the Aging is required under a $1,051,411 contract to: establish pilot community senior service programs in 10 localities and to use this experience to demonstrate benefits, feasibility, and potential of this type of program. The NCOA, a nonprofit agency which has already been associated with other programs that enlist participants past 50 years of age in service programs, envisions three levels of service in a community service program: (*a*) voluntary service with no renumeration; (*b*) voluntary service with field expenses paid for those who cannot pay for such items as transportation, meals away from home, or other similar expenses which participation in such a program may require; and (*c*) service on a part-time or temporary basis at an hourly wage which would usually reach $1,500 to $1,600 a year.

A second contract was awarded to the National Council of Senior Citizens. The $1,129,520 agreement requires the Council to establish senior aides programs in 10 communities in order to open up socially useful part-time jobs in community service and to fill those jobs with low-income jobless individuals of age 55 or over.

Establishment of two major pilot programs intended to fulfill several objectives of the proposed older American community service program is a welcome and timely step that can provide great impetus to the next appropriate goal—development of a comprehensive national program using all available resources at the Federal, State, and local levels.

The committee recommends that appropriate congressional units and Federal agencies keep close watch on the two new demonstration programs, with special attention to such questions as: (1) establishment of work relationships with State agencies on aging, (2) effect on existing programs in which unpaid volunteers participate, (3) the role of the Administration on Aging in future development of additional programs, and (4) further refinements of training techniques suitable for older persons preparing for part-time work (similar to techniques already employed in such projects as Operation Medicare Alert and Operation Green Thumb.)

IV. SPECIAL-PURPOSE SERVICE PROJECTS

As the outlines of a national program on community service begin to take shape, three special-purpose programs funded through the

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[30] Statements by President Johnson and Secretary Wirtz at the Feb. 15, 1968, White House ceremony appear on p. 206 of this report.

Office of Economic Opportunity are continuing to demonstrate the vitality and usefulness of elderly Americans in significant areas where services are vitally needed.

A. Foster Grandparents

Approximately 3,800 persons were participating at the end of the year, working in 154 institutions. A report from the Administration on Aging, which administers this program, appears on page 178 of this report.

B. Green Thumb

One thousand two hundred were participating by the end of the year in seven States, working to beautify highways and on other projects intended to make special use of the talents of retired farmers. The program is part of the Department of Labor's Operation Mainstream, described on page 198 of this report. Under a renewal of the Green Thumb project contract announced by the President on February 15, 1968, $3.5 million has been allotted for Green Thumb for 9 months, which represents a doubling of Green Thumb financing for 1968 over 1967.

C. Project FIND

Discussed in chapter VII.

CHAPTER III

COSTS AND ORGANIZATION OF HEALTH CARE

Years of debate over medicare during the first half of this decade necessarily focused attention on crucial issues related to the financing of health care for the elderly. Within the last 1½ years as the new national health insurance system helped pay hospital and doctors' bills for millions of older Americans, attention has now turned to health-care costs—costs that have risen dramatically since 1965.

The increase as reported by the Department of Health, Education, and Welfare:

- Medical prices rose 6.6 percent in 1966, as compared to an average increase of 2.5 percent a year through 1960–65.
- Hospital daily charges jumped up 16.5 percent in 1966 as compared to an average 6-percent annual rise in the prior 5 years.
- Physicians' fees, which had been rising at about 3 percent a year from 1960 through 1965, went up 7.8 percent in 1966.

Figures recently released by the Department of Labor show that this precipitous rise continued throughout 1967. Between December 1966 and December 1967 the overall cost of medical care advanced another 6.5 percent over the already high level at the beginning of 1967. The sharpest increase was in hospital daily service charges, which advanced 15.5 percent during 1967.

Sharp differences in opinion about the reasons for the increases were discussed at length during the past year. The administration called several conferences [1] and has received or will receive recommendations on individual problem areas. Several possible contributing factors are also discussed in this chapter. Whatever emerges from the continuing scrutiny and debate on current practices, it is safe to say, as one eminent authority on health care organization did say last year:

> * * * the problem of rising costs is going to be one of the strongest educational instruments to clarify that our system of providing health care is not as efficient and effective as it could be. Throughout the whole history of medical care developments in the world, the problem of rising costs has stimulated improved patterns of organization.[2]

To direct public attention to health care organizational deficiencies of special importance to the elderly, the Health Subcommittee of this committee has begun a study of "Costs and Delivery of Health Services to Older Americans." [3] Testimony taken thus far has resulted in several interim findings and recommendations.

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[1] For summary of conferences and reports, see p. 209.

[2] P. 91, Dr. Milton I. Roemer, professor of public health, University of California, Los Angeles, Calif., at a hearing, "Costs and Delivery of Health Services to Older Americans," by the Subcommittee on Health of the Elderly (Senator George Smathers, chairman), Senate Special Committee on Aging, Washington, D.C., June 22–23 and New York City, Oct. 19, 1967.

[3] Hearings cited in footnote 2.

I. IMPACT OF MEDICARE

Medicare and medicaid [4] have already raised some levels of health care and helped dissipate the fear of financial disaster in the case of catastrophic or sustained illness in later years. Nevertheless, the two programs have also had adverse effects that should be eliminated or alleviated; and there is some evidence that some low-income elderly under part B of the medicare program may be paying more now for care than they did in the past.

Until medicare came into being, the No. 1 problem of older Americans undoubtedly was the fear, and often the bitter reality, that they could not pay for vitally needed hospitalization and other health-care costs, especially those that mount markedly in the case of chronic illness.

Some measure of the impact of medicare can be made simply from the size of the program. Latest available information [5] shows that:

1. Hospital insurance protection (part A) [6] is extended to 19.3 million Americans. Supplementary medical insurance (part B) now covers more than 17.9 million Americans.

2. Their insurance coverage, according to an HEW memorandum [7] issued on January 3, had yielded:
   - $3.1 billion for inpatient and outpatient hospital services for 5.3 million hospital admissions.
   - $1.18 billion for physicians' bills and other medical services.
   - $275 million for the 400,000 admissions to skilled nursing homes providing extended care services.
   - $40 million for services rendered by 250,000 home-health plans.

3. In addition, the number of medical facilities rendering services under the medicare program increased during the year, reaching the following totals: 6,888 hospitals, 5,343 extended-care facilities, and 1,880 home-health agencies.

Medicare is leaving its mark, not only upon the individuals who were relieved of heavy financial burden and worry, but also upon the organization of services. Most of the effects are positive. Some are causing concern.

A. Medicare as a Force for Improvement

Fundamental to the philosophy of medicare is that the program should raise, not lower, the quality of health care for the elderly and, indirectly, for the entire population. That philosophy was evident in the description of progress toward that goal given to the subcommittee by a panel of witnesses from the Department of Health, Education, and Welfare.[8] Key excerpts:

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[4] The term "medicare" is used to refer to the insurance-type programs authorized by title 18 of the Social Security Act, as enacted in 1965, which helps those over 65 to pay hospital and doctors' bills and related health care charges without a showing of financial need. "Medicaid" is the program authorized by title 19 of the act, also enacted in 1965, which, in States that cooperate and share in financing the program, provide for "medically indigent" individuals of all ages assistance with health care charges on a means-test basis.

[5] Letter from Commissioner Ball of the Social Security Administration appears on p. 211.

[6] Part A of medicare helps pay for hospital bills and certain followup care and services. Part B of medicare, usually referred to as "supplementary medical insurance," helps pay for doctor bills and a number of other medical items and services not covered under the part A hospital insurance program. Unlike part A, for which there is no charge, a monthly premium is required for part B coverage.

[7] Text on p. 187.

[8] Pp. 3-36, hearings cited p. 39, footnote 2.

* * * one major contribution of medicare * * * has to do with raising the quality of care provided older patients.

Providers of service have been required to meet specified standards. For extended-care facilities and home-health agencies, these standards were the first to be nationally recognized.

Professional organizations such as the Joint Commission on Accreditation of Hospitals and the American Osteopathic Hospital Association have been stimulated to reconsider their own standards with the aim of raising them.

States are reviewing and strengthening their licensure programs in ways closely akin to the certification process under medicare.

A special effort is being made by the Social Security Administration to assure the quality of performances by independent clinical laboratories through raising their personnel standards.

Medicare standards have provided benchmarks for determining the adequacy of care now provided by our health resources.

For example, the survey of hospitals—including both participants and those denied participation—showed that 46 percent had some deficiency and that 89 percent of the extended care facilities needed to improve their operations to meet medicare's quality goals.

With this information in hand, we developed a program of consultation and training for State health departments to assist them in their facility certification process and to equip them with sufficient technical and program know-how so they can, in turn, assist the operators of facilities in their efforts to achieve the standards.

For the elderly patient and his family, these standards and our efforts to improve them mean a growing confidence in the quality of care purchased.[9]

* * * * *

Medicare has also made available insured alternatives to hospital care. These include: hospital outpatient service where that is appropriate for diagnosis or treatment; and posthospital extended care and home health care, where further stay in a hospital is not the most appropriate level of care. Also included is the coverage of physicians' services for home and office visits.[10]

From a hospital administrator's viewpoint also,[11] the progress was heartening:

* * * Part A of title 18 has been the most successful component of this multifaceted program. Hospital care is being rendered to the aged of our community as a right, and has relieved those persons from a terrifying burden. On the whole, hospitals are now on a firm, viable financial footing for the first time in their history. The program has had a salutary effect on standards of hospital care, especially in its insistence

[9] Pp. 24–25, hearings cited p. 39, footnote 2.
[10] P. 9, hearings cited p. 39, footnote 2.
[11] P. 386, hearings cited p. 39, footnote 2.

> on utilization committees and review. In our own institution we are expanding the function of the utilization review committee to encompass the whole area of medical audit and quality control * * *

Among other long-range dividends expected from medicare are: (1) medicare will more clearly show the need for, and hasten the development of, area-wide community planning of all health, medical, and manpower resources, (2) more doctors may be encouraged to specialize in geriatrics, and (3) the requirement that participating medical institutions conform to title VI of the Civil Rights Act is intended to give members of minority groups access to high-quality care.

B. Medicare: Areas of Concern

Just about every witness who directed the subcommittee's attention to possible shortcomings in medicare prefaced his remarks by saying that he emphatically supported the program and wanted it to increase or improve its coverage, rather than to withdraw it.

Limitations on Coverage: As foreseen by its designers, medicare covers only about 40 percent of the aggregate medical care of the elderly, according to a Social Security spokesman who described the gaps:[12]

> The items not covered include such things as drugs, eye glasses, hearings aids, psychiatric care and hospital care beyond 90 days. Also excluded are expenses deriving from the coinsurance provisions that I mentioned and the deductibles.
>
> The hospital and other benefits of part A of medicare probably pay for 25 percent of the aggregate costs of older persons and part B probably pays for another 15. That is where we get the total. For persons who are hospitalized the combined benefits cover perhaps half of their aggregate medical expenses. In other words, people who are hospitalized have higher expenses, and medicare covers a higher percentage of those expenses than is the case where the person is not hospitalized.

Of the items not now covered, costs of prescription drugs apparently are the most troublesome to many medicare participants. The subcommittee record shows more requests for medicare coverage of drugs than on any other kind of coverage. Similar sentiment has been expressed by members of Congress and the National Council of Senior Citizens. The Secretary of Health, Education, and Welfare is conducting a study on a proposal to establish quality and cost standards for drugs for which payment is made under the Social Security Act,[13] and a proposal to cover drugs under the medical insurance program. He is required to report his findings and recommendations to the President and the Congress by January 1, 1969. Two other studies now under way may also ultimately increase medicare coverage. The Health Insurance Benefits Advisory Council of the Social Security Admin-

[12] P. 20, hearings cited p. 39, footnote 2.

[13] In addition, President Johnson's 1968 Health Message recommended that "the Congress authorize the Secretary of Health, Education, and Welfare to establish a reasonable cost range to govern reimbursement for drugs now provided under medicare, medicaid, and the maternal and child health programs."

istration is reviewing the utilization of services under medicare and making recommendations for program changes. The Secretary is also studying the extension of coverage under the medical insurance program to the services of additional types of licensed practitioners performing health services in independent practice.

Deductibles and coinsurance.—Hospitalization insurance, or part A of medicare, simply requires that the first $40 of a hospital bill be paid by the individual patient, not by medicare. In insurance parlance, this is a "$40 deductible." The beneficiary must pay the first $10 per day of hospital charges for the 61st through the 90th day of hospitalization in a spell of illness and the first $20 of each day's charges during any days after the 90th day which he may use from his 60-day "lifetime reserve." These are "coinsurance" charges.

As to part B—the voluntary program of supplementary medical insurance—the beneficiary must pay the first $50 of each year's covered charges himself, without any part B reimbursement. This is known as the "deductible." Of each covered charge during that year over the first $50, he must pay 20 percent, the "coinsurance."

Coinsurance and deductibles under part B came in for considerable criticism at the hearings, largely on the grounds that these requirements might have actually *increased* costs for some low-income participants most in need of its help, indicated in this statement by the Rev. Lucius Cervantes, Professor of Sociology at St. Louis University and Assistant to the Mayor of St. Louis: [14]

> An elderly person can be much worse off with medicare as it now stands than he was before without it.
>
> Where before medicare he might have managed, for example, to stretch his $60 monthly social security and $37 State old-age assistance checks to cover rent, food, clothing, and incidentals he is no longer able to do it because he now has deducted $3 a month under title XVIII plus $50 deductible and finds that he must pay $86 per year and then 20 percent of the health service balance when previously he was paying half that for his total doctor's bill.

Howard C. Ohlendorf, chairman of the Planning Committee on Aging, Health, and Welfare Council of Metropolitan St. Louis, gave additional details: [15]

> With the advent of medicare, older individuals qualifying under the program, who previously used the outpatient clinic services provided at city hospitals, are now billed the full fee for a clinic visit, whereas prior to medicare, they were billed approximately one-eighth of this amount. This is very frustrating to many of them who are living on reduced or fixed incomes and cannot afford to pay this fee. Once the hospital has billed the patient in the amount of the $50 deductible, they are no longer billed for services. They are, however, charged the 20 percent of the full clinic fee at each clinic visit. If the patient could not pay the $50 deductible fee, or the following 20 percent, this is collectible under medicare as a bad debt. It would seem that some different way of handling this situation could be arranged to alleviate

[14] P. 121, hearings cited p. 39, footnote 2.
[15] Page 133, hearings cited p. 39, footnote 2.

the personal suffering and worry on the part of the older patient.

A similar complaint was registered by Dr. James G. Haughton, first deputy administrator of the Health Services Administration for the city of New York: [16]

> To our dismay we find that medicare has, in some instances, increased the cost of care to the elderly. In New York City, patients who previously paid $1 or $2 for a clinic visit, are now required to pay 20 percent of a $20 per visit clinic fee or $4 and 20 percent of the doctor's fee of $8 when, previously, the same doctor provided his services in the clinic without compensation. A $1 or $2 premedicare visit is therefore costing the patient $5.60.
>
> Physicians in private practice have taken the position that because medicare is available they can now charge their full fee to the elderly patient since he is only required to pay 20 percent of the fee. The fact is, however, that in some cases 20 percent of the doctor's prevailing fee is more than he charged an over-65 patient of limited resources before medicare.

Summing up the case against coinsurance and deductibles, William Hutton of the National Council of Senior Citizens said: [17]

> Many aged sick would rather suffer in silence than admit they cannot produce the $40 for the first day of hospitalization, the initial $50 for doctor bills, or subsequent one-fifth of all doctor costs as coinsurance for medical insurance.
>
> The people I am talking about, Mr. Chairman, include many proud Americans whose sweat and toil helped to make this country great. They don't wish to admit their failure by throwing themselves on the mercy of the welfare people and taking advantage of medicaid. It might be pointed out here, however, as it has been by Mr. Edelman, that only 29 of our 50 States have medicaid programs in operation. Elderly poor in 21 States are out of luck insofar as meeting the deductibles and coinsurance features of medicare are concerned even if they are prepared, in their desperation, to go the welfare route.
>
> The truth is that the deductible and coinsurance features of the medicare program merely discriminate against the elderly poor who need the most help. Any hospital administrator will tell you that deductibles and coinsurance are not necessary to control utilization and they certainly will not control abuses. People with plenty of money never have much difficulty getting into a hospital.
>
> Frankly, the National Council of Senior Citizens fought against the inclusion of deductibles in the original King-Anderson bill, and after 1 year of their operation in the medicare program we are even more convinced that we were right.
>
> Our medicare program is a program of social insurance but the use of deductibles and coinsurance comes strictly from

[16] Page 507, hearings cited p. 39, footnote 2.
[17] Page 55, hearings cited p. 39, footnote 2.

the practice and thinking in commercial casualty insurance. The basic concept of fire, auto, marine, et cetera, insurance is the pooling of risks to protect against loss from undesirable and often preventable accidents. The deductible is promoted as a guard against carelessness—or paying the consequences.

But in today's world everyone requires health services. Modern medicine embraces preventive care and health maintenance as essential elements. The casualty insurance concept simply does not fit in a medicare program established as an element of our social insurance system.

Asked by subcommittee chairman Smathers to estimate the effects of reducing or eliminating deductibles, the Department of Health, Education, and Welfare indicated "a concern that health services be available to all aged persons who need them and that medicare beneficiaries should not be deprived of care they need," but added, "we are not prepared to make any recommendation to modify the deductible or coinsurance provisions." [18]

Mr. Robert J. Myers, Chief Actuary for the Social Security Administration, also submitted a report in which he estimated that the cost of eliminating the part A deductible and coinsurance (not including the coinsurance on the 60 days of lifetime reserve, which was enacted later) would be approximately $510 million annually, or about 0.17 percent of taxable payroll. Mr Myers estimated that eliminating the part B deductible and coinsurance would require that monthly premiums be more than doubled by an increase of $8.25 of the combined monthly premium per beneficiary, at a cost of about $860 million from the general fund of the Treasury, and a similar aggregate increase of premiums charged part B beneficiaries.[19]

The HEW reply also observed: [20]

One point to consider in this connection is that a reduction in cost sharing which carried with it a substantial increase in premiums might have the effect of reducing enrollment in medical insurance with the entire medical care costs being borne out-of-pocket rather than only the deductible and coinsurance. Such larger out-of-pocket payments would have a greater inhibiting effect on use of care than would present cost sharing.

Reimbursement under part B.—Doctors' bills are reimbursable under part B only to the extent that they do not exceed an amount considered reasonable. This provision came under attack from critics at the New York hearing who said: (1) some physicians had set their fees considerably higher in the months before medicare began in order to collect excessive amounts now, and (2) that as one New York State senator expressed it, "nothing in the legislation prohibits a doctor from charging his patient any amount in excess of the 'reasonable and customary fee'." [21] In other words, if the doctor's fee is higher than the usual charge, the patient must make up the difference, even after having paid the deductible and coinsurance on the amount of the bill which is considered reasonable.

[18] Page 22, hearings cited p. 39, footnote 2.
[19] Page 23, hearings cited p. 39, footnote 2.
[20] P. 22, hearings cited p. 39, footnote 2.
[21] P. 433, hearings cited p. 39, footnote 2.

A still more fundamental point was made by Dr. Martin Cherkasky, the same hospital administrator who had found so much to praise in part A: [22]

> It is becoming increasingly obvious that the way services are paid for has direct and immediate implications on the way services are delivered and organized. There is really no such thing as just a program for financing health care. Part B of medicare, although making specific allowances for prepaid group practice, really is a payment system designed to expand and enrich solo, fee-for-service practice. In one stroke it effectively sabotages the movement toward broad, comprehensive total coverage for the aged. Among its major defects is the lack of payment for preventive health examination. Further, it separates doctor services from hospital, from extended care and nursing home service. Payment is made to physicians on the basis of charges or fees, and to institutions on the basis of costs. The aged patient is confused and harassed by deductibles and coinsurance.

Still in the early stages of its inquiry, the Subcommittee on Health of the Elderly cannot now make recommendations on deductibles, coinsurance, and reimbursement. It would draw the attention of those now studying aspects of the program, however, to these observations from Dr. Cherkasky: [23]

> You know, all of us * * * thought that part B was going to pay for medical costs, for doctors' costs. When one considers the hospital benefit deductible and coinsurance, the lack of coverage for drugs and dental care, it is safe to say, I believe, that less than 50 percent of the total medical-care costs incurred by the aged are being covered by title 18, parts A and B. This is a far cry from what we thought we were doing with this legislation.
>
> The main message, however, that I wish to bring to your attention this morning is one of principle and concept. *Structurally, the fundamental defect in title 18 is the separation of part A and part B. This separation is unfortunate not only because of its administrative difficulties which have turned out to be legion but because it has tended to freeze existing modes of medical practice and prevented major innovative developments in the delivery of health services.* [Emphasis added.]

The implications of Dr. Cherkasky's statement are vast, but certainly well worth careful attention in the continuing evaluation of the vitally needed, historic medicare program.

Three-day hospitalization requirement.—Title 18 requires [24] that a beneficiary be hospitalized for a minimum of 3 days as a condition to eligibility for extended care and home health care benefits. Testimony received by the subcommittee leads to the conclusion that instead of saving medicare funds, this requirement results in unnecessary hospitalization and unnecessary expenditures in order to qualify elderly patients for that which many of them really need, extended care or home health care benefits, both of which are less costly than hospitalization.

[22] P. 394, hearings cited p. 39, footnote 2.
[23] Page 387, hearings cited p. 39, footnote 2.
[24] Subsecs. (i) and (n), sec. 1861, Social Security Act.

Testimony received by the Subcommittee on Health indicates that the present requirement brings undue pressure to bear upon the physician to hospitalize his elderly patients whether or not hospitalization is necessary, in order to qualify them for these types of medicare benefits. This generates serious ethical problems for the physician, inasmuch as medical ethics forbids unnecessary hospitalization. The dilemma facing physicians of many medicare beneficiaries was graphically presented by one of the witnesses at the subcommittee's first hearing,[25] who testified:

> This man should be in a nursing home * * * the total bill for the nursing home would be $1,400. Now, if he admits that patient to the hospital for 3 days * * *, he can then transfer the patient to the nursing home and instead of paying $1,400, the patient pays $400.
>
> * * * by admitting this patient to the hospital for a workup which is not really necessary but which could be medically justified, he will save the patient $1,000. Now in a situation like that what do you do? Do you admit the patient for 3 or 4 days of hospitalization so you can save him $1,000 or do you send him directly to the nursing facility?
>
> These are tough questions in medical ethics.

It is therefore not surprising that many physicians question this 3-day requirement and that the American Medical Association has adopted a resolution [26] urging its elimination.

To summarize, the subcommittee sees four advantages to eliminating this requirement:

1. Its elimination would prevent unnecessary charges upon the Federal hospital insurance trust fund resulting from unnecessary hospitalization to meet the 3-day requirement;
2. Unnecessary occupancy of scarce hospital beds would be prevented;
3. Unnecessary strains upon the consciences and ethical principles of physicians would be prevented; and
4. Freedom would be given the physician to order the type of care which he deems best for the patient, without having to concern himself with the patient's eligibility for medicare benefits.

Some new type of procedure, however, would have to be substituted to assure that assigning the patient to an extended care facility or to home health service is medically justified. Dean George James of the Mount Sinai School of Medicine, New York City, when asked if he favored the elimination of the 3-day requirement, answered: [27]

> I would be in favor of sound methods of evaluating the medical care of the patient rather than the counting up the number of days he has been in the hospital for eligibility.

Dr. Milton I. Roemer, professor, School of Public Health, University of California, Los Angeles, said: [27]

> I think the important consideration in medicare is to require a diagnostic workup of the patient, with perhaps

[25] P. 42, Dr. William A. Nolen, surgeon of Litchfield, Minn. Hearings cited p. 39, footnote 2.
[26] Full text of resolution is reproduced on p. 223 of appendix.
[27] Page 94, hearings cited p. 39, footnote 2.

> specified standards being written in as a condition for nursing home admission * * * It would serve the individual better and probably then it would save money in the long run * * * Some of the 3-day hospital admissions now are essentially abuses; the management of the patient did not really require hospital admission * * * I think many individual physicians would be able to do a proper diagnostic workup in a private office.

Therefore, it appears that while the 3-day requirement cannot be eliminated without substituting some type of safeguard, it might well be eliminated when such a substitution can be made.

> **The committee recommends dispensing with the 3-day medicare requirement where it is possible to make an objective determination, by means of a diagnostic workup or otherwise, concerning medical justification for assigning a beneficiary to an extended care facility or authorizing home health care services for him, and where such determination has been made.**

II. IMPACT OF MEDICAID

Medicaid was designed to free low- and moderate-income persons of all ages from the economic consequencies of illness while giving them access to high quality medical care. A new classification—"medically indigent"—was devised in order to direct medicaid assistance to the poor and to families or individuals whose income might be technically above traditional welfare levels, but who were nevertheless unable to pay for such care when it was needed.

One measure of the potential importance of the program is the number of U.S. jurisdictions that have accepted the medicaid challenge. Latest reports show that 37 States and three U.S. territories had programs in operation under title 19. They are:

California	Massachusetts	Oregon
Connecticut	Michigan	Pennsylvania
Delaware	Minnesota	Puerto Rico
Georgia	Missouri	Rhode Island
Guam	Montana	South Dakota
Hawaii	Nebraska	Texas
Idaho	Nevada	Utah
Illinois	New Hampshire	Vermont
Iowa	New Mexico	Virgin Islands
Kansas	New York	Washington
Kentucky	North Dakota	West Virginia
Louisiana	Ohio	Wisconsin
Maine	Oklahoma	Wyoming
Maryland		

Older Americans are among the chief beneficiaries of this program, as these statistics [28] for August 1967 indicate:

—3,005,000 Americans of all ages received medicaid medical vendor payments during that month;

[28] "Medical Assistance Financed Under the Public Assistance Titles of the Social Security Act, August 1967," Social and Rehabilitation Service, Department of Health, Education, and Welfare.

—Of that number 1,124,000 recipients of medicaid were eligible on the basis of having reached the age of 65; and
—$102,500,000 of medicaid assistance went to these recipients who were eligible on the basis of having reached that age.

An appraisal of the ultimate value of medicaid is difficult to make at this point because of recent congressional cutbacks [29] and because of uncertainty by individual States. (At this writing, reductions in coverage were under consideration in New York and in Maryland. The California program, having survived one proposed rollback, was still under discussion.) The subcommittee will seek, in 1968, comprehensive data on the effect of such reductions in individual programs.

Even at this early stage in its study, however, the Subcommittee on Health of the Elderly has received testimony clearly indicating that certain features of the program bear close study because of their potential importance to the elderly.

A. Difficulties and Limitations

Difficulties in implementing title 19 (medicaid) were described by witnesses at the subcommittee's New York City hearing. One statement gave this summary: [30]

> Title XIX, because its implementation is dependent upon State enactments within very broad Federal guidelines, is very permissive * * *. As a result, the geographic mobility of the needy population is diminished by the need to live in States which provide liberal programs * * *. Residents of the poorest States may also suffer a serious disadvantage, since even the 17 percent matching which these States must provide may be beyond their means although the will to participate exists * * *.

Another difficulty was described in the same statement:

> * * * the most important weakness in the law. Title XIX is a public welfare law * * *. All eligibility, therefore, is based on proven need. This approach is particularly onerous to medically needy persons * * *. This is especially true of persons over 65 who have been independent all their lives and are especially proud of their continuing independence during their declining years and therefore refuse * * * to "barter their dignity for their health care."

This point was also made by representatives of community houses of New York City in replies to a questionnaire. One of them observed: [31]

> Many of the elderly in our neighborhood react very definitely negatively to the welfare context into which medicaid has been put * * * there are many individuals in this group

[29] Sec. 220 of the "Social Security Amendments of 1967" sharply restricts the power of participating States to fix maximum income limits for medicaid eligibility. After July 1, 1968, no Federal medicaid matching will be made for any family which has an income more than 150 percent of the highest amount which would ordinarily be paid in that State as cash benefits under aid for dependent children to a family of the same size without any income or resources. On Jan. 1, 1969, that percentage drops to 140 percent, and on Jan. 1, 1970 it drops to 133⅓ percent.

[30] P. 508, Dr. James G. Haughton, first deputy administrator, Health Services Administration, City of New York, hearings cited, p. 39, footnote 2.

[31] P. 528, Mrs. Celine G. Marcus, Lenox Hill Neighborhood Association, hearings cited, p. 39, footnote 2.

who refuse to have anything to do with welfare even though patently eligible.

Another questionnaire respondent reported: [32]

> Many elderly individuals react negatively to the welfare context into which medicaid has been placed. They complain bitterly that they spent a lifetime of struggling to live on incomes smaller than welfare standards in order to avoid the stigma of "relief." It is therefore hard to accept the welfare implications of medicaid. Many had to be talked into applying for medicaid because of this, many will not apply for this reason.

These same neighborhood house workers commented on a closely related problem—the requirement that medicaid applicants disclose their assets:

> * * * the elderly feel it is unfair to have to declare savings and also that the limits set on savings are unreasonably low.
>
> * * * * *
>
> These are the elderly people who are afraid that they do not qualify for medicaid because of the amount of their savings. Their greatest fear is that somehow these savings would be taken from them.

Fear of losing a nest egg is a big problem, as described at the same hearing by Miss Patricia Carter, of the Hudson Guild-Fulton Center: [33]

> In our center we have almost had to do it on a "you do me a favor" basis. We promise them that they are not going to have their nest eggs taken away, and if "you do me a favor you will apply. All you will get is refused, if you are not eligible."

Another medicaid problem has been the difficulty older individuals have in understanding the program and its requirements. Miss Helen M. Harris, executive director of United Neighborhood Houses, New York City, testified: [34]

> Literature about the program was confusing and hard to understand. Application forms were long, complicated, and too demanding. Producing the last eight wage stubs, bank balances, insurance policies, and savings accounts was often so difficult many an elderly person threw up his hands and refused to complete the application.

An illustration of the confusion of some elderly medicaid beneficiaries was given at the subcommittee's hearing in New York City by State Senator Seymour Thaler: [35]

> I had an elderly man walk into my office and he said, "Senator, I got a problem." He took out a billfold and he opened up a long line of glass-paned envelopes and he pointed to it and he said in broken English:

[32] P. 529, Maria Kron, Henry Street Settlement, hearings cited, p. 39, footnote 2.
[33] P. 440, hearings cited p. 39, footnote 2.
[34] P. 443, hearings cited p. 39, footnote 2.
[35] P. 432, hearings cited p. 39, footnote 2.

"This is my medicaid card, this is medicare, part A. This is my Blue Cross. This is my union health card because I am a retired member of the bricklayers union. And my medicaid card is limited because I have all these other things."

I said, "What is your problem?"

He said, "I got a bellyache, what do I do?"

Difficulties are also encountered when patients find that a doctor or a hospital exercises the option not to treat enrollees. Walter Newburgher, president of the New York City Congress of Senior Citizens, gave this account of the experiences of a man and wife:[36]

These people had easily qualified for medicaid. They have no savings at all, no other income except very modest social security benefits. The husband became so violently ill that the wife had no recourse but to call the police who immediately summoned an ambulance and he was transported to a city hospital.

The wife signed him in and then phoned her family doctor who was well acquainted with their financial status and the fact that they had been enrolled under medicaid. The doctor appeared concerned that the wife had signed her husband into a city hospital and suggested that she sign him out again and remove him to a private hospital where he could take care of him.

Upon her arrival at the suggested hospital she was asked to pay $75. Luckily she had just cashed her social security check. Some days later she received a bill for $35 from an anesthetist and at this point she appealed to me. I contacted the hospital and explained that these people were on medicaid, only to be told that this particular hospital does not take medicaid patients and that as far as they were concerned this man was on medicare.

The original payment was $40 to part A and $35 for part B. I then spoke to the doctor and reminded him that these people were enrolled in medicaid. He merely shrugged his shoulders and reiterated that this hospital does not take medicaid but that this was all they would have to pay. When I reminded him there was still the matter of the 20-percent coinsurance, he stated as a rule the surgeon accepts the 80 percent as a total payment.

A week later the man underwent surgery which produced another bill from the anesthetist which the wife was able to borrow from friends.

After the operation the surgeon notified the wife that he wanted to see her in his office. She went there with trepidation fearing that a malignancy had been uncovered. However, the surgeon explained to her that his fee for such an operation was $750 but all he would derive under medicare was $400, which evidently was all that the operation was worth. He would, however, in view of the couple's financial condition be satisfied if she would send him a money order for $100.

[36] P. 461, hearings cited p. 39, footnote 2.

The wife in her elation that no malignancy was involved borrowed the $100 and paid. Total cost $285, the equivalent of three social security checks, despite the fact that medical service without cost whatever was available under medicaid.

Growing dependence upon outpatient departments by medicaid recipients in hospitals that do accept enrollees is also causing concern. A medical director of a hospital gave the subcommittee this appraisal of the situation:[37]

> Older persons, the chronic sick, and children in ever-increasing numbers continue to seek care in the outpatient departments in hospitals in urban areas. The elderly are by and large the poor and the medically indigent, formerly the Kerr-Mills recipients and now the title XIX aged. *The care they receive in outpatient departments is fragmented, impersonal, and given with little dignity. There have been few efforts by the hospitals to give these aged persons services which include a plan of care, comprehensive in scope, with continuous responsibility by designated health personnel. Services have not been designed to maintain the older person independently in his community medically and emotionally secure with maximal usefulness to himself, his family, and society.*

B. Potential Usefulness of Prepaid Group Practice

Group, prepaid, practice of medicine—to be discussed later in this chapter—can be a useful means of providing medicaid benefits in those relatively few cities or communities where it exists or where it may soon be established. Under an arrangement of this type, the medicaid program pays a specified amount for each medicaid enrollee periodically to a group practice organization in return for its commitment to provide specified services to that beneficiary when care is needed. Advantages of this method were described by Mr. James A. Brindle, president of the Health Insurance Plan of Greater New York City.[38]

> Prepaid group practice can play a very important role in furthering continuity of care by having the family physician take responsibility for coordinating the whole course of treatment of a patient. The physicians in the group act as a team both when the patient is ambulatory and when he is hospitalized. He does not go from one clinic to another, from one physician to another.
>
> A critical component of prepaid group practice is its concern with preventive health services. Also, it goes beyond traditional medical care by utilizing social services and health education. These benefits apply in HIP to the 115,000 people enrolled under medicare and medicaid just as they do to the 645,000 other enrollees in the plan.
>
> Another characteristic of the group practice prepayment plans is that you do not have additional bills; the premium paid by the Government and by the member of the plan in

[37] P. 279, Dr. Frank F. Furstenburg, medical director, Sinai Hospital of Baltimore, hearings cited p. 39, footnote 2.

[38] Pp. 478, 481, hearings cited p. 39, footnote 2.

the case of medicare actually covers the cost and there are no large out-of-pocket payments to be made * * *

*   *   *   *   *

In 1951, 4 to 5 years after the start of service, HIP became part of a comprehensive study which compared morbidity levels, disability due to illness, and medical care practices in HIP and in the city at large. It was found that a larger proportion of the HIP membership saw a physician during the year; they were more likely to receive preventive health services; more of them had family doctors, pediatric care for their children, and dental attention, than did the general population. Also, HIP members appeared to have a lower threshold for recognizing acute illnesses and they tended to seek medical care earlier in the course of illness than was the case in New York City as a whole * * *

In fact, hospital utilization is substantially lower in HIP than in the fee-for-service medical insurance in this area.

TWO ADDITIONAL NEEDS

It is still too early to measure the ultimate effects of medicare and medicaid upon health services for the elderly, and additional attention will be given to that subject by the Subcommittee on Health of the Elderly. Two additional recommendations—related to both programs—are called for at this time:

The committee recommends educational programs to apprise the elderly of their rights, privileges, and opportunities under medicaid and other health programs for the elderly, of the procedures which must be followed to take advantage of these programs, and of their opportunities for prevention and early detection of illness and ill health in old age.

Dr. Cecil G. Sheps, general director of Beth Israel Medical Center, New York City, made an incisive observation about the need for educational efforts: [39]

Many old people, particularly the poor, who live in the slums of our cities, are isolated from adequate medical care. This is so not only because of the fact that * * * generally the services of physicians and others are not as readily available as in the more well-to-do areas, but also because *this important population group has not yet learned what good medical care means. Therefore thay do not have adequate expectations and do not make sufficient demand for the care which they ought to have.* [Emphasis added.]

Dr. Sheps called for "vigorous programs of special health education" to help the elderly understand what they have to gain.

Another statement of the need for better informational services for beneficiaries of medicare and medicaid was given the subcommittee by Mr. Frank Wallick of the legislative staff of the United Auto Workers. Drawing upon lessons learned from a widespread UAW consultation program, he said:

[39] P. 397, hearings cited p. 39, footnote 2.

> Many who came to see us did not fully and accurately understand the benefits under medicare. This is no reflection upon their mental ability because the law is extremely complicated * * * Confusion about procedures for claiming reimbursement * * * is the most common problem brought to us.

While the Senate was considering H.R. 12080, the proposed Social Security Amendments of 1967, Subcommittee Chairman Smathers introduced an amendment which would have directed the Secretary of Health, Education, and Welfare to conduct a full and complete study and investigation of the feasibility of instituting and conducting one or more informational or educational programs designed to result in the prevention or reduction in the incidence of illness and ill health among individuals covered by medicare. The Senate Finance Committee adopted this amendment, in effect, by including in its report on the bill a direction to the Secretary to conduct such a study and to report to Congress prior to January 1, 1969, as discussed in more detail in connection with the next recommendation.

In every way possible, the medicare programs should foster greater understanding of the need for health maintenance, concentrating on the prevention of illness, rather than almost solely upon treatment of it.

The committee is pleased to note the inclusion of the following passage in the report of the Senate Finance Committee on H.R. 12080, the Social Security Amendments of 1967: [40]

> Preventive health care, including periodic health examinations and disease detection services, can assist in reducing the incidence of serious illness. The committee believes that health insurance coverage of some of the costs of such examinations and services would reduce financial barriers to using preventive medicine and to early detection of disease and thereby might help to increase the use of such services. The result might then be to reduce serious and disabling illness as well as the need for more intensive and costly health care.
>
> The committee also believes that older people might profit greatly by being better informed concerning steps that they can take to prevent and treat illness. Many steps to improve health can be taken by the person himself if he were aware of their importance. Moreover, older people with health problems may not know of the health resources and treatment methods which are available to them.
>
> The committee, therefore, instructs the Secretary of Health, Education, and Welfare to conduct a study of the possible coverage under medicare of the cost of comprehensive screening services and other preventive services designed to contribute to the early detection and prevention of disease in old age, and the feasibility of instituting and conducting informational or educational programs designed to reduce illness among medicare beneficiaries, and to aid them in obtaining needed treatment. The Secretary will report to

[40] Pp. 70-71, S. Rept. 744, 90th Cong., 1st sess. (1967).

the Congress, prior to January 1, 1969, his findings and recommendations resulting from these studies.

This committee will anticipate the Secretary's report with great interest, and will cooperate with any efforts which may result to improve this Nation's efforts toward prevention of illness and ill health in old age.

III. THE OVERALL "CRISIS" IN ORGANIZATION

Medicare has made hospitalization more accessible for many elderly Americans, but the delivery of other kinds of health services—even through medicaid—is often hindered or made impossible by faulty organization of those services. Low-income elderly are major victims of fragmentation, inaccessibility, or nonexistence of services. Problems in central urban areas, where many elderly reside, seem to be on the increase and have caused a need for new modes of delivery for essential services.

Longstanding problems in the organization of health care are now, as we have seen, coming to light nationally because of the attention drawn to them by rising costs. Those problems, as they affect all age groups, were admirably summarized in the November 1967 report of the National Advisory Commission on Health Manpower. That Commission, concerned primarily about present and future national health personnel needs, discovered that merely increasing *numbers* of personnel would solve nothing; needed, too, were changes in organizational structure in order to make the best possible use of manpower. The Commission, coming "face to face with a paradox," also found: [41]

> On one hand, the numbers of physicians, hospital beds, and health services per person are generally equal to or greater than they were 30 years ago; research has vastly expanded medical knowledge; and the growth of private and public health insurance programs, along with Government support for the needy, have greatly reduced financial barriers to care. On the other hand, despite this apparently improved situation, there is widespread and serious talk of a "health crisis" in the country, a crisis which is believed to be upon us now or just around the corner. The indicators of such a crisis are evident to us as Commission members and private citizens: Long delays to see a physician for routine care; lengthy periods spent in the well-named "waiting room," and then hurried and sometimes impersonal attention in a limited appointment time; difficulty in obtaining care on nights and weekends, except through hospital emergency rooms; unavailability of beds in one hospital while some beds are empty in another; reduction of hospital services because of a lack of nurses; needless duplication of certain sophisticated services in the same community; uneven distribution of care, as indicated by the health statistics of the rural poor, urban ghetto dwellers, migrant workers, and other minority groups, which occasionally resemble the health statistics of a developing country; obsolete hospitals in our major cities;

[41] P. 1, report cited, footnote 40, p. 54.

costs rising sharply from levels that already prohibit care for some and create major financial burdens for many more.

There *is* a crisis in American health care. The intuition of the average citizen has foundation in fact. He senses the contradiction of increasing employment of health manpower and decreasing personal attention to patients.

A similar conclusion was reached by an eminent public health authority who addressed the subcommittee:[42]

While we have made a great deal of progress over the last 30 years in the United States in financing medical services, for both young and old, our social machinery for delivering those services has remained almost at a horse-and-buggy level. Perhaps it is a team of horses, rather than an old gray mare, that deliver the product, but medical care organization has hardly caught up to the motorcar era, let alone the jet plane.

The crucial fact is that most of the expanded economic support for health service has been applied to a framework of medical and dental practice in isolated individual offices and a patch quilt of hospitals, drugstores, and laboratories which are characterized by extravagance, inefficiency, and frustration for the patient and provider alike. Half the Nation's general hospitals are of under 100 beds—a size much too small to render optimal scientific services soundly and economically. Eighty-five percent of clinical physicians and 95 percent of dentists hold forth as solo practitioners, despite the enormous development of specialization demanding professional teamwork.

Thousands of small, independent drugstores dispense a bewildering array of drugs at very high prices, inflated by the cost of a fantastic volume of competitive advertising, robust manufacturing profits, and an elaborate network of middlemen between producer and consumer.

Dental treatment absorbs the scarce and expensive time of highly trained professionals, doing tedious tasks that could be readily assigned to technicians under supervision.

Preventive medicine is widely preached but seldom practiced, while geriatric rehabilitation is a fiction in the thousands of small proprietary nursing homes that accommodate the vast majority of chronically ill and aged patients whose numbers are increasing daily.

Though this is a grim capsule sketch, Mr. Chairman, it could be easily documented with reams of facts and figures. While American medical science at its best is capable of wonders in reducing disability and saving lives, these wonders are applied far less than they could be. Our age-adjusted mortality rates in the United States are higher than those of many other countries of lesser wealth and, at that, spending lower proportions of their gross national product on health care. The difference lies in the way we spend our health dollars. Our social machinery has simply not caught up with our scientific capacity.

[42] P. 81, hearings cited p. 39, footnote 2. Testimony by Milton I. Roemer, M.D., professor, School of Public Health, University of California, Los Angeles.

HOW CURRENT DEFICIENCIES AFFECT THE ELDERLY

Older Americans are certain to be major victims of service inadequacies or costliness, largely because their average income levels are lower and their rate of chronic illness [43] higher than for younger people. A further complicating factor is that many elderly individuals live in central urban areas, where city governments experience great difficulty in maintaining, much less raising, the quality of services for people who may have become dependent upon them in the absence of others. (In New York City, for example, nearly half the population receive their medical care at public expense.)[44]

A. The Common Problems

As the Manpower Commission report makes clear, deficiencies in health services are not limited to low-income groups. The subcommittee received moving documentation of that fact from Dr. Milton I. Roemer, professor of public health, UCLA. He told of difficulties encountered by his own father in California:[45]

> May I take the time of a distinguished committee of the U.S. Senate to tell of one aged patient who, like most old people, suffered from multiple diagnoses? He had a serious eye problem—actually two diseases: glaucoma and keratitis—for which he received care at a nearby medical center, in the department of ophthalmology. His personal doctor, a good internist, however, had diagnosed a mild diabetes, and for this periodic visits were necessary to an office 8 miles away. Painful corns and bunions, impairing the ability to walk, were not within the specialty of the personal doctor, so these required periodic visits to a podiatrist at an office 6 miles in another direction. Dental care, in an effort to save the few remaining teeth, so that dentures would fit more firmly and food could be more properly chewed, required numerous visits to a dentist at still another location.
>
> Then a bladder problem developed and prostatic disease was suspected. At about the same period, the patient showed lethargy and confusion, suggesting a mild cerebrovascular accident. The personal doctor made a home call and the decision was to hospitalize. A bed was not immediately available—except in a small proprietary hospital which the family refused—and it was not till 10 days later that he could be admitted to a good voluntary general hospital 15 miles away. After X-rays, cystoscopy, and other examinations there, his treatment was stabilized. In the workup, it was discovered that a drug the ophthalmologist had been prescribing for many months was causing serious side effects, which had been missed by the internist since these two specialists had never communicated with each other. The patient was then admitted to a sanatorium, selected for its

[43] Statistics from a Department of Health, Education, and Welfare study cited at hearings of the subcommittee during September 1966 show that chronic diseases affect almost half of our total population and more than 7 out of 10 persons aged 45 and over. Of the approximately 87,000,000 Americans with one or more chronic condition, 22,600,000, or more than one-fourth, report some degree of activity limitation.

[44] P. 6, Comprehensive Community Health Services for New York City, report of the Commission on the delivery of personal health services.

[45] P. 84, hearings cited p. 39, footnote 2.

closeness to the family home, so that visits from the patient's children would be possible daily.

This was one of the "better" nursing homes—it was certainly expensive enough at $32 a day paid by medicare—but this was evidently not costly enough to support a proper staff. After a few days, because of lack of proper surveillance, this aged patient was found roaming on the street. When this happened a second time, the commercial proprietor decided to discharge the patient as "too difficult to care for." It took 5 weeks of nursing care at home, with daily problems of incontinence of urine and feces, before a bed in another nursing home became available.

The latter facility proved to be better managed and the patient improved. After only 2 weeks, however, he was getting up from a chair one day, when he fell and fractured his left hip. This required an orthopedic surgeon, readmission to the hospital, and preparation for a major operation. But then complications to the diabetes set in, because of the traumatic shock of the fracture. A delay of over 24 hours in reporting a critical laboratory test nearly cost the patient's life at this time. Had the hospital been adequately staffed, this delay would not have occurred. A skillful operation, with a pinning of the broken bone, was done. Special-duty nurses costing $111 per day—over and above the medicare coverage of the hospital bill—had to be hired because of the shortage of regular hospital nurses.

I have not recounted the other details of multiple drug prescriptions, special services of an appliance shop to adjust the bed at home, the physical therapy required for a knee injury, and much more. This patient was my widowed father, who lived with my wife and me for 9 years after his retirement from 51 years of medical practice. My abbreviated account of his medical care problems applies only to the last year, or it would be much longer. Accounts like this could be told thousands of times over, each day in the United States, and would doubtless be more complex and disturbing for a family less well informed about the jungle of medical care delivery.

Elderly individuals who are merely trying to maintain their health with periodic checkups or receive routine treatment may experience other kinds of difficulties, even if they have the means to pay. A social worker now directing a citywide health service project in New York described the problem:

The elderly receive fragmented medical care. They may attend a union health center for an annual medical checkup; they may travel to an arthritis clinic, a heart clinic, or a diabetes clinic on different days in one or more hospitals, and may, in addition, visit one or more neighborhood doctors when they feel too ill to travel to clinics or feel they cannot wait long periods in the emergency rooms. *Different medications and courses of treatment are prescribed by individual doctors.*[46] [Emphasis added.]

[46] P. 450, hearings cited p. 39, footnote 2.

Dr. George James, former commissioner of health for New York City, and now dean of Mount Sinai School of Medicine in that city, told the subcommittee of one 76-year-old man who would have had to attend 10 different clinics to receive checkups and treatments for several ailments.

B. Low-Income Elderly in Urban Areas

For the elderly poor, problems of the kind described above are intensified and multiplied. As Dr. Frank F. Furstenberg, medical director of the Sinai Hospital of Baltimore, told the subcommittee:[47]

> The poor elderly also meet tremendous obstacles in obtaining needed health services. They are not only faced with inadequate numbers of health personnel for their needs, but such personnel is not present in their own neighborhoods. In addition, the elderly are faced with real transportation problems to reach the health resources available in their community. When public transportation is not available, the elderly often cannot afford substitutes such as taxi fare to hospitals or clinics. Organized medical services do not exist and physicians' services are often not available on nights and weekends and so the aged find themselves forced to use emergency services of hospitals where they receive fragmented care and certainly not a plan of care adequate to their needs.
>
> Some of the necessary services for sensitive care of the older person such as home health aides, visiting housekeepers, meals-on-wheels, social services, are in short supply or are simply not available. The entire concept and development of comprehensive health teams brought to the neighborhoods where the elderly live is yet to be implemented.

The subcommittee has received extensive information primarily from two cities, St. Louis, Mo., and New York City. Parallels were strikingly similar. Father Cervantes estimated that approximately 75 percent of the disadvantaged elderly in St. Louis were not receiving seriously needed medical assistance.[48] He related the difficulties in providing such services to the "central city overburden," or the rising demand for services in core areas where tax resources are already under heavy pressures. He added:

> It so happens that the city of St. Louis is already spending $25 million—one fourth of its limited budget—on its health services. It so happens that the administration and staff of this hospital system are unusually competent and dedicated. But it is also true that St. Louis as other cities should be spending far more to provide quality health services to their disadvantaged and medically indigent citizens. Municipal health services have deteriorated and this inadequacy of service is characteristic of the total spectrum of city services for the simple reason that the cities are all but bankrupt. We must bear in mind that the cities during the coming decade will have a revenue gap of $262 billion.

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[47] P. 278, hearings cited p. 39, footnote 2.
[48] P. 114, hearings cited p. 39, footnote 2.

The role of chronic illness in causing the budgetary strains was also described: [49]

> The problem of chronic illness in the Greater St. Louis area has been primarily a problem of the core city of St. Louis because of the unusually large number of persons 65 and over residing within the city of St. Louis. In the city of St. Louis in 1960, 12.3 percent of the total population was 65 and over. By 1970 it is estimated that it will reach 15.3 percent. By the same token in 1970 it is estimated that in St. Louis County the percentage will be 6.4 percent. To make this problem more apparent, almost 55 percent of metropolitan aged population resides in the city of St. Louis; whereas about 20 percent lives in St. Louis County. A public assistance picture adds another dimension to the extent of the problem of chronic illness. In the year 1963, of the 102,409 old-age assistance cases in the State of Missouri, 13.1 percent were located in the city of St. Louis as compared to 2.7 percent in St. Louis County. Of the total of the permanent and total disability group 29.1 percent were in the city of St. Louis and 4.3 percent in St. Louis County.
>
> It is estimated that there are some 24,000 cases of heart disease in the city of St. Louis, 22,000 cases of hypertension, 7,725 cases of diabetes, 12,225 cases of visual difficulties, 29,250 cases of hearing defects, and almost 10,000 cases of paralysis of one or more limbs due to either cerebral vascular disease or to other neurological deficits.
>
> The city of St. Louis has been and is now doing something about the problem of chronic illness and coordinating care. However, because of the extent of the problem and the late start, the solutions are not easy.

New York City, said Dr. James, is "aging by 20,000 persons a year," and by 1970 "we expect to have 1 million persons over the age of 65, making New York's aged the sixth largest city in the United States." And yet, in the face of growing numbers of the elderly in the city, the subcommittee was told by the city's health services administrator: [50]

> * * * *family doctoring has completely broken down in the low-income areas of this city, and I speak of areas with at least 40 percent of the city's population.* (Emphasis added.) This is simply because private physicians are no longer settling or practicing in these areas. So the old pattern is really no longer a workable reality, and as a partial result of the breakdown in this old pattern, we have the following situation here in New York City:
>
> Our city hospitals at any given time have at least 5 to 10 percent of their acute-care, general-care beds occupied by older people who are there because there is no other resource in the community. One could estimate the cost of this at $15 to $25 million a year in the city hospitals alone.
>
> We have in New York City a shortage of nursing-home beds, which we are in the process of correcting by construction planning largely under State loans. *There is, however, increas-*

[49] P. 127, hearings cited p. 39, footnote 2, testimony by Alex Morris, M.D.
[50] P. 362, hearings cited, p. 39, footnote 2.

ing evidence that we will have a problem of older people remaining in nursing homes simply because again there is no other appropriate place for them to go and live." [Emphasis added.]

* * * * *

What I really fear is that if the present trend continues where there are increasing numbers of aged where families are unable to care for their older members in their small apartments, where there are older people without families, and finally with the increasing shortage of neighborhood family doctors, that we shall have an immense institutional population of older people.

I fear this because while at times these institutions are necessary, most frequently they are the enemy of the older person and they, of course, will also represent a tremendous unnecessary drain on our tax dollar and our professional resources.

An example of the "breakdown of family doctoring" was provided in the Bronx neighborhood where the subcommittee hearing was conducted. The director of an OEO neighborhood center said: [51]

Thirty years ago the area we serve was populated by 25,000 people and had a minimum of 25 doctors' offices, many dentists and pharmacists practicing right in the area. At the present time the population has nearly doubled, to 45,000, and there are only five doctors practicing in the area, one on a part-time basis. There are six dentists, two of them on a part-time basis, and nine pharmacists. The need for medical manpower is critical.

At the present time the poor must make their way through a variety of emergency rooms, subspecialty clinics, and welfare services. For many the emergency room has become the chief source of medical care.

Many of the elderly are able to walk and do not require home care services. A large number, however, are somewhat disabled and require some home care services. Others are bed-bound and require the full range of a hospital-based program. Unfortunately, few hospitals have home care programs. For the great majority of the poor, home care health services do not exist.

A similar report was received from Dr. Leo Gitman, director of community health at the Brookdale Hospital Center, Brooklyn: [52]

We have compared the four least deprived health areas in our hospital community with the four most deprived. The population per physician in the former is 1,142, and in the latter 6,325. This is almost a six-fold difference. The age distribution of the physician is also significant. Eighty-four percent of the physicians practicing in the most deprived areas are over age 50, whereas 58 percent are over age 50 in the least deprived areas.

[51] P. 420, hearings cited p. 39, footnote 2; testimony by Dr. Harold B. Wise, project director, Montefiore Hospital neighborhood medical care demonstration.
[52] P. 490, hearings cited p. 39, footnote 2.

In two of the four most deprived health areas with a population of 43,000, there is a total of two physicians, one in the 66 to 70 and one in the 71 to 75 years age bracket.

INTERIM RECOMMENDATIONS RELATED TO HEALTH CARE ORGANIZATION

1. Neighborhood health centers similar to those now provided through an Office of Economic Opportunity program should be provided on a broader basis, drawing upon other Federal agencies in order to yield widest possible service where most needed.

Discussion.—Section 211–2 of the Economic Opportunity Act provides grants to establish comprehensive health care centers for the poor of all ages. As pointed out by the OEO Acting Director for Health Affairs, Dr. Joseph T. English, "the guidelines under which such centers are planned have particular relevance to the aged poor, since age and infirmity often increase the barriers to health care beyond the barrier of poverty alone." [53]

Dr. Harold B. Wise, Director of the Bronx OEO Neighborhood Medical Care Demonstration project visited by the subcommittee, described the OEO concepts in actual practice: [54]

> We have organized a health system where the services are simple for patients so that you don't have to go to a left heart doctor and a right heart doctor and a kidney doctor, you go to your doctor and if he needs a specialist and he is called in for a consultation then your doctor carries out the treatment. It sounds old fashioned but I am talking about a family doctor.
>
> To the family doctor we have added a nurse and a family healthworker and we have organized the way we practice so that we can do it with fewer doctors than most institutions do it. So if most institutions need one doctor per thousand, we think we can give equally good or better medical services by using fewer doctors and giving the work that doctors don't have to do to public health nurses and family healthworkers.
>
> The family healthworker has extended our care so that she goes into the home and looks after many of the nursing and social service activities and really works together with the doctor as a team to extend his hands. That is how we have organized it and we have recruited in our training program people from the area and trained them for the positions. We think that there are many people now working with us as family healthworkers or health technicians who under different circumstances would be doctors had they been given the opportunity, and we are going to approach various agencies to see if they can be given this opportunity. There is no reason why somebody in a community who has displayed his competence as a medical technician cannot go on and become a doctor or a family healthworker and go on and become a nurse.

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[53] P. 567, hearings cited p. 39, footnote 2.
[54] P. 417, hearings cited p. 39, footnote 2.

The Bronx project is affiliated with a progressive New York City hospital and has attracted a well-qualified staff. Nevertheless, difficulties arise because of the magnitude of need and because of other problems. Dr. Wise gave the following recommendations for more widespread utilization of the project concept, and his recommendations undoubtedly would have application elsewhere:[55]

1. Provide training funds to demonstrate the various kinds of employment for the elderly in the health and social service fields.
2. Make certain that every urban renewal or Federal housing project has consulted a hospital with a home care program and has provided for flexible housing, housekeeping maintenance and provision of meals for a large percentage of the elderly.

   Provide for a recreation facility to be part of every new project, with required consultation with the elderly for these projects.
3. That funds now available for hospital construction be made available for health center and home care facility construction, and that financial incentives for home care services be strengthened.
4. Five-year grants. The most time-consuming and wasteful procedure of the health center program is the necessity for annual grant submission. Because of this regulation, it is very difficult to recruit professional staff where they cannot be assured of long-term contracts. In addition, key staff spends considerable time preparing for new fund requisitions.

CAN "PARTNERSHIP FOR HEALTH" HELP?

The "partnership for health" legislation (Public Law 89–749) was held by several witnesses as a possible means of developing new health services where needed most.[56] Dr. Carruth J. Wagner, Assistant Surgeon General in the U.S. Public Health Service, said that the "Federal-State-local partnership"[57] can be of help, but only individual communities can identify obstacles to good health care and make their own plans to overcome them.[58] A representative[59] of the Hospital Planning Assocation of Allegheny County, Pittsburgh, said that delivery systems can be improved—with reduced costs for comparable service—through comprehensive planning of all health agencies in a city, county, or region. He said that Public Law 89–749 "could have the most profound impact on the cost of delivering quality health care to people."

Dr. Cherkasky, the director of the hospital associated with the Bronx Neighborhood Center, also saw widespread potential usefulness of partnership for health, but he had a suggestion for even more direct action:

> I believe that partnership for health legislation is a great step forward. If properly done, it will permit for the first time some kind of coordinated and integrated planning for health services on a regional and community basis. It will

[55] P. 421, hearings cited, p. 39, footnote 2.
[56] President Johnson's Health Message of 1968 asked Congress to appropriate $159 million for partnership for health in 1969, an increase of $35 million over fiscal 1968.
[57] P. 32, hearings cited p. 39, footnote 2.
[58] P. 32, hearings cited p. 39, footnote 2.
[59] P. 218, hearings cited p. 39, footnote 2.

also provide some modest amount of funds for individual agencies to develop certain new service programs.

True, we have in the past encountered some grave difficulties in dealing with the multiplicity of Federal funding programs. The multiplicity of agencies that fund for health at the Federal level is overwhelming. The past year we attempted to get Federal funds for the construction and operation of an ambulatory center in the South Bronx and we failed even though there was good will and cooperation on the part of all Federal agencies involved.

It seems to me that major institutions embarking on significant health care programs in a community should be able to approach one agency in the Federal Government to receive an appropriate amount of money and support. It could be that the partnership for health legislation will eventually be able to provide such an opportunity. The major thrust of the program, however, is on coordinated planning. At the present time I believe it is questionable whether it will solve the problem of direct, single-door funding for a complete program, from a single Federal department to a single provider of service.[60]

Fortunately, the means for examining experimental methods of health care delivery is now at hand. The Department of Health, Education, and Welfare is about to activate a National Center for Health Services Research and Development. The committee and its Subcommittee on Health of the Elderly request that the Center give careful attention to the potential usefulness of neighborhood health centers and health maintenance programs for the elderly.[61]

2. Group practice of medicine should be encouraged where needed in every way possible in order to make health services more generally available to the elderly, as well as other age groups.

The group practice principle, as mentioned earlier in the discussion of the Bronx OEO project, is intended to provide one-stop service for families and individuals in a health care center at which the services of medical specialists and other practitioners are available. Even in poverty areas, group practice can be attractive to qualified, well-motivated physicians—in the opinion of Dr. George G. Reader, director of comprehensive care and teaching program of Cornell Medical College—if the following principles are recognized: [62]

(1) That group practice is more conducive to satisfactory working conditions than solo practice; (2) that status in a teaching hospital or university faculty is likely to increase participation; (3) that active research opportunities—a spirit of inquiry—enhances interest. It is possible that young physicians could be induced to spend several years in this endeavor as part of their career development, if the opportunities offered were similar to others in the teaching hospital in academic medicine and specialty training.

[60] P. 394, hearings cited p. 39, footnote 2.

[61] The subcommittee has received conflicting testimony about the value of health maintenance centers operated solely for the elderly tenants of public housing projects, and will continue its study of this matter.

[62] P. 403, hearings cited p. 39, footnote 2.

Other witnesses made compelling arguments for more widespread group practice.[63] Conclusions reached at the National Conference on Group Practice (Oct. 19–21, 1967, Chicago) [64] are persuasive and well worth sympathetic public and professional attention.

3. Home health services are vitally needed to prevent hospitalization or to provide help upon discharge from hospitals. Present efforts to provide such service are inadequate, and a higher priority should be put on meeting this need.

While the subcommittee hopes to achieve a much greater mastery of the subject of home health services as a result of future studies and hearings, it is already convinced that they offer great hope in three areas:

1. As an alternative to institutionalization, where medically feasible, home health care is a much less costly method of care, and offers great hope for reducing outlays both of patients and those of various levels of government.

2. As such an alternative, home health care decreases demand for scarce hospital and nursing home beds. This, in turn, shortens waiting lists and makes possible prompter institutionalization for those for whom there is no alternative;

3. There is evidence indicating that many patients recover more rapidly and are happier receiving home health care in familiar surroundings, close to their families and friends, than they would in an institution.

4. Medical manpower shortages are intensifying problems of delivering health services to the elderly, particularly in urban areas. Innovations in training of personnel, including new categories of "Paramedical" skills, should be encouraged.

Dr. Wagner of the U.S. Public Health Service recognized that "serious shortages exist in all the medical specialties." [65] Perhaps the most significant for the elderly is the nursing shortage, where the current deficit is 125,000 just to fill existing vacancies. He added that the Office of Education, the Vocational Rehabilitation Administration, and the Department of Labor are cooperating to "match medical manpower supply with demands."

Suggestions for new departures in training were advanced at the hearing. Subcommittee Chairman Smathers called for training of personnel, similar to the military medical corpsmen, who could perform many nonprofessional functions that now take the physicians' time. Senator Smathers also said he was gratified by establishment of a Federal "Re-Med" program to channel discharged military medically trained veterans into the health field.[66] Dr. Sheps added:

> The only way in which these new types of personnel can do the best job is if they are part of an organized program. In your Marine station, the medical officer was indeed there, he was available, and he was supervising what these men were doing.[67]

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[63] See pp. 478 and 479 of Mr. Brindle's testimony for discussion of major advantages.
[64] A summary of major findings appears on pp. 209–210 of this report.
[65] P. 25, hearings cited p. 39, footnote 2.
[66] Pp. 410–413, hearings cited p. 39, footnote 2.
[67] Pp. 410–411, hearings cited p. 39, footnote 2.

IV. TWO SPECIAL AREAS OF CONCERN

A. Elderly in Mental Institutions

Information received from several sources in 1967 suggests that organized attention should be given to the problem of so-called geriatric patients in public mental hospitals.[68] Dr. Israel Zwerling, director of the Bronx State Hospital in New York City, described current trends.[69]

> The magnitude of this problem is increasing relatively as well as absolutely, that is, the percentage of first mental hospital admissions accounted for by persons over 65 years of age is increasing more rapidly than is the total population of persons over 65 years of age. The reasons for this change are undoubtedly complex. In part, the greater longevity consequent to improved medical and surgical care permits more persons to survive to a sufficiently advanced age to manifest the symptoms of chronic brain syndrome. More important in my view are the accelerating pressures of urbanization and technologic change; these pressures are altering cultural value orientations, with productivity increasingly becoming a measure of worth, with respect for tradition and for the past diminishing, and with family life becoming more individualistic and increasingly typified by the two-generation, mobile nuclear family. The aged in our society are becoming increasingly more alienated, more isolated, less valued and on each count more vulnerable to mental illness.

Dr. Zwerling also took the subcommittee on a tour of a so-called "hotel ward" at Bronx State Hostpital where patients had achieved almost complete self-reliance free of institutional practices. Many could be discharged, said the doctor, but they remained in the ward because of deficiencies in existing services such as homemaker, suitable nursing homes, and counseling. Often, patients remained in the hospital because no public housing was available.

The committee also received details of efforts in Michigan to provide milieu therapy within the Ypsilanti State Hospital in order to prepare elderly patients for discharge, coupled with an "Operation Friendship" which provides much-needed services intended to help the patients adjust to independent living in the community. With such assistance, individuals who have been hospitalized for many years have been discharged and are now back in the community.[70] Other promising programs—intended either to help prevent institutionalization or to provide services to speed discharge when appropriate followup services are available—have also come to the attention of the committee.

The committee concurs with suggestions that this committee, with the cooperation of the Administration on Aging and other Federal agencies, prepare several models demon-

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[68] Other matters related to mental health discussed in report by National Institute of Mental Health, p. 216.

[69] Pp. 583-585, hearings cited p. 39, footnote 2.

[70] From testimony by Dr. Wilma Donahue, pp. 183-185, "Long-range program and research needs in aging and related fields," before U.S. Senate Committee on Aging; hearings in Washington, D.C., Dec. 5-6, 1967.

strating effective programs intended to help institutionalized "geriatric patients" be discharged, as well as those who might be institutionalized in the absence of other forms of help.

B. National Attention to Disease Prevention

Concerned primarily about the need for health screening for early disease detection, the Subcommittee on Health of the Elderly conducted hearings [71] in 1966 that led to several more general conclusions, including:

1. Chronic disease costs this Nation approximately $57½ billion a year, and the elderly are its chief victims.
2. Despite this high cost, medical care in this Nation is geared primarily for action in the least productive field of medicine—*treatment* of illness. In terms of social good and reduction of suffering, *preventive* medicine offers much more potential long-range reward.

Since the time of that hearing, the committee and its Subcommittee on Health of the Elderly have received much additional commentary on the need for national action to promote greater awareness of the need for preventive measures. Health screening on a wide scale appears to be an appropriate means to begin such efforts.

A report from the Adult Health Protection and Aging Branch of the U.S. Public Health Service appears on page 213 of this report and gives details on four pilot programs now testing health screening under widely varying circumstances. Details on health maintenance programs are also given.

Such programs, while welcome, are not sufficient to correct what has been described as an "imbalance of attention" [72] which focuses Federal funds and widespread attention on the obviously ill person, while withholding the funds and concern needed for actions that will prevent such illness. The committee recognizes that illness must be treated, and it calls for high-quality treatment for all in need, but it also makes this finding:

Greater emphasis and financial support must be provided for programs intended to promote preventive medicine. The committee reaffirms the 1966 finding, submitted by its Subcommittee on Health of the Elderly, that "there is a great need for additional efforts to prevent chronic disease on a national scale. Federal legislation should be enacted to establish a multiphasic health screening program on a large scale with eventual expansion nationwide."

[71] "Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques," hearings before the Subcommittee on Health of the Elderly (Senator Maurice B. Neuberger, chairman), U.S. Senate Special Committee on Aging, held in Washington, D.C., September 20, 21, and 22, 1966. Report, "Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques," Subcommittee on Health of the Elderly, December 30, 1966.

[72] Testimony by Herbert M. Domke, M.D., p. 130, hearings cited p. 39, footnote 2.

CHAPTER IV

HOUSING AND A LIVABLE ENVIRONMENT

President Johnson's message[1] on older Americans—recognizing that "decent housing plays an important role in promoting self-respect and decency and dignity in later years"—reported that in the past 3 years the total Federal investment in special housing programs for the elderly has more than doubled. It now stands at $3 billion.

Steady gains were reported in 1967 for all federally assisted housing programs of help to the aged,[2] but the year was of significance in this field primarily because of two milestones:

- It was the first full year of operation for the rent supplement program.
- It was the year the model cities program announced its initial planning grant awards.

The rent supplement program.—After an uncertain start, it had application requests that exceeded its statutory contract authority. Because appropriations were below the level originally authorized by the Congress, it may be necessary to reject many otherwise acceptable projects for rent supplements. To a considerable extent, the scope of the program is thus restricted, but it is already yielding ample evidence of its special helpfulness to the elderly.

The model cities program.—75 cities are now receiving Federal financial aid in planning comprehensive city demonstration projects. This is the first phase of fulfilling the pledge made in the Demonstration Cities and Metropolitan Development Act of 1966, that "improving the quality of urban life is the most critical domestic problem facing the United States." One survey[3] indicates that more than 400,000 persons aged 65 and over live in the designated areas.

I. RENT SUPPLEMENTS AND THE ELDERLY

The rent supplement program was conceived as an instrument to encourage the private sector of the economy to invest in housing for lower income families. Payments are made to the owner by the Department of Housing and Urban Development. Supplement payments are calculated as the difference between one-fourth of the tenant's income and the fair market rental as approved by HUD.

Tenant eligibility is limited to persons whose income is below the maximum level set for public housing, and who satisfy one of the following conditions: (1) displaced by governmental action; (2) 62 years of age, or over; (3) physically handicapped; (4) occupy sub-

[1] Text on p. 165.
[2] A report from the Department of Housing and Urban Development appears on p. 224, other information in part III of this chapter.
[3] As reported in "Aging" publication of the Administration on Aging, p. 5, January 1968.

standard housing; or (5) occupy a dwelling affected by a natural disaster.

In the administration of the program, 90 percent of the rent supplement funds are channeled through the 221(d)(3) program for low- and moderate-income multifamily housing. Five percent of these funds are authorized to be used in section 202 direct loans for rental housing for the elderly, and the FHA section 231 program of mortgage insurance for multifamily rental housing. The remaining 5 percent is to be used for section 221(d)(3) below market interest rate projects without specified age requirements.

Under the 221(d)(3) market interest rate program, 32 rent supplement projects were underway in 1967. These projects represented approximately $2.3 million in rent supplements, for 2,500 units, most of which are eligible for supplements.

By December 31, 1967, nearly $30.7 million of the $37.8 million available to the section 221(d)(3) market interest rate program had been reserved.

The experimental provision of the act allows 5 percent of the program funds to be used to assist low-income elderly or handicapped occupants under the section 202 and 231 programs. At year's end, $1.7 million of the $2.1 million available under these programs had been allocated. These commitments covered 124 projects containing 2,800 units, out of an overall project total of 15,000 units.

The rent supplement program has been hampered by the limited funding it has received. As of December 31, 1967, rent supplement reservations, contracts, and applications totaled $47.2 million. On February 9, 1968, the total had risen to $52 million. The last figure is $10 million above the total contract authority approved by the Congress.

The shortage of funds has meant a reappraisal of the type projects that may be eligible for supplements, as well as a reassessment of project construction time, location, cost and design, and other features.

Without more funds many projects will have to be rejected. This will have an especially unfortunate effect on the sponsors of housing for the elderly, for their ability to have projects approved will be narrowed considerably.

Rent supplement hearing.[4]—Testimony was invited last year from witnesses who have had direct experience with the rent supplement program. Their comments provide insight into the special usefulness of that program to the elderly.

The Reverend George F. Packard, president of St. Mary's Roland View Towers of Baltimore, said:

> Let me just give you one illustration as to how this works.
>
> We have one woman who is living in one of our buildings. We have two buildings at the present time. And this woman was living on the third floor of a house. She had a room. She had to walk down to the second floor for cooking privileges. And she only could cook two meals a day in this kitchen that she had access to.
>
> And this woman is now, by virtue of the rent supplement, living in our modern apartment house, high-rise apartment

[4] "Rent Supplement Assistance to the Elderly," by the Subcommittee on Housing for the Elderly (Senator Frank E. Moss, chairman), U.S. Senate Special Committee on Aging, Washington, D.C., July 11, 1967.

house, with her own completely equipped apartment, in an elevator building. And this woman is now in her eighties.

This gives you an idea as to what it means to the people who need rent supplement in order to help them to live.

Another witness, Dr. Paul L. Niebanck,[5] of the Institute of Environmental Studies, University of Pennsylvania, focused attention on the need for rent supplements in the case of persons who have been relocated as a result of land redevelopment:

> In the case of the elderly who are required to move to make way for redevelopment projects * * * fully 2 out of 5 are wholly without the ability to sustain themselves and make ends meet at the same time, and only 1 out of 5 possess any degree of real financial freedom.

Dr. Niebanck went on to say that "* * * of great relevance to the elderly households affected by redevelopment is (the fact) that there is no present mechanism of sufficient scope or power that is able to focus directly on their housing and related needs at the time of displacement * * *. In the meantime, even the best relocation and rehousing efforts will continue to be thwarted or greatly inhibited. Thus, it is clear that supportive mechanisms, such as rent supplementation, must be viewed as one of the primary tools for the reconciliation of the gulf between the need for low-cost units that is created by clearance programs and the number that is being provided by housing programs."

Mrs. Dorothy Duke, Director of Housing for the National Council of Negro Women, testified as president of the board of directors for a housing project in Oberlin, Ohio. Like other witnesses, she praised the rent supplement program and asked for its extension. She also had a few suggestions for improving it:

> Statistical data on incomes for elderly is monumental, yet we must continue to state again and again and again that there is not now in existence a workable program to meet the housing needs of elderly people of all incomes.
>
> Reviewing the testimony I and others that work in the local scene gave in April 1965 for the omnibus housing bill before Senator Sparkman's committee, not too much has really changed.
>
> We still have thousands of elderly people "dropping through the rent cracks," as I call them, of public housing, the 202 program, and now we have added the rent supplement program.
>
> As president of the board of trustees for the housing development which received the first rent supplement payment that was made in the country, I would like to illustrate my points with some examples.
>
> These were taken from actual applications made to Firelands Retirement Centers when it became known we were going to have rent supplements available. I believe they speak for themselves.
>
> The first person, here, pays $35 a month rent with assistance from Aid for Aging.

[5] P. 17, hearing as cited in footnote 4, p. 69.

> The next three are indicative I think of what I am trying to present.
>
> There is a 70-year-old female with an annual income of $606. She has $5,100 in assets, including the cash value of her life insurance policy. This person, according to our present regulations, is too wealthy for rent supplements.
>
> The next person, a 71-year-old female, with annual income of $2,700 ($2,600 is maximum income allowance in Ohio for single elderly) as long as she continues to work, which will not be much longer—total assets, $450—she is also too wealthy for rent supplements.
>
> The next person, with an annual income of $2,500, and $4,900 in [6] assets, is poor enough.
>
> I am trying to point out the ridiculous financial limitations that Congress has placed on this program.

The Reverend Louis D. Mitchell, associate executive director, Division of Christian Social Concern of the American Baptist Convention, said rent supplements makes it financially feasible for privately owned and operated housing to meet the needs of low-income people "in ways that increase the hopes and capacities of the poor to participate in the economy without stigma." He, too, saw a need for policy adjustments:

> * * * It is important that the rent supplement program allocations be made in a way to allow ample time to develop housing projects for the elderly poor, and to process applications for needed rent supplement and mortgage insurance commitments.
>
> Again, we are underscoring previous testimony about the time that is needed to get through the red tape that is necessary to make this money available for those who need it most * * *
>
> The project development and application process requires 18 months to 2 years, or longer. Therefore, we recommend making ample funds available for initiating rent supplement projects for approximately 3 year periods. * * * [7]

IMPORTANCE OF THE PROGRAM

Still young and undoubtedly in need of further refinements,[8] the rent supplement program is one of the most potentially helpful instruments in all efforts to make livable shelter more available to those now denied it.

Philip N. Brownstein, Federal Housing Commissioner at HUD, gave the subcommittee a summary of its importance when he said:

> * * * A substantial number of poverty stricken elderly people are now able, or will be able, to live in decent housing using only a reasonable portion of their severely limited incomes for rent.

[6] P. 26, hearing as cited in footnote 4, p. 69.

[7] P. 34, hearing as cited in footnote 4, p. 69.

[8] The administration's Housing bill of 1968 (S. 3029) calls for increased rent supplement authorizations. Section 202 provides funds of $150 million yearly prior to July 1, 1969, to be increased by $40 million on July 1, 1969, and by $100 million on July in each of the years 1970, 1971, and 1972.

The current authorization is for $40 million from July 1, 1967 (of which $10 million was appropriated) and $45 million for July 1, 1968.

It means that they no longer must surrender 35 or 40 or 50 percent or more of their monthly funds for shelter. They can begin to live again, at least somewhat free of the desperate fear that their retirement years will outlast their savings, reducing them to paupers.

It means that older people no longer have to depend on their adult sons and daughters for independence, nor suffer the knowledge that such contributions are being given at the expense of their grandchildren.

I know that in the course of this hearing and from the evidence you gather, your record will be filled by those who have firsthand knowledge of how the rent supplement program is in reality improving the lives of older people who are its beneficiaries, as well as contributing to a better life for their children and grandchildren.

This is a program which has an immediate impact on human misery, and permits its displacement by decency and dignity.[9]

Now in its second year of operation, the rent supplement program has proven to be a versatile and helpful instrument for providing housing for the elderly and others in a manner that preserves dignity and independence of the renter.

In every way possible, the program should be extended to serve additional numbers of Americans who, in any of several ways, stand in special need of its assistance.

Technical assistance should be provided to help sponsors of projects involving rent supplements.

Discussion.—In many instances, nonprofit sponsors do not possess the requisite technical or financial know-how to insure the proper planning and development of their projects. Too often they become discouraged in the mass of detail and effort that is required.

S. 3029, the overall housing bill for 1968, includes a provision that would be of special usefulness to sponsors of projects involving rent supplements. (Such assistance, under terms of the bill, would also be helpful to senior citizens housing, low and moderate income rental housing, and housing for the elderly or handicapped.)

Sec. 106 of the bill provides that "technical assistance" can be provided to sponsors with respect to the construction, rehabilitation, and operation of low- and moderate-income housing. Such help is o t of vital importance to sponsors of housing for the elderly.

Through the loans under the technical assistance provision of the bill, the Secretary of HUD would be authorized to provide help in preliminary surveys and analyses of market needs; preliminary site engineering and architectural fees; site acquisition; application and mortgage commitment fees; and, construction loan fees and discounts.

II. PROMISE OF THE MODEL CITIES PROGRAM

Congress voted $312 million last September to fund this frankly experimental program which—in the words of HUD Secretary Robert Weaver—is meant to seek an answer to this question:

[9] P. 7, hearing as cited in footnote 4, p. 69.

> How do we free the slum environment for children and their parents, for the elderly and the handicapped, for the unemployed and the uneducated, for those who are physically ill, and for those who are socially isolated?

His reference to the elderly was apparently one response to President Johnson's directive, made in his message on aid for the aged, that HUD "make certain that the model cities program gives special attention to the needs of older people in poor housing and decaying neighborhoods."

This committee was also informed by mid-year that the Administration on Aging had joined in the screening of applications for planning funds, in order to give data and counsel on special problems of the elderly.

How the program works.—In November 1967, HUD announced the names of 63 cities that had been given planning grant awards. (An additional 12 cities were given similar grants on March 11, 1968.)

Grants thus far are limited to planning activity. Cities that successfully complete acceptable plans will later share in the approximately $275 million available for implementation. The program will insist on:

"Total Attack" Approach.[10]—All available resources to be mobilized on the social, economic, and physical problems.

Innovation.—As a "search for new paths to the local solution of local problems," the program offers opportunity for: "experimentation, imagination, and innovation in every aspect," including new approaches to local administration and the use of new technology to reduce costs.

Human Resources Development.—The basic thrust is "the linking of projects and activities designed to develop human resources with those for improving the physical environment."

Physical Revitalization.—To "transform wornout areas into 'model' neighborhoods," the program will focus not only on housing and necessary community facilities, but also on recreation areas and "the other amenities necessary."

Rehabilitation.—To be accomplished with "minimal relocation of residents from the area" and "to gain cost reductions through economies of larger scale upgrading of housing."

Increased Housing Supply.—A "substantial increase is sought."

Citizens Participation.—"The program is intended to open up opportunities for the constructive involvement of citizens in the affected neighborhoods and the city as a whole in planning and carrying out of program activities * * * residents must benefit from the jobs that are created by the projects and activities carried out in the program."

Private Initiative and Enterprise.—All kinds to be encouraged—"the initiative and enterprise of individual homeowners, contractors, and builders to improve housing and environmental conditions; the involvement of business leaders and financial interest in carrying out the program * * *."

Federal financial assistance is given in three ways:

—Grants to city demonstration agencies to pay 80 percent of planning costs.

[10] Summarized from: "Model Neighborhoods Under the Demonstration Cities Act," HUD publication.

—Grants to pay 80 percent of city demonstration agency administration costs; and
—Grants up to 80 percent of the local and State contribution toward carrying out the projects designated in the approved plan.

Importance to the elderly.—Fifty-eight percent of those persons over 65 years old who live in urban areas live in the central city. Many are in the urban core because they have always lived there. Many moved there when they became single. Among their many problems in the city are: small quarters in old buildings; they are often displaced by government programs;[11] transportation may be minimal; and social or health services unavailable or inappropriate.

In a program meant to be innovative—as model cities is—it would appear that many promising ideas could be developed to deal with such problems and others. Some inkling of the possibilities was given by the Administration on Aging in January when it gave examples of programs for older people already included in the applications for grants:

—The development of specially designed units and financial arrangements such as cooperatives and condominiums for the elderly in Richmond, Calif.
—A program in Trinidad, Colo., of services in the areas of health, financing, and mobility for the elderly poor, especially those who are socially isolated.
—A mobile day and night care program called Operation SMILE (Support Manchester's Ill, Lonely, Elderly) in Manchester, N.H.
—A "social service hot line" through which local residents may obtain information about available social services 24 hours a day in Detroit, Mich.
—Tests of guaranteed annual income programs in Dade County, Fla., and Honolulu, Hawaii. Other cities are also considering introducing such a program.
—Improved transportation systems in a number of cities. Kansas City, Mo., plans to subsidize buses for elderly.
—Construction of quiet recreation areas especially for older people in New Haven, Conn.
—A garden park where older people may raise flowers in Honolulu, Hawaii.
—Health unit trailers or neighborhood health centers concentrating on detection of such conditions as glaucoma and cancer.
—Multipurpose centers.
—Satellite resource centers.

Older Americans are among the many individuals who will benefit from the transformation of old, decaying slums into "model neighborhoods" under the recently funded model city program. Their unique problems and special needs—as well as the contributions they can make to the citizen participation aspects of individual projects—should not be overlooked. In this period of intensive preparation, before actual implementation of plans, careful attention should be given to the elderly.

[11] Dr. Paul L. Niebanck, p. 18–25, hearings cited, p. 69, footnote 4.

Discussion.—The Senate Special Committee on Aging, after a study of Office of Economic Opportunity policies and programs, said the following in a report issued in 1966:

> Elderly Americans go unnoticed not only because of decreased mobility and limited opportunities for mingling with other age groups, but also because their problems are not as dramatically visible as those of other age groups.[12]

The committee comment was meant to explain to some degree why, in the opinion of numerous and authoritative witnesses heard by the committee, the OEO had overlooked or underestimated the many problems faced by the elderly poor.

Major progress has been made within the OEO on projects for the elderly since that time (see ch. IX for details). The lesson learned by the committee in its hearings on poverty, however, is that questions about inclusion of the elderly should be raised in the early, formative period of a program. Accordingly, the committee is tentatively planning to hold hearings, in 1968 on "The Model City Program and Older Americans." Senator Frank E. Moss, chairman of the Subcommittee on Housing of the Elderly, has been asked by the committee chairman to conduct the study.[13]

III. STATUS OF FEDERAL PROGRAMS

A. Low-Rent Public Housing

This is the pioneer housing program that has been the single greatest contributor to better housing for the elderly. As the following tables show, the program is continuing its pace-setting performance.

In 1967, out of a total of 72,000 public housing units under annual contribution contracts, 35,507 were units for the elderly. The total low-rent public housing figures, cumulative through December 31, 1967, show 155,500 housing units for the elderly.

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[12] P. 5, The War on Poverty as it Affects Older American, S. Rept. 1287, June 20, 1966.
[13] Additional details on this and other programs in HUD report, p. 224.

92-654—68——7

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
HOUSING ASSISTANCE ADMINISTRATION

Federally aided public housing projects with all or some units designed specifically for the elderly, with annual contributions contracts executed, cumulative through Dec. 31, 1967

State or territory	Total public housing units for the elderly	Projects with all units for the elderly		Projects with some but not all units for the elderly	
		Number of projects	Number of units	Number of projects	Number of units for elderly
Total	[1] 154, 967	983	[1] 91, 343	1, 390	[1] 63, 624
Alabama	2, 704	16	894	95	1, 810
Alaska	25			1	25
Arizona	81			3	81
Arkansas	3, 060	22	1, 256	82	1, 804
California	4, 429	20	1, 479	22	2, 950
Colorado	903	9	803	7	100
Connecticut	3, 377	40	3, 095	6	282
Delaware	269	1	149	3	120
District of Columbia	1, 268	2	423	7	845
Florida	3, 872	19	2, 242	25	1, 630
Georgia	3, 570	20	1, 758	90	1, 812
Hawaii	534	4	422	4	112
Idaho	120	3	120		
Illinois	13, 449	96	9, 274	108	4, 175
Indiana	3, 640	21	2, 599	14	1, 041
Iowa	585	9	514	4	71
Kansas	1, 732	6	618	14	1, 114
Kentucky	3, 470	17	1, 998	74	1, 472
Louisiana	2, 558	10	352	54	2, 206
Maine	482	4	482		
Maryland	1, 312	4	350	7	962
Massachusetts	7, 759	67	5, 948	16	1, 811
Michigan	4, 711	45	4, 012	20	699
Minnesota	7, 390	42	4, 637	13	2, 753
Mississippi	155	1	30	9	125
Missouri	2, 562	8	788	30	1, 774
Montana	16			2	16
Nebraska	3, 822	57	3, 201	17	621
Nevada	516	2	275	3	241
New Hampshire	1, 270	12	980	4	290
New Jersey	12, 228	78	10, 636	32	1, 592
New Mexico	429	3	142	15	287
New York	17, 216	40	5 081	106	12, 135
North Carolina	1, 972	11	1, 023	53	949
North Dakota	203	4	152	5	51
Ohio	7, 898	30	3, 697	30	4, 201
Oklahoma	1, 853	5	490	44	1, 363
Oregon	1, 959	11	871	7	1, 088
Pennsylvania	9, 251	60	5, 401	73	3, 850
Puerto Rico	120			12	120
Rhode Island	3, 340	28	3, 190	1	150
South Carolina	646	5	377	7	269
South Dakota	147	2	73	9	74
Tennessee	3, 335	21	2, 211	68	1, 124
Texas	6, 826	61	3, 396	148	3, 430
Utah					
Vermont	155	2	130	1	25
Virginia	397	1	50	6	347
Virgin Islands	158	1	84	7	74
Washington	3, 073	31	2, 709	9	364
West Virginia	930	5	450	13	480
Wisconsin	3, 190	27	2, 481	10	709
Wyoming					

[1] Includes adjustments not distributed by States.

B. Direct Loans for Rental Housing

This program was designed to make good housing available to low- and moderate-income elderly persons.

At the end of 1967, net loans totaling $400 million for 250 projects—containing 33,000 units—had been approved. This represents an increase in 1967 of nearly 6,000 units.

The attached tables show the loan program activity for 1967, and the cumulative figures for the program to December 31, 1967.[14]

Department of Housing and Urban Development
Housing Assistance Administration

Elderly housing loans program, sec. 202, summary of approved projects from inception of program through Dec. 31, 1967

State	Number of projects	Number of units	Aggregate project cost
Total	251	32, 916	[1] $399, 454, 836
Arizona	2	273	3, 284, 550
Arkansas	1	136	1, 640, 000
California	31	3, 768	46, 347, 484
Colorado	9	796	8, 998, 476
Connecticut	5	547	6, 654, 974
Florida	21	4, 015	47, 101, 476
Georgia	5	882	10, 693, 738
Illinois	7	499	6, 358, 466
Indiana	3	142	1, 796, 744
Iowa	9	657	7, 457, 706
Kansas	2	151	2, 205, 000
Kentucky	1	143	1, 969, 000
Louisiana	2	263	3, 277, 220
Maine	2	75	967, 000
Maryland	10	1, 880	24, 370, 006
Massachusetts	7	1, 098	13, 256, 000
Michigan	10	1 383	16 537 812
Minnesota	14	1, 169	14, 405, 465
Mississippi	1	101	967, 000
Missouri	6	1, 027	12, 437, 000
Montana	6	484	5, 674, 659
Nebraska	1	56	636, 000
New Jersey	9	1, 746	20, 905, 500
New Mexico	2	153	1, 778, 000
New York	6	948	11, 677, 000
North Carolina	1	142	1, 314, 000
North Dakota	3	158	1, 643, 289
Ohio	17	2, 433	29, 449, 500
Oklahoma	4	402	4, 328, 144
Oregon	3	610	7, 462, 000
Pennsylvania	16	2, 983	38, 737, 000
South Dakota	4	154	1, 712, 576
Tennessee	4	619	7, 165, 657
Texas	6	843	8, 530, 766
Utah	2	334	4, 358, 000
Washington	7	959	11, 734, 328
West Virginia	2	105	1, 516, 000
Wisconsin	2	145	2, 096, 000
Wyoming	4	276	3, 332, 300
Puerto Rico	4	361	4, 679, 000

[1] Federal loan amount totals $396,819,000 (rounded to nearest thousand).

[14] See p. 8 of HUD report.

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
HOUSING ASSISTANCE ADMINISTRATION

Elderly housing loans program, sec. 202, approved projects, calendar year 1967

State and city	Name of project applicant	Aggregate project cost	Number of units
1967 program total		$72, 626, 205	5, 838
California:			
Half Moon Bay	Ocean View Foundation	620, 000	50
Long Beach	New Hope Home, Inc	1, 600, 000	140
Oakland-Berkeley [1]	Satellite Senior Homes, Inc	2, 839, 000	200
San Francisco	Bethany Center Senior Housing, Inc	1, 904, 000	134
Santa Cruz	Christian Church Homes of Northern California	587, 000	47
Santa Monica	Westminster Towers, Inc	3, 845, 000	285
Colorado:			
Grand Junction	Foundation for Senior Citizens, Inc	102, 000	9
Loveland	Big Thompson Manor, Inc	598, 000	58
Connecticut:			
Bethel	Augustana Homes, Inc	1, 211, 000	101
New Haven	New Haven Jewish Community Council Housing Corp	2, 707, 000	217
Florida:			
Fort Lauderdale	Gateway Terrace	2, 415, 200	256
Jacksonville	Edw. Waters College Senior Citizens Housing	1, 540, 000	192
Do	Riverside Presbyterian Apartments, Inc	2, 520, 000	205
Do	Cathedral Manor, Inc	2, 605, 000	207
Melbourne	Trinity Tower, Inc	2, 000, 000	156
Orlando	Kinneret, Inc	2, 165, 000	168
Pompano Beach	St. Elizabeth's Gardens, Inc	1, 881, 005	152
Tampa	Florida Gulf Coast Apartments	1, 653, 000	150
Do	Tampa Presbyterian Community, Inc	2, 716, 000	210
Georgia: Atlanta	Atlanta Area Presbyterian Homes	2, 996, 000	240
Iowa: Rockwell City	Golden Buckle Home, Inc	140, 000	11
Kansas: Topeka	First Christian Church Apartments, Inc	1, 625, 000	101
Louisiana: New Orleans	Monsignor Wynhaven Apartments	2, 600, 000	201
Maine: Rockland	Methodist Conference Home, Inc	642, 000	48

Massachusetts:			
Beverly-Danvers and Peabody-Salem.[1]	North Side Housing Corp	3, 825, 000	313
Springfield	Springfield Hobby Club Housing	1, 698, 000	168
Michigan:			
Detroit	Independence Hall, Inc	2, 978, 000	216
Lansing	United Church Manors	1, 075, 000	100
Muskegon	Muskegon Retirement Apartments	2, 535, 000	192
Missouri: St. Louis	Council House Redevelopment Corp	4, 011, 000	303
New Jersey: East Orange	Senior Citizens Housing Association of East Orange	1, 680, 000	127
Ohio:			
Cincinnati	Cincinnati, Business and Professional Women's Retirement Housing	1, 830, 000	136
Sandusky	Sandusky Bay Kiwanis Senior Citizens, Inc	1, 875, 000	153
South Dakota: Mitchell	Wesley Acres, Inc	445, 000	34
Tennessee: Chattanooga	Jaycee Future, Inc	2, 437, 000	204
Washington: Yakima	Yakima First Baptist Homes	2, 050, 000	153
West Virginia: Charleston	West Virginia Homes, Inc	916, 000	59
Wisconsin: Wisconsin Dells	Dells Housing, Inc	505, 000	41
Wyoming: Casper	Skyline Towers, Inc	1, 255, 000	101

[1] Combined project.

C. Mortgage Insurance for Multifamily Rental Housing

This program[15] serves elderly persons whose income is too high for low-rent public housing and housing for low- and moderate-income persons.

There has been a low rate of activity in this program because of the restrictions in the money market in 1967, and the increase in foreclosures.

The attached tables show that in 1967, only 11 new projects containing 1,622 units were approved. There were 281 projects containing 43,162 units for the program from its inception to December 31, 1967.

Department of Housing and Urban Development
Federal Housing Administration

Net commitments issued on elderly housing projects under secs. 207 and 231 through Dec. 31, 1967

State	Projects	Units	Mortgage amount
Alabama	1	80	$800, 000
Alaska			
Arizona	18	4, 504	51, 064, 629
Arkansas	2	139	1, 446, 000
California	49	9, 200	119, 439, 868
Colorado	22	2, 146	24, 529, 387
Connecticut	4	469	7, 486, 600
Delaware	1	234	3, 540, 300
District of Columbia	2	659	8, 666, 704
Florida	15	4, 097	50, 290, 859
Georgia	1	48	436, 800
Hawaii			
Idaho	1	32	311, 000
Illinois	7	1, 067	12, 525, 334
Indiana	3	407	5, 900, 000
Iowa	5	474	4, 926, 100
Kansas	5	603	8, 082, 000
Kentucky	7	764	8, 869, 050
Louisiana	5	324	3, 761, 400
Maine			
Maryland			
Massachusetts	1	25	225, 000
Michigan	6	1, 080	11, 097, 700
Minnesota	13	790	9, 370, 700
Mississippi	2	331	3, 855, 100
Missouri	5	944	12, 928, 769
Montana	2	158	2, 115, 000
Nebraska	9	1, 115	14, 106, 205
Nevada	2	394	4, 480, 200
New Hampshire	1	170	1, 379, 100
New Jersey	3	621	7, 459, 200
New Mexico	1	60	787, 000
New York	4	301	3, 641, 009
North Carolina	2	264	1, 350, 000
North Dakota	2	95	1, 127, 330
Ohio	10	1, 553	18, 981, 900
Oklahoma	3	261	3, 479, 800
Oregon	10	1, 598	18, 204, 500
Pennsylvania	2	442	5, 902, 300
Rhode Island			
South Carolina			

[15] See p. 224, HUD report, for additional details.

Net commitments issued on elderly housing projects under secs. 207 and 231 through Dec. 31, 1967—Continued

State	Projects	Units	Mortgage amount
South Dakota	3	122	$1, 030, 300
Tennessee	5	573	7, 261, 500
Texas	23	3, 609	43, 667, 184
Utah	2	408	5, 326, 600
Vermont			
Virginia	2	384	6, 358 400
Washington	9	1, 685	20, 653, 200
West Virginia			
Wisconsin	8	524	5, 424, 507
Wyoming			
Puerto Rico	3	408	5, 310, 700
Virgin Islands			
U.S. total	281	43, 162	527, 599, 235

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
FEDERAL HOUSING ADMINISTRATION

Commitments issued during the year of 1967 on section 231 projects for the elderly

State	City	Name of project	Number of units for senior citizens	Mortgage amount
Arizona	Phoenix	Beatitudes No. 2	133	$1, 840, 500
	Phoenix	Phoenix Manor No. 2	80	937, 900
California	Modesto	Neighborhood Manor	104	1, 300, 500
	Stockton	Lee Center	174	1, 901, 400
Iowa	Des Moines	Horace Mann Home for the Aged.	121	2, 575, 900
Minnesota	Buffalo	Retirement Center of Wright County.	71	994, 000
	Northfield	Lutheran Home of the Cannon Valley.	66	900, 000
Nebraska	Omaha	Skyline Manor	220	2, 580, 900
Ohio	Columbus	Wesley Glen Retirement Center.	210	4, 184, 800
Virginia	Fairfax County.	Vinson Hall	293	5, 023, 100
Puerto Rico	Guaynabo	San Patricia Manor	150	2, 067, 300
Total			1, 622	24, 306, 300

D. Housing Improvement and Repair Loans and Grants

Loans and grants under this program are designed to assist homeowners whose properties are within urban renewal or code enforcement areas. A significant number of older persons have participated in these programs.

In 1967, approximately 2,050 loans were approved, amounting to $10.9 million. In addition, 2,500 grants were approved, for a total of $3.5 million.

E. Centers for Community Service Programs

Grants are provided to provide assistance in financing the development of centers for programs of community service. Such centers will offer senior citizens services within such facilities.

Under this program, two senior citizens centers have been approved. In 46 out of 118 other neighborhood centers, there are plans to offer senior citizens special service on welfare, social security, and legal aid matters, and other services.

IV. INNOVATIONS AND CONSIDERATIONS ABOUT ENVIRONMENT

For a committee study [16] of present and long-range trends in housing, HUD provided information on experiments or departures from old policies, including:

—Granting Regional Administrators new authority to speed up housing unit production.

—Organization of Tenant Services Division for low-rent public housing.

—Start of a priority system in HAA to provide communities public housing under the "leasing" program in the shortest possible time.

—Beginning of FHA Housing Counseling Service to insure that FHA provides equal treatment to all prospective buyers and renters, including the elderly.

ENVIRONMENT—PRESENT AND FUTURE

Long-term considerations related to the quantity and quality of housing and other forms of shelter for the elderly will receive continuing attention from the Subcommittee on Housing for the Elderly. The need for such perspective was given during the year in estimates that present efforts are in need of considerable bolstering. Prof. Robert Morris, of Brandeis University, said, for example, that the achievement rate in Federal programs in housing [17] for the elderly is only about 10 percent, but he acknowledged that other age groups are similarly deprived and that "most communities in America have been reluctant to extend programs of true low-cost housing development, with or without Federal support, and it has been this reluctance which has produced the suffering on the parts of some millions of older persons as well as those of younger persons."

Excerpts from the testimony [18] of Prof. Louis E. Gelwicks, research associate at the Institute for the Study of Aging at the University of Southern California, gave additional insight into the importance of a livable environment to the elderly, now and in the future:

> * * * for the elderly, as well as others, the overwhelming emphasis in the development of shelter has been placed upon methods of reducing the initial cost of construction. It is time we placed greater emphasis on the long-range return on the

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[16] Pp. 367-389, "Long-Range Program and Research Needs in Aging and Related Fields," hearings before the U.S. Senate Special Committee on Aging, Washington, D.C., Dec. 5-6, 1967.

[17] P. 39, hearings cited in footnote 16.

[18] P. 169-178, hearings cited in footnote 16.

investment, particularly the return to the user, and the return to society. The immediate personal environment assumes far greater importance to the aged than it does for the younger, more mobile adult * * * We need to investigate more than construction systems. We need a human systems analysis.

*   *   *   *   *

The quality of the environment is of major concern to the elderly individual. It is he who is least able to adapt to it, to alter it, or to leave it * * *

*   *   *   *   *

The best we have been able to do to date regarding an improvement in the quality—not quantity—of the living space is to produce checklists of technical standards of design for those contemplating the construction of buildings for the elderly.

*   *   *   *   *

The city is the most common home of the aged * * * and there are millions of elderly people struggling to maintain their health and identity with an environment which is losing its identity. We are compartmentalizing our cities to achieve greater efficiency—housing in this section, shopping in another, and health services all in one center. But whom does this efficiency ultimately serve? Certainly not the individual who lacks an automobile or the energy to travel several miles on substandard and overcrowded public transportation. The neighborhood is disappearing when we need it the most, and before we have even defined the qualities which made it a significant component of our life space. * * *

* * * It is my opinion that we are not providing an appropriate environment for our elderly citizen at any level of complexity, nor are we developing the research and knowledge which might enable him to provide it for himself. One of the reasons that we have failed to do so is that we are wasting the physical environment. * * * We can only avoid this waste, however, if we are willing to commit the required resources to improve and increase interdisciplinary environmental research; establish information and storage and retrieval systems to process the knowledge we have; and finally provide training for those professionals who will either undertake research or must apply the knowledge.

The tragic thought about environmental waste is that we not only waste a portion of the efforts of the people creating, financing, and building the physical environment, we also waste much of the life of the people who live in it.

CHAPTER V

NURSING HOMES AND OTHER LONG-TERM CARE FACILITIES

Study and investigation of nursing home conditions in many parts of this Nation were rewarded in 1967, with passage of legislation intended to elevate standards and strengthen State control of nursing home operators and operations. Enactment of these measures as part of the Social Security Amendments of 1967 was accompanied by other developments in the long-term care field, including an apparent increase in awareness that a wide range of extended care and other facilities will be needed more and more as our older population continues to increase and as medicare, medicaid and new social forces cause reappraisal of existing resources.

I. LEGISLATIVE BREAKTHROUGHS

Hearings conducted by the Subcommittee on Long-Term Care [1] within recent years resulted in the discovery of conditions clearly requiring corrective and preventive legislation. Among the revelations were:

- Nursing homes were operating while continuously in violation of State licensure laws.
- Drugs were being prescribed and purchased for patients who never received them.
- Patients were entering nursing homes and staying there months and years without a reevaluation of their condition.
- In some instances the apparent owners of nursing homes are not in fact the true owners, making code enforcement difficult.
- Some nursing home operators, victims of unscrupulous moneylenders, reduce services to patients in order to meet large debt payments and exorbitant interest rates; and
- Many public assistance patients were being maintained in homes that are unsafe and endanger their lives.

A. The Cleveland Findings

Perhaps the most detailed available account of nursing home abuses in any one city was the testimony given in 1967 by a representative of the Welfare Federation of Cleveland.[2] Her testimony, which was supplemented by a Government report that had been requested by Subcommittee Chairman Moss, included the following declarations:

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[1] "Conditions and Problems in the Nation's Nursing Homes," hearings before the Subcommittee on Long-Term Care (Senator Frank E. Moss, chairman), U.S. Senate Special Committee on Aging; Indianapolis, Ind.—Feb. 11, 1965; Cleveland, Ohio—Feb. 15, 1965; Los Angeles, Calif.—Feb. 17, 1965; Denver, Colo.—Feb. 23, 1965; New York City, N.Y.—Aug. 2-3, 1965; Boston, Mass.—Aug. 9, 1965; Portland, Maine—Aug. 13, 1965.

[2] Testimony of Mrs. Mary Adelaide Mendleson, before the Committee on Ways and Means, House of Representatives, hearings on H.R. 5710, President's proposals for revision in the Social Security System, Mar. 9, 1967, p. 860.

> There is, we believe, serious doubt whether you, the Federal Government, are in fact purchasing the kind and quality of care you think you are purchasing (through medicare, medicaid, and old-age assistance payments.)
>
> You are entitled to ask, for example, whether some of the physicians' services you are purchasing have in fact been furnished; we believe not.
>
> You are entitled to ask whether some of the pharmacies you support financially have actually supplied necessary and proper medications for which they are paid; we believe not.
>
> You are entitled to ask whether Federal vendor payments in the amount of at least $212 million annually are buying either the quality of care you have a right to expect or, in some instances, even the care itself; we believe not.

The witness also cited specific examples of abuses revealed during an extensive federation study of nursing home conditions:

> A State inspector reported finding that a particular home, having served a light supper at 4 p.m., made no provision for breakfast for its 40 patients, approximately 20 of whom were bedfast, and almost all of whom were public assistance recipients.
>
> Our study also revealed that some physicians who were billing the State for two visits a month for old-age assistance patients in the nursing homes were not always seeing these patients two times a month. Bills rendered were for services not provided.
>
> As a further example of possible fraud, I am reminded of payments made under the medical assistance program to a doctor for alleged medical care furnished a number of patients. This "physician," however, is neither listed in the telephone directories as a physician or registered with the Academy of Medicine.
>
> Another curious fact, found in some instances, was that drugstores were being paid for "furnishing" more drugs than the patients, or the nurses, or the nurses' records indicate were received.
>
> One pharmacist has admitted that several nursing homes offered percentage kickbacks if he would service their telephone accounts. It was made clear that if the prescription is not for an unreasonable quantity, there would be no check by the authorities; and there was no way of knowing that the patient allegedly receiving the drugs either sees them or needs them.

The GAO study.—Preparatory to a full public discussion of the Cleveland situation, Subcommittee Chairman Moss had—in September 1966—requested the General Accounting Office to review the policies and procedures of Federal, State of Ohio, and county agencies concerned in any way with operation of nursing homes or related services in the Cleveland area.

That GAO report [3] raised serious questions about the adequacy of existing policies and controls, as indicated in the major findings listed here:

FINDINGS

It is our opinion that, because of inadequacies in pertinent policies, procedures, and controls or in their implementation, practices or deficiencies of the types described in the allegations, which provided the bases for our inquiry, could exist without detection by appropriate authorities or, if detected, could continue without appropriate corrective action. Therefore, we believe that the results of our review, as shown in this report, demonstrate that each of the areas to which we directed our inquiry would warrant further examination or investigation, and in greater depth, to ascertain the extent to which the alleged practices or deficiencies do, in fact, exist and to develop suggestions for needed improvements in related policies, procedures, and controls.

Although our review was of limited scope and was concentrated in Cuyahoga County, we believe that the information obtained and the deficiencies and weaknesses found with respect to pertinent policies, procedures, and controls indicate that improvement in program administration may well be needed on a statewide basis to better insure that practices of the types indicated by the allegations do not go undetected or uncorrected.

In this connection, we found that HEW had not provided its responsible field representatives with specific instructions or guidelines for use in making continuing reviews of the State and local administration of program activities relating to providing nursing home care, medical services, and prescribed drugs for aid for the aged recipients in Ohio. On the basis of our review of records and our discussions with responsible officials in the HEW regional office, it appears that neither the regional representatives of the Bureau of Family Services, Welfare Administration, nor the cognizant HEW auditors have performed independent reviews of the State and county procedures and controls followed with respect to these program activities.

B. Progress on Legislation

It was against this background that members of the subcommittee, stirred by the many problems believed to exist nationwide, pressed for passage of legislation [4] designed to strengthen State enforcement procedures and assure quality care for public assistance recipients.

Senator Moss' bill was reintroduced as an amendment to the Social Security Act, which, as enacted, amends title XIX (medicaid) provisions relating to required services under State medical assistance

[3] Report to Subcommittee on Long-Term Care, Special Committee on Aging, U.S. Senate. Inquiry into Alleged Improper Practices in Providing Nursing Home Care, Medical Services, and Prescribed Drugs to Old-Age Assistance Recipients in the Cleveland, Ohio, Area. By the Comptroller General of the United States, March 1967.

[4] Originally introduced in 1966 as S. 3436 and S. 3384, and again in 1967 as S. 1661 and S. 1662.

plans, and standards for skilled nursing homes furnishing services under approved State plans. Contained in the measure are requirements for medical review teams, recordkeeping agreements, ownership disclosure, nursing home-hospital arrangements, meal planning and supervision, and State licensure of nursing homes.

Senator Kennedy of Massachusetts, a member of the subcommittee, introduced as an amendment a new version of a bill that required the licensing of nursing home administrators participating in title XIX programs, provided for grants to States for training and instructing individuals to qualify as licensed administrators, and provided for establishment of a National Advisory Council on Nursing Home Administration to advise the Secretary of HEW and the States.

Each of the amendments was introduced out of a growing concern that the Federal Government is paying for services not actually rendered or of poor quality. They were introduced, too, out of a realization that simply increasing assistance rates would in some instances merely increase profits rather than the quality of care. Comprehensive legislation was needed.

Senator Moss summed up the case for his amendment before the Senate Finance Committee when he said:

> * * * it seems to me perfectly proper for the Federal Government to establish reasonable specifications for services purchased in large part with Federal funds. Federal funds must not be used to pay for services not actually rendered. Federal funds must not be used to buy services of poor quality, and Federal funds must not be used to maintain aging citizens in surroundings that endanger their very lives.

Senator Kennedy, testifying in support of his amendment, cited the following reasons for his measure:

> Denial of Federal funds for nursing-home care is a drastic step. I urge such a drastic step because of information elicited in an important series of hearings in 1965 held by the Subcommittee on Long-Term Care of the Special Committee on Aging, because of information developed by my staff and the staff of that committee, and because of my own personal visits to many nursing homes.
>
> This information has convinced me that the operator or administrator of a nursing home is the key person in assuring that the care received by nursing-home patients is of a very high quality. The operator is, after all, the man who hires and fires the staff, the man who orders the food, the man who schedules visits by physicians and, in general, the man who sets the standards by which each individual nursing home operates.

Reasonable cost.—One provision of Senator Moss' amendment which was not enacted, but which is most significant, is that providing for the payment of reasonable cost for nursing-home care provided under title XIX programs.

At present a majority of States establish, through negotiation or through administrative or legislative action, a single rate of reimbursement for the care of public assistance nursing-home patients in the State. Some States classify patients according to the care they

require and establish varying rates for patients needing maximum care, intermediate care, and minimum care. Problems arise in both systems because the former system may be incapable of producing equitable results, and the latter might tend to establish a monetary incentive to keeping patients in a maximum care state. Chairman Moss' dissatisfaction with the present systems of reimbursement is expressed in the following extract from his testimony on the amendment:

> In short, our present approaches to payment for care tend to discourage initiative and promote passivity in patient care, to penalize excellence, and to assure the continuance of marginal and even substandard homes by giving them a relative financial advantage.
>
> It seems to me that we must adopt the principle of payment of full costs for services actually provided to our publicly assisted nursing-home patients. By using the phrase "reasonable cost," however, I do not wish to imply that I would like to see simply the adoption of the principles of reimbursement now developed for title XVIII. I am not in a position to make a detailed critique of the principles of reimbursement, but I am aware that neither the providers of service nor the administrators of the program are entirely satisfied with them.[5] I am particularly concerned that the 2 percent plus factor, or 1½ percent in the case of proprietary nursing homes, may operate as a disincentive to economical operation and cost reduction. However, I believe we should establish the principle of paying the full cost of care actually rendered, and I think it would be desirable to allow some experimentation under the title XIX program with different methods of determining reasonable cost.[6]

Another significant amendment which was enacted into law was introduced by Senator Jack Miller a member of the subcommittee. It is concerned with assistance in the form of institutional services in intermediate-care facilities. This provision should have a far-reaching effect upon the provision of nursing-home services to the aged blind, or permanently and totally disabled, in that it will encourage the placement of patients in facilities according to their needs and discourage the tendency to utilize facilities designed to provide a higher degree of care than is necessary. It will have the further effect of promoting more specific and precise definitions of the various categories of care which will facilitate proper patient placement.

> **Nursing-home legislation enacted in 1967 was necessary for correction of the problems and abuses associated with the nursing-home industry. However, meaningful and comprehensive progress will not be achieved until the resources of the total health community are utilized to provide the quality and degree of care desired for the elderly in a truly comprehensive "spectrum of facilities."**

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[5] 1967 amendment to the Social Security Act authorizes the Secretary of HEW to develop and engage in reimbursement experiments with physicians who would otherwise be entitled to receive payment on the basis of reasonable charge, and organizations and institutions which would otherwise be entitled to reimbursement or payment on the basis of reasonable cost, for services provided.

[6] The statement of Senator Moss introducing the reasonable cost amendment is printed in full in the appendix. See appendix, p. 245.

Discussion.—Among matters that will receive subcommittee attention are integration of nursing-home care into the health care system to a greater extent, maximum utilization of home health care services, and communitywide planning for a proper balance of acute, long-term, institutional, and noninstitutional services, need for physicians and other health personnel to be oriented in the care and treatment of long-term chronic illness, and need for hospital affiliations with nursing homes.

CHAPTER VI

CONSUMER INTERESTS OF THE ELDERLY

Older Americans are no more homogeneous as consumers than they are in any other capacity. Tastes and budgets vary widely, as in other age groups. Elderly consumers, however, received increasing attention from government agencies and private organizations in 1967 for several compelling reasons.

These reasons, discussed at some detail during hearings before a unit of this committee [1] and at conferences in many cities, are considered in this chapter.

I. UNIQUE PROBLEMS AND CHALLENGES

Consumer problems became a leading issue on Capitol Hill in 1967 largely because of the enactment or advancement of major legislation that in one way or another closed longstanding gaps in marketplace protection.[2]

For the elderly in particular such progress is welcome, because of special problems faced by so many of them as consumers:

A. The Income Squeeze

Total income for all 19 million Americans past 65 comes to about $40 to $45 billion,[3] but—as seen earlier—millions of older Americans live on about half as much income as younger people. Each dollar must count for more.[4]

In addition, homeownership usually provides the major asset of older individuals or couples. Increased taxes cause concern and reduced spending, sometimes on necessities. Heavy dependence upon homeownership is one contributing factor, too, to the success of dubious "home repair schemes" among the elderly.[5]

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[1] Subcommittee on Consumer Interests of the Elderly (Senator Harrison A. Williams, chairman), U.S. Senate Special Committee on Aging, hearings January 17–18, 1967, Washington, D.C. and February 3, 1967, Tampa, Fla.

[2] A summary of major legislation appears on p. 252 in letter from Mrs. Betty Furness, Special Assistant to the President for Consumer Affairs.

[3] Additional statistics on Elderly as Consumers, see p. XIV of this report, and also Chapter I, dealing with retirement income.

[4] Dependence upon fixed income causes continuing concern about long-range adequacy of such funds. From St. Petersburg, Fla., where many elderly have retired, came this description of making ends meet (p. 262, hearings cited, footnote 1): "* * * Because of their physical condition and lack of transportation, because of limited income, these folks are forced to live in this area, handy to stores, restaurants and churches. * * * We have talked with people with a 50-cent-per-day allowance for food. How do they manage? They sleep late, go to one of the Central Avenue Drug or dimestores and have waffles and coffee. Late in the afternoon they have a quarter left for more waffles or a bowl of soup. Malnutrition is rampant. When questioned about the lack of public knowledge concerning their plight, one old gentleman stated that, 'He was raised in an era when one stood on his own two feet, and where demonstrations and rioting in the streets was considered un-American.' "

[5] Fred B. Causey, attorney for the Federal Trade Commission in Atlanta, Ga., told the subcommittee (p. 287, hearings cited p. 90, footnote 1) cases in which salesmen in questionable aluminum siding "improvement" plans also profited from arranging to finance the sale.

B. Heavy Expenditures for Health

Even with medicare, such expenditures are formidable. William Bechill, Commissioner of the Administration on Aging, told the subcommittee, for example, that older Americans spent an average of $50.20 for medicines from June 1964 through June 1965, $41.40 for prescriptions and $8.80 for nonprescribed. People under 65 in the same year spent $18, or a little more than one-third spent by older people. Fearful of deductible and coinsurance features of medicare [6] and gaps in coverage,[6] many elderly keep a reserve fund for emergencies even at the cost of giving up necessities.

C. The Changing Marketplace

Dr. James L. Goddard, Commissioner of the Food and Drug Administration, reminded the subcommittee [7] that "it is far more difficult to be an intelligent patient today than it was a generation ago," because of radical changes in the science of therapeutics within the past 20 years. He added:

> And, while we may all take comfort in the fact that our parents do have better care, we may be somewhat discomforted to learn that they are generally unaware of the significance of the care they receive, of the drugs prescribed for them, of the devices that are used for their health—and of the many medical frauds and cheats that are directed at their ignorance of this "new medicine."

Questions about health products from elderly consumers are numerous, according to reports from FDA district offices. Dr. Goddard said that the questions most frequently asked are: [8]

1. How much vitamins and minerals do I really need?
2. Are all drugs safe and effective?
3. How can I control my weight without the use of all sorts of drugs and devices?
4. Why does the print on drug labels have to be so small as to be unreadable for elderly people?
5. Do I always have to go to a doctor, or can I do some doctoring on my own?
6. Where can I find medical assistance given to me in my own language?
7. Why don't cosmetics carry labels that list all the ingredients?
8. Hasn't the soil been depleted so that our food really isn't all that nutritious?
9. If a machine is patented, does that mean it is safe and effective to use?

FDA-sponsored conferences (see next part of this chapter) are intended to help provide answers.

The modern supermarket.—Commissioner Bechill, too, discussed complexities of shopping today, but he did not limit his commentary to health products: [9]

[6] See pt. I, ch. III, of this report.
[7] Dr. Goddard's testimony, pp. 67-89, hearings cited, p. 90, footnote 1.
[8] P. 83, hearings cited p. 90, footnote 1.
[9] P. 6, hearings cited p. 90, footnote 1.

The technological advances of recent years have affected the foods we eat, the medicines we take, the appliances we use. Our choice of these products, in most cases, must be based on information reaching us through a highly sophisticated and persuasive mass media advertising industry. Day-to-day marketing practices often are in complete contrast to those to which older consumers were once accustomed. The corner store and the friendly butcher with whom our parents dealt have been replaced by the large self-service store.

The typical supermarket before World War II stocked approximately 1,500 separate items, but today it carries over 8,000. Ninety percent of the prescriptions written today are for drugs that were unknown 20 years ago. Many of the new products used every day are highly complex so that, as it has been stated by one consumer educator, the user is called upon to be an amateur electrician, mechanic, chemist, toxicologist, dietician, and mathematician—but he is rarely furnished the information needed to perform these tasks proficiently."

My point is that marketing has become increasingly impersonal. The consumer often does not know precisely how much he pays for consumer credit, whether one prepared food has more nutritional value than another, whether the performance of a product will, in fact, meet his needs, or which of the package sizes is really a bargain.

Studies by this committee [10] have already brought to light that the complexity of the modern marketplace offers increasing opportunities for distortion or omission of facts. This, together with immobility, illness, loneliness, and other factors affecting many older people, makes them susceptible to fraudulent schemes or at least places them at a disadvantage in finding the best buys for their limited funds.

Consumer complaints and actual court cases conducted by the various consumer protection agencies reveal the heavy incidence of exploitations and misrepresentations foisted upon the elderly—and particularly the elderly poor.

D. Some Persistent Problems

Questions about such matters as hearing aid availability and the sale of health insurance through the mail [11] are received regularly by the subcommittee and will receive careful attention. Another matter of some concern are so-called earning schemes. An FTC official, after carefully noting that most franchise contracts are offered by bona fide companies with every intention of living up to the agreement, testified: [12]

Another area in which the elderly are frequently victimized, along with many other people, is that of business

[10] A reference to hearings conducted in 1964 by the Subcommittee on Frauds and Misrepresentation Affecting the Elderly. Findings are discussed in a report, "Frauds and Deceptions Affecting the Elderly, Investigations, Findings, and Recommendations." Jan. 31, 1965.

[11] A letter from Paul Rand Dixon, Chairman of the Federal Trade Commission, to Subcommittee Chairman Harrison A. Williams (p. 253 of this report) tells of those mail order promoters "who dangle bright promises even to the extent of persuading the aged to take the tragic step of abandoning long-standing policies which in reality afford greater protection."

[12] P. 287, hearings cited p. 90, footnote 2.

> opportunities offered for sale, either franchises or businesses represented as a going business. You usually find again the problem that this can sometimes take the savings of a lifetime because these franchises may run as high as $10,000 or even higher. And some people fork out that kind of money and later find out all in the world they have is a franchise.
>
> Another area of business in which deception of this type is not infrequent, is in the sale of food freezer plans with the representations being that you can own and buy the food freezer and the food for the same cost you are going to pay for the food. This is frequently found to be untrue. In fact, the business—I have had people tell me that the usual result is that the food costs go up over what they were before. The people start living a little higher and higher again. Here again financing is a critical element that I have observed in aiding the unscrupulous to foist this kind of thing on the elderly people and others.

II. RESPONSE BY AGENCIES

Important as new protective legislation is, Federal actions on behalf of elderly consumers has also put heavy emphasis on educational programs and other actions that will help States to do the same. A marked increase in such activities was reported in 1967.

A. Administration on Aging

Commissioner Bechill reported [13] that the AOA is supporting pilot demonstrations in 10 areas of great concern to older Americans: (1) sound nutrition,[14] (2) economy food purchasing, (3) the careful purchase of credit, (4) avoidance of quackery, (5) avoidance of fraudulent products and practices, (6) safe and effective use of drugs, (7) accident prevention, (8) management of retirement income, (9) medicare and supplementary health insurance plans, and (10) care of clothing and household equipment.

He also reported that approximately 60 projects [15] approved for funding had elements of consumer protection. A later report from AOA [16] noted that a majority of senior activity centers funded under title III of the Older Americans Act have an element of education in their services.

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[13] P. 9, hearings cited p. 90, footnote 2.

[14] Some evidence on the need for attention to nutritional needs is provided in this excerpt from a letter submitted to the subcommittee by Mrs. Marcelle Levy, director of the New York State Office for the Aging (p. 166, hearings cited p. 90, footnote 1):

"There is significant evidence to indicate that more than half of the elderly, who became institutionalized in a period of a year, have as a complication to their principal health problem, a long-standing malnutrition.

"The New York State Departments of Social Welfare and Health have, through regional conferences and meetings, assisted long-term care institution operators in effecting nutrition programs to combat this problem. Unfortunately, the effectiveness of such practices cannot be easily transferred to the individual prior to admission. One can only conclude that in all too many cases, the precursors of malnutrition are lowered income fostering poor eating practices. Unfortunately, the effect after a period of time is inevitable. It would be interesting to know the number of noninstitutionalized in this age group who have this problem and are never identified. *A fair estimate based upon current income data would indicate that approximately 9 million persons in the 65-and-over age group are faced with this as a daily recurring reality.*" [Emphasis added].

[15] P. 8, hearings cited p. 90, footnote 1. Mr. Bechill also gave several examples, including a demonstration food service program in Dade County, Fla., a Chicago senior citizens' mobile service project that will, among other things, provide purchasing information for the aged person, and an accident prevention study in Colorado.

[16] Text on p. 178.

The Hudson Guild consumer education project.—One noteworthy example of direct help to consumers was provided in this effort, which is supported by the New York State Office for the Aging under the Older Americans Act. A full-time consumer specialist is now at work in a center serving a large number of elderly in a Manhattan public housing project. In testimony before the Subcommittee on Health of the Elderly, the director gave many examples of difficulties caused by misunderstanding of medicare, medicaid, and social security. The director also gave this account of the project status:[17]

> Our program has: (1) demonstrated a need for adequate food programs, (2) cooperated in a medicaid alert, (3) developed a drug plan, (4) attempted to involve older people in social action, (5) initiated an information program with welfare, (6) held a citywide conference on consumer problems of older people, and (7) began testing various educational techniques. Our next year will be focused on social action and the development of a family security program.[18]

Project Money-Wise Senior.—Another approach to consumer education of the elderly was provided during September and October of 1967 by this pilot program, which was conducted in Boston, Mass. by the Bureau of Federal Credit Unions under the sponsorship of the Massachusetts Commission on Aging and the Consumers Council of the Bay State. An AOA report on the project makes these observations:

> The agenda of the 4-week consumer education program included an overview of the effects of poverty on the elderly, marketing and shopping weaknesses of the older poor, recognition of fraudulent practices, financial counseling and budgeting, use of credit, and discussions of available public services.
>
> The executive secretary of the Massachusetts Commission on Aging, John T. Sweeney, stated, "It is our opinion that Project Money-Wise Senior is one of the most important and worthwhile projects that the Massachusetts Commission on Aging has ever been involved in. Without exception, every single participant derived great benefit from this program and they have returned to their community groups, not only better informed for themselves, but in a position to assist others in making sure that senior citizens get the most products and services for their meager incomes. I believe that it would be of inestimable value to the senior citizens of this country and their communities if this project was conducted in every State in the Union."
>
> The commission plans to follow-up on Project Money-Wise Senior by placing the older participants in title III projects, senior citizens organizations, and consumer groups in their communities.

(Consumer education and related programs have also been underwritten by the Office of Economic Opportunity by approximately $8

[17] P. 441, "Costs and Delivery of Health Services to Older Americans," before the Subcommittee on Health of the Elderly (Senator George Smathers, chairman), Senate Special Committee on Aging, hearings in Washington, D.C., June 22–23 and New York City, Oct. 19, 1967.

[18] Reports of the project can be obtained by writing to Hudson Guild, 119 Ninth Ave., New York, N.Y. 10009.

million. These programs have involved buying clubs, credit union self-help, budget counseling services, and neighborhood legal services. These programs, while serving all of the poor in the communities affected, are of particular help to the elderly.)[19]

Nutritional services demonstration.—A $2 million provision for such a program was included in the Older Americans Act Amendments of 1967. The AOA is working with the Public Health Service and other agencies to develop new approaches and information about food services to be presented through this program.

B. The Food and Drug Administration

Working in consultation with the AOA, the Food and Drug Administration is conducting widespread conferences on "The Older Citizen in Today's Market Place."[20] The purposes of those conferences, as expressed in a recent magazine article,[21] is "to penetrate the world of our elderly citizens and bring to their doorsteps awareness of the new medicine, the new foods, and the new hazards of the marketplace."

State agencies on aging are working with the FDA and, in some cases, acting on their own to hold conferences on such issues as quackery and buying practices.

Survey on quackery susceptibility.—Seven Federal agencies are cooperating in an intensive study intended to explore types of consumer response to claims made for worthless or questionable health products. The survey was first recommended in a report [22] by a unit of this committee and is now nearing the end of its first phase. It is anticipated that the study will be completed during the coming year.

C. Federal Trade Commission

FTC Chairman Paul Rand Dixon told the subcommittee that the Commission is intensifying its efforts on all consumer complaints related to health products.[23] While recognizing that primary responsibility in this area rests with the FDA, he said he "is not at all unmindful that the Commission also bears a direct and substantial responsibility in this respect." In 1967, the FTC and FDA worked to explore and develop coordinated programs for maximum effectiveness of each agency.

Some reasons for the FTC concern in this area were expressed in an excerpt from a Commission cease and desist order submitted by Mr. Dixon:

> The need for protection of the public becomes particularly acute where misrepresentations are made with respect to health claims and the efficacy of drugs since the appeal of such representations falls most poignantly on those persons who are in distress, frequently the aged and the infirm.
>
> Moreover, today, with medicare a reality, many people may be consulting doctors for the first time in their lives.

[19] OEO report on p. 259 of this report.
[20] A report on the FDA consumer education program for the aging appears on p. 255 of this report.
[21] "Meeting Senior Citizens: Dialogs for Action," FDA Papers, December 1967–January 1968 (reprinted on p. 255 of this report).
[22] "Frauds and Deceptions Affecting the Elderly—Investigations, Findings, and Recommendations: 1964", A report of the Subcommittee on Frauds and Misrepresentations Affecting the Elderly to the U.S. Senate Special Committee on Aging, Jan. 31, 1965.
[23] P. 91, hearings cited p. 90, footnote 1.

> They will be learning that aches and pains and discomforts of all kinds may be symptoms of diseases which they had never heard of before or never before associated with their own distress.
>
> Consequently, advertised claims of drug efficacy will have increasing relevance to this segment of our population and will offer hope of relief to millions in our population who may have previously ignored such advertising not realizing their possible application to their own conditions.[24]

At year's end, Mr. Dixon also reported [25] that the Commission increased its efforts to encourage State actions against deceptive practices. He said nine States either broadened or enacted general protective legislation in 1967. Three States passed laws to require licensing hearing aid fitters and dealers, bringing up the total to five: Florida, Indiana, Michigan, Oregon, and Tennessee.

D. President's Committee on Consumer Interests

A report appears on pages 252–253.

III. PRODUCT DESIGN AND THE ELDERLY

An entirely new field of study was suggested to the subcommittee in this declaration from Mrs. Geneva Mathiasen, Executive Director of the National Council on the Aging:

> * * * I wish today, to make the point that our society is not sufficiently aware of the older group as consumers and the amount of money they spend in the aggregate.
>
> There is little doubt that older people are adversely affected by the current preoccupation of producers and purveyors of consumer goods with the "Pepsi generation," in spite of the fact that there are nearly 2 million more people in the United States today who are 60 and over than there are teenagers. In the aggregate, * * * people over 65 * * * spend between $35 and $40 billion. While many individuals are poor, a few are very rich, and a good number are well to do. Their incomes are increasing. It is estimated that in 10 years this will be a $55-billion market. At present, it is not being exploited either by the producers or by the sellers of goods.
>
> The National Council on the Aging, concerned with the overall well-being of older people, believe that their needs will be met in part by health and welfare services, but also by the production and marketing of consumer goods suited to their special requirements and readily available.

Mrs. Esther Peterson, then Special Assistant to the President on Consumer Affairs, made a similar point:[26]

> Much marketing effort today is directed at developing special products for that segment of our population that is young. This is entirely proper. But I think that industry

[24] P. 90, hearings cited p. 90, footnote 1.
[25] A report on FTC activities and consumer problem areas in 1967 appears on p. 253.
[26] P. 48, hearings cited p. 90, footnote 1.

would do well to examine * * * what products merit special design for the elderly.

Congressional authority to influence product design and development is limited, as it should be. But this committee can perform a function encouraging public discussion and by suggesting certain actions by Federal agencies that may have positive effects for the elderly consumer of all income groups and for manufacturers and providers of services and housing. Arguments for such action were well expressed by Mrs. Mathiasen:

> For many years, NCOA has directed attention to a number of areas where the inventiveness which characterizes modern industrial design and engineering might be utilized *to help create a living environment conducive to the well-being of individuals as they grow older, to help them retain independence and perform their daily tasks with less effort, and to enjoy with greater zest their leisure time.* (Emphasis added.) Whether a dress has a zipper up the back or up the front may make the difference between a woman's being able to dress herself or not. The simple act of rising from a chair, or getting in and out of a taxicab, can add or subtract years to a man's apparent age, depending on how the chair or taxicab is designed.

A case can also be made for the fact that better design—particularly in public buildings and transportation facilities—helps all people, including those who may have a disability of some kind. Alan R. Logan, chairman of the Governor's Committee on Employment of the Handicapped in Florida, discussed that point:

> All elderly are in some degree physically limited. But all physically limited people are not elderly. The public is all of the people and all things "public" should be truly that.[27]

Certain exploratory suggestions seem appropriate at this time:

Design of clothing.—Mrs. Dorothy Behrens, designer-director of vocational guidance and rehabilitation services in Cleveland, said that a study of clothing available for elderly women in that area yielded only "poorly designed, uninteresting clothing in monotonous patterns and unsuitable colors in limited sizes for older women—as younger women's measurements are used as standard for patterns."[28] Over the years, the Department of Agriculture, through its home economics studies, has interested itself in this special problem.

In 1939–40, the USDA made a nationwide study of body measurements for women in the 18-, 19-, and 20-year-old brackets, with modest additional samples in middle-aged groups.

In the late 1950's, the USDA undertook a study of clothing for handicapped women. Special apparel were designed for the handicapped and exhibits of these specially designed clothes were made available for inspection by interested consumer groups and manufacturers. This body of knowledge was not, however, put to use by the clothing industry. Mrs. Behrens' Cleveland agency did adopt these designs, operating in part with public funds.

[27] P. 307, hearings cited p. 90, footnote 1.
[28] P. 29, hearings cited p. 90, footnote 1.

Recently, the Department of Agriculture entered into a 3-year contract with Boston University for a study of the body measurements of women in the 70-to-79 age bracket. This study will be completed in June 1970.

The USDA also provides clothing design assistance through the auspices of its Extension Service, through instruction and the distribution of design materials.

This area of clothing design is one that requires attention if the consumer needs of the elderly are to be met. The Administration on Aging should take on the task of bringing together sufficient consumer statistics so that manufacturers of clothing could be encouraged to produce such items of wearing apparel in the retail clothing market.

Another possibility: exploratory discussions by the Administration on Aging and the President's Special Assistant on Consumer Affairs and the Rehabilitation Services Administration.

Living arrangements.—Many older Americans move from houses they have owned most of their adult lives into smaller apartments. Often, major adjustments must be made. An experimental apartment—outfitted by the American Association of Retired Persons in consultation with national trade associations and Mrs. Peterson—demonstrated that even crowded quarters can be furnished at modest cost.[29]

Mr. Edward H. Noakes, a member of an American Institute of Architects study group, had some fundamental questions about the planning of apartments:

> With a little thought, apartments generally could be planned with kitchens whose counters, sinks, ovens, and storage could all be adjusted up or down with the use of a screwdriver, their bathrooms could have walls designed to take one or any combination of grab-bars. Such apartments would be a godsend to people who want to live independently but can't find the environment.[30]

Haley Sofge, director of the Miami Housing Authority, told of practical lessons he has learned in day-to-day experience:[31]

> I feel, sir, that there is much still to be learned in the design of apartments suitable to the needs of the elderly. All Federal programs concerned with elderly housing are still subject to evaluation as to the design and use of materials, in particular in the kitchen and the bath. For instance, in dealing with the elderly person who needs a refrigerator we actually found that he needed a larger refrigerator due to the fact that he was limited in his ability to shop. The elderly wait for a welfare check and they do not make too many trips to the store. When they do, they bring home a large amount of groceries at one time. It may be possible to develop a special top burner and oven for the elderly, with built-in safety features, and the volume of elderly housing may warrant such a study by industry. In fact, industry has a role here and possibly we should interest industry in special design studies

[29] Testimony by Mr. William Fitch, then executive director of AARP, pp. 113–126, hearings cited p. 90, footnote 1.

[30] P. 39, hearings cited p. 90, footnote 1.

[31] P. 273, hearings cited p. 90, footnote 1.

> of elderly needs in terms of furniture, bath and kitchen equipment—and I am not speaking of an institutional design but one that would assist the elderly.

Prompted by such commentary, Subcommittee Chairman Williams wrote to Robert Weaver, Secretary of Housing and Urban Development, and asked whether a HUD conference would be of help. The Secretary replied: "I know that industry is becoming more and more interested in the senior citizens housing market, and your suggestion that we might sponsor a conference to discuss new designs has great merit." The Secretary also saw wide opportunity in new Federal programs for experimentation in other ways to improve living arrangements.[32]

Clearly, there is more room for experimentation and discussion about the design of apartments and fixtures used in federally assisted housing accommodations for the elderly. The receptive attitude at HUD to suggestions already received leads to the conclusion that further exploration will be productive.

Furniture design also received subcommittee attention. Dr. Michael M. Dacso, director of Goldwater Hospital Service in New York City, has conducted studies on furniture design and its relation to physical well-being of the elderly. He has concluded that health scientists and furniture manufacturers should engage in extensive consultation:

> It has been repeatedly pointed out that with advancing years skill, strength, and sensory functional capacity are diminished, even in the absence of any identifiable disease. The combination of these factors create a situation which presents a considerable safety hazard. Therefore, in addition to practicality and esthetic appearance the furniture designer must constantly bear in mind the importance of safety provisions. These safety measures will have to be considered not only in the design and construction of furniture but also in the materials used. In considering the need for designing a new type of furniture for elderly people I do not believe there is any question about the need for intimate cooperation between the furniture designer, manufacturer, and those who are by the very nature of their profession acquainted with the physical and emotional demands of the elderly person. It must be recognized that in addition to the architect, the furniture designer is in the best position to alter the elderly person's physical environment to suit his comfort and functional

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[32] P. 245, hearings cited p. 90, footnote 1. Other excerpts from the Secretary's letter:

"I think the suggestion that sponsors of housing for the elderly seek the advice of older people an excellent one, and I know that some already have met with representatives of aging groups for this purpose. While the applicants and their architects are responsible for the development and preparation of plan, specifications, etc., the ideas of older citizens, as the prospective consumers of such housing can be quite helpful, and we will be glad to encourage sponsors under each of our programs to consider their suggestions.

"As you know, President Johnson, in his recent Message on Older Americans, directed that we make certain that the model cities program gives special attention to the needs of older people in poor housing and decaying neighborhoods. Our standards for the model cities program already require that there should be maximum possible use of new and improved technology and design, including cost-reduction techniques, and this will be applicable to housing for the elderly as well as other structures.

"The provisions for special grants supplementing assistance available under existing grant-in-aid programs also can be very helpful to the elderly. Since these supplemental grants, which can be up to 80 percent of the total non-Federal contribution are not earmarked, they may be used without further local matching for any project or activity included as part of the approved comprehensive model cities program. In addition, since these supplemental grants must be used first to support new and additional projects and activities not otherwise assisted under an existing Federal grant-in-aid program, these funds might very well be used, at least in part, in developing new functional design standards for housing for the elderly."

needs. The need for cooperation is so obvious that one often wonders why it has not been recognized before. It is hoped that a promising cooperation between health scientists and furniture designers will develop in the future, resulting in additional constructive steps to make the elderly person's life safer and more comfortable.

Architectural barriers.—This is the term used to describe any design deficiency that reduces accessibility to a building or any other public facility, such as a subway or a pedestrian walkway over a road. Mr. Noakes, who is chairman of an AIA project to eliminate such barriers, told the subcommittee that more careful planning is required in our public buildings so that they can accommodate the non-average man—in this case, the handicapped or elderly person.

> It may not be the height of folly to continue to build and construct for the average man, but it is certainly out of step with modern social, medical, and political science to ignore the needs and aspirations of the millions who are temporarily or permanently incapable of adapting to average design conditions, to say nothing about the added burden on the public treasury.

In referring to the need for attention in the planning and the design of rapid transit systems, Mr. Noakes continued:

> There are also legal and moral overtones when taxpayers are excluded, by design, from the enjoyment of a publicly financed venture such as the rapid rail system now being designed for Washington, D.C.

One legislative effort to meet the problem of architectural barriers head on was the introduction in the Senate of S. 222,[33] a bill to insure that public buildings financed with Federal funds are so designed, and constructed, as to be accessible to the physically handicapped.

The bill requires the Secretary of the Department of Health, Education, and Welfare to prescribe regulations establishing standards of design and construction for public buildings so that they are accessible to and usable by persons who are physically handicapped. The Administrator of the General Services Administration would carry out the necessary functions under these regulations.

This measure passed the Senate on August 25, 1967, and is now pending before the House Committee on Public Works. Hearings have been held on the proposal.

During hearings on this measure by the Subcommittee on Public Buildings and Grounds of the Senate Committee on Public Works, Mr. Moses Gozonsky, Deputy Assistant for Problems of the Elderly and Handicapped, Renewal and Housing Assistance, HUD, testified:

> * * * we support the objectives of S. 222. Who, with any regard of his fellow citizens can be complacent when some are unable to gain access and egress from a building conveniently; or are unable to move about within a building from place to place; are rendered unemployable; or are unable to obtain whatever services are offered therein—all because of building

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[33] Introduced by Senator Bartlett with 18 cosponsors.

design which fails to take into consideration physical handicaps * * *

With respect to housing and other facilities, pending a determination by the Congress that architectural barriers be eliminated to the extent feasible, in programs financed and administered by HUD, we would welcome and encourage the voluntary submission of plans by sponsors which would include provisions for the handicapped. With costs of construction already so high, and continuing to increase, we would, however, want to examine most carefully the impact on costs of special design features before approving their inclusion, however socially desirable. Otherwise, we may find all too often, our efforts to provide an ever-increasing supply of decent housing for millions of low-income persons and families thwarted by excessive prices which neither the general public nor the handicapped can afford.

IV. THE "MODEST BUT ADEQUATE BUDGET"

Still another difficulty described to the subcommittee was the model budget established by the Bureau of Labor Statistics to serve as a guide in estimating the needs of a retired couple.

BLS is charged with the task of identifying those groups in the population whose living standard is below an acceptable level, and of gaging the size of such groups. Findings of such surveys are used as tools in shaping public policy. Surveys of this type are initiated for the purpose of informing the public of the less-than-adequate income groups, or at the request of the Congress to define a specific area in which legislative policy is concerned.

BLS surveys are considered in the development of public policy for:

(1) Potential consumption of agricultural products;
(2) Industrial market analyses; and
(3) Estimates of expendable income.

Another use of standard budgets is in the area of Federal policy or legislation. "The Budget for an Elderly Couple," created by the Social Security Administration in 1948, was used to determine the adequacy of social security payments, along with other financial resources, for an adequate level of income.

Several Federal and State laws require the administrative determination of need, or the cost of a defined adequate living standard. Such determinations are necessary in the following instances, to name but a few:

(1) State minimum wage laws;
(2) Public assistance under social security; and
(3) Eligibility for public housing.

The BLS budget for an elderly couple or elderly individual has been criticized because, it is alleged, budget items are determined by current spending habits rather than by estimate of need.

BLS RESPONSE TO CRITICISM [34]

In 1963, in an effort to increase the effectiveness of this budget, the Bureau of Labor Statistics named an advisory committee com-

[34] P. 326, hearings cited p. 90, footnote 1.

posed of the major users of standard budgets. This committee recommended that the budget be revised within the following guidelines:

> That the "modest but adequate" budget for a retired couple be revised—following the broad concepts and general procedures used for the original budgets;
>
> That budgets be developed reflecting a lower and a higher standard of living; and
>
> That * * * in addition to large cities, cost estimates be obtained for a sample of medium-sized and small cities as required to prepare estimates of the average budget cost for the urban United States.

In a letter to the subcommittee, Commissioner Arthur M. Ross of the Bureau of Labor Statistics traced briefly the history of the retired couple's budget, from its inception in 1946–47, through the revision program discussed above. The closing sentences of his digest of this "budget" set forth the scope of the revised "modest but adequate" budget for a retired couple:

> A revision program * * * was initiated in the autumn of 1965. A new list of goods and services which provide a "modest but adequate" standard of living for a retired couple in terms of standards prevailing in the 1960's has been developed and autumn 1966 prices have been collected * * *

With greater coverage than was previously the case, the new budget, to be released in May of this year, is intended to be a more timely reflection of the budgetary needs of an elderly couple or individual.

CHAPTER VII

SOCIAL SERVICES FOR THE ELDERLY

If somehow adequate income, good housing, and inexpensive health services could be made available to *all* older Americans tomorrow, there would still remain a large and growing need for social services designed for a population in which the proportion of newly retired persons and their older predecessors increases each year.

Such was the theme sounded again and again during 1967 to this committee in testimony [1] and correspondence. That theme, and its ramifications, was perhaps most emphatically expressed by a professor of social work from Boston University: [2]

> Given an adequate system of social, health and housing security, many older people require a series of social services as "*social utilities*" (emphasis added) to cope with normal problems associated with the aging process. Social utilities are services which are offered to everybody as a matter of right, as much as "*public utilities*" are considered essential for the functioning of all of us. They will include counseling in relation to problems older people have with regard to family relationships, adjustment to a world of leisure, adjustment to new peers, et cetera. They will include group services to help people relate to their contemporaries, to develop skills in establishing new inter-personal relations, they will include services to enhance their sense of personal well-being.
>
> Even if we had an adequate social security, health and social utility system, residual social services will have to continue to be provided for those individual older people who cannot cope with the difficulties and frustrations which they experience in the later years. It is imperative that we plan for the future and for this reason I would propose that we devote our efforts to the development of a social utility system which is available to every retired or older person without having to prove need. Under such a system, social services would be considered as a matter of right and accessible to any one at any time at any place.

Other efforts to predict and prepare for long-range service needs were made during 1967, a year in which the most significant events were a reorganization of service programs within the Department of Health, Education, and Welfare, and the first report on service needs revealed through Project FIND.

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[1] "Long-Range Program and Research Needs in Aging and Related Fields," hearings before U.S. Senate Special Committee on Aging, Washington, D.C., December 5-6, 1967.

[2] Pp. 314-315, Dr. Louis Lowy, hearings cited in footnote 1.

I. REORGANIZATION OF SERVICES WITHIN HEW

A new Social and Rehabilitation Service, created by a reorganization plan announced in August 1967, unites under a single executive both HEW's income support programs and its social service and rehabilitation programs needed by many families and individuals.[3] Miss Mary Switzer, former Commissioner of Vocational Rehabilitation, was named as the first SRS Administrator. The Administration on Aging is now a unit within SRS, and it has assumed new responsibilities for providing services to the elderly.[4]

A. The New AOA Role

Through its three major grant programs, the Administration on Aging has assisted in the development of pilot and continuing services or projects. During 1967 alone, 400 projects were funded under title III (community planning services, and training). The largest number (227) of title III projects during that period was awarded to multipurpose senior centers.[5]

New Service Responsibilities.—The reorganization plan also assigns to AOA responsibilities for services to the elderly poor under public assistance programs. Such services are provided through State welfare agencies. As of December 20, 1967, 39 jurisdictions were providing services with 75-percent Federal matching.[6]

B. Overall Objectives

A report submitted to this committee by Miss Switzer lists the following as among the objectives of SRS with respect to achieving increased and better coordinated services for the aged:

- To reach increasing numbers of older people who want to remain active and help others in the community.
- To reach hidden populations of older people now isolated from contact with community services that could help them.
- To provide recreational and educational opportunities for thousands who now "have nothing to do."
- To expand social as well as physical and vocational rehabilitation services for the aged.
- To provide the elderly, particularly elderly poor persons, with a wide range of counseling, consumer education, homemaker, and information and referral services often unavailable to them.
- To step up training and rehabilitation for older blind persons whether they are in their own homes or in nursing homes.
- To expand support for research and demonstration projects to develop new rehabilitation opportunities for the aging.

The 1967 HEW plan that resulted in the establishment of the Social and Rehabilitation Service will undoubtedly have its far-reaching effects upon the provision of social services for older Americans of all income groups. Objectives of the reorganization, as expressed when the plans were announced,

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[3] Other effects of the reorganization upon the role of the AOA are discussed in ch. IX, pp. 128-131.
[4] A report on the reorganization, prepared by the SRS appears on pp. 271-277.
[5] A more detailed account of AOA grants for service and other purposes may be found on pp. 173-176.
[6] Additional details on pp. 271-277.

are laudable. Close attention, however, must be paid to the implementation of the program, with special emphasis upon its role in the development of future social services for the elderly.

II. SERVICE IMPLICATIONS OF PROJECT FIND

"Outreach" is the word generally used to describe projects intended to search out people who, though they may be most in need of service, are either unaware that such services exist, or are reluctant—for reasons as varied as timidity or chronic disability—to use them.

The need for "outreach" for the elderly poor was demonstrated during 1967 by Project FIND.

A. Extent of Program

Designed to find the friendless, isolated, needy, and disabled older persons in the community, FIND was administered during 1967 by the National Council on the Aging under a $700,000 contract with the Office of Economic Opportunity.

Elderly poor have been employed to seek out other elderly poor individuals, determine their needs, and to assist them in availing themselves of community resources for meeting their needs. The demonstration projects, conducted through OEO Community Agencies, are in:

Alexandria, La.
Hammond, Ind.
Huntington, W. Va.
Milan, Mo.
Muskegee, Okla.
New York City
Philipsburg, N.J.
Pontiac, Mich.
St. Petersburg, Fla.
Warren, Pa.
Washington, D.C.
Watsonville, Calif.

The Community Action Agencies in these communities were chosen from among 75 CAA's which applied to participate in the project. They were chosen as representing various regions of the Nation and as providing a good urban, rural, and central city sampling. In addition, 14 other Community Action Agencies put into operation FIND-type projects for the elderly poor of their areas with their regular community action agency funds, and cooperated with the demonstration by reporting their experience with these projects.[7]

B. "Confidence in Project Concept Confirmed"

Full documentation on the extent and success of the project is not yet available. An interim report made to this committee [8] in December, however, was optimistic about prospects:

> We have by now interviewed some 20,000 people in the communities involved in the project. This represents almost 10 percent of the estimated total number of older persons in the project's target areas. We have only preliminary reports

[7] The contract between the Office of Economic Opportunity and the National Council on the Aging under which the Project FIND demonstration was conducted during 1967, is discussed on pp. 259-260.
[8] Pp. 49-63, testimony by Mr. Jack Ossofsky, OEO project Director for NCOA, hearing cited, p. 103, footnote 1.

from the local projects, however, even these early reports bring to our attention what the community aides are finding as they knock on doors and talk to the elderly. We welcome the opportunity to share with you a few examples of what we are encountering and some impressions we have gotten from the project's first few months of work.

The first comment that seems in order is that our confidence in the concept of the project has been confirmed. Locating and talking with the elderly, particularly in our case the elderly who are poor, determining problem areas, and doing something about the problems, has shown itself to be of considerable importance to the individual and communities. In community after community, people were uncovered who lived isolated, in unbelievable poverty, in illness, in filth, in inadequate housing; people who are too frail, too unaware, too cut off from the mainstream of the community to make use of existing services, or to ask for the help to which they are entitled. While in many communities there are services that can be brought to bear to improve the lives of the elderly, in many instances services are inadequate or too far away, too inaccessible to the elderly. Project FIND has sought to close the gaps between the person in need and the agency set-up to help, and to stir the consciousness of the community where the help does not exist.

Examples of program at work:

In Hammond, Ind., in the project's first week of operation, an aide located a 105-year-old woman. The team captain looked at the address and remarked that she had worked many times in that area; she tried to visualize the house, but she could not understand how the lady could have been so invisible. This woman received $72 public assistance from which she paid $55 for rent. After paying for her laundry and medicines the only money left was for food. Her basement was often filled with water, she needed help with shopping, dressing, bathing, et cetera. She wanted to get into a home but did not know how to go about it. Within a few weeks the project had arranged for her acceptance into a comfortable home for the aged.

*　*　*　*　*

In mentioning problems of housing earlier, we referred to some of the dilapidated housing in which many of those interviewed live, and the need for repair services. One other recurring problem mentioned to us by the elderly is the pressure they feel from real estate taxes on their homes. We feel that this is an area that requires further examination and study.

Another aspect of housing that has come sharply to our attention from the New York City project is one which is typical in central city areas where urban renewal is about to take place.

Our New York project, while interviewing older people living in a number of hotels just off Times Square, learned

that several hundred older residents in these hotels (many of whom had lived there 20 and more years) were threatened with sudden, unexpected evictions because the properties had been sold and new office buildings were to rise on these sites.

The project rallied the residents, organized public protests, and brought the matter sharply before the officials of New York City. As a result of the project's help, the evictions were delayed, attempts are being made to relocate the elderly in suitable housing, and moving expenses and other assistance is being provided these tenants. As renewal projects grow in our central cities, often using Federal as well as State funds or tax abatements to encourage new housing, as well as office buildings, special care needs to be taken to protect the rights of tenants in the housing being destroyed. We will be giving this matter further study, but urge consideration by this committee of the special needs of older people who reside in great numbers in these single occupancy dwellings, and for whom moving and adjusting to a new neighborhood can present serious financial, social, and health hazards. They need protection.

* * * * *

Three other areas of need which keep coming to our attention are transportation for the elderly, escort services, and friendly visiting services. In both urban and rural areas the elderly report difficulty getting around in part because of the often high cost of transportation, but often too, in rural areas, because of the unavailability of public transportation. With advancing age and declining resources, many of those who previously drove cars stop doing so. Our projects find one of their most valuable services are driving people to doctors, shopping, to surplus commodities depots, and so forth. While inadequate transportation is a problem facing all age groups, it tends to complete the isolation of the elderly.

Just as Operation Medicare Alert[9] in 1966 revealed the need for sustained outreach efforts, FIND is revealing great gaps in the provision of services. As the NCOA testimony said:

We believe that the few months of operation of the project confirms the need for a Project FIND in every community, urban and rural. Our projects are presently funded only through March of next year and we do not yet know what the future of OEO's funding,[10] and therefore the project's fate, will be. In several cases the local communities have located so many people who were not being served by existing agencies, that they are beginning to look for ways of making the projects permanent. It seems to us that this initial experiment already indicates that a permanent network of such

[9] "Needs for Services Revealed by Operation Medicare Alert," hearings and report of Subcommittee on Federal, State, and Community Services, (Senator Edward Kennedy, chairman) U.S. Senate Special Committee on Aging, 1966.

[10] During March 1968 the Office of Economic Opportunity extended for an additional 8 months its contract with the National Council on the Aging to conduct Project FIND demonstrations.

programs to seek out and serve the elderly poor should become a nationally funded priority program.

C. Senior Opportunities and Services

Congress showed its interest in using the elderly poor to provide services needed by the elderly poor by including in the Economic Opportunity Amendments of 1967 a provision authorizing a "special program" to be known as "Senior Opportunities and Services."

While not identical to Project FIND, this newly authorized special program has enough similarities to it that the Project FIND demonstration projects which have been carried out should provide much valuable information to guide SOS planners. Unfortunately, as this is written, no funds have been administratively allocated for SOS, although there is a possibility that some community action agencies will inaugurate local programs of the SOS type with their regular community action funds. However, the fact that SOS is authorized supports a hope that funds will eventually be made available.

Project FIND and the anticipated SOS could be significant developments in the field of services for the elderly. They represent progress in devising ways of using the elderly to provide services needed by the elderly, thus benefiting both those who serve and those who are served.

III. FUTURE SERVICE NEEDS

Far-ranging questions about future services for the aging and aged were raised in testimony [11] taken by this Committee in 1967, suggesting that careful consideration should be given at the Federal, State, and community levels to fundamental goals and methods related to the delivery of those services.

A. What Is Needed

Dr. Walter Beattie, dean of the School of Social Work at Syracuse University, submitted a tentative working model [12] for planning of services to the aging. Even a partial listing of services mentioned by the dean is impressive:

Adjustment and Integrative (to permit the older person to participate in community life and utilize his capacities): specialized casework service to the older person and/or his family; old age assistance where needed, recreation services, day activity centers, retirement preparation.

Supportive (to aid the old person to remain in familiar habitat or retain his usual living arrangement): friendly visiting, organized home care, home meal service, homemaker-housekeeper service, and transportation by motor service.

Congregate and Shelter Care (to help those who can no longer live in the open community due to physical and/or mental infirmity): day care, homes for the aged, special housing, inpatient medical-care and long-term nursing, substitute family care.

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[11] Hearing cited p. 103, footnote 1.
[12] P 313, hearing cited p. 103, footnote 1.

Protective services (to protect rights and welfare of those unable to provide for own needs and handle own finances): a coordinated and focused procedure for providing legal, medical, and social services.

Dean Beattie also pointed out that "the aging population changes with each generation as does the society of which it is a part and such change is likely to increase the need and demand for services." Among the changes foreseen by the dean: "The aged in decades ahead will increase in numbers, with many more living in their very advanced years; that is, 85 and older," and there will be "far more women than men;" and a "much more universal phenomenon of two generations within the family beyond the ages of 65; in fact we will have five-generation families which, although not living under one roof, will increase the complexity of intergenerational roles and responsibilities." In addition, a member of "the next generation of the aged will bring to his later years more than a restricted occupational view of life through a broader educational background."

B. Some Questions for the Future

In the face of foreseeable increased demands for service, serious questions arise about even the present capacity to deliver them. Mr. Milton Shapp, representing the National Council on the Aging, said, for example: "* * * Experience indicates that, in most communities, skilled casework and counseling service for the elderly is inadequate or nonexistent," even though there is a growing recognition of such needs in multipurpose senior centers, housing projects, and elsewhere.[13]

Herbert Shore, executive director of the Dallas Home and Hospital for the Jewish Aged, also commented about scarcity of services: [14]

> I suspect we have yet another problem that centers about the desire "to coordinate," which implies that there is something in existence to coordinate. In most communities, the problem is not one of coordination of the community. I know of none where a wide array of services are actually offered on anything but a demonstration program basis. When we list the wide array of services that we know about in the field of gerontology, we are usually thinking of pilot programs which would serve only a handful of people. I suspect our problem is not so much the creation of new services, but the actual provision of services we already know about * * *

A similar view about "coordination" was expressed by Dr. Wilma Donahue, director of the Division of Gerontology at the University of Michigan: [15]

> The theme of coordination has long since worn thin from use in calling for it. Everyone believes in it, everyone asks for it, yet, to the despair of those dedicated to it, little actual coordination ever takes place at any level of society. We continue to duplicate services while failing to fill obvious gaps. We jealously guard what we consider our programs, feeling that we would be lesser persons if we merged them into a

[13] P. 17, hearings cited p. 103, footnote 1.
[14] P. 325, hearings cited p. 103, footnote 1.
[15] Pp. 186-187, hearing cited p. 103, footnote 1.

coordinated whole. We continue to put the older persons' needs after our own desires.

I believe that one of the most important goals to which the policymakers can address themselves is that of designing and then recommending patterns of coordination of social services at the community level. Not only would such a plan help determine what services should be provided but would help determine who needs what services. For example, one generalization often heard is that social services should be provided to help older people stay in their own homes as long as possible. But no one has determined the threshold at which point the social cost of scarce professional manpower is no longer justified or at what point the provision of a gamut of services actually fosters dependency and causes social isolation of the persons being served. Another example are the food services deemed necessary, especially for shut-ins, but which have been notably unsuccessful in this country. In part I believe the lack of success stems from the failure to clearly determine the goal of such a service. For some it is to improve the nutrition of older people regardless of whether or not they are able to prepare their own meals, for others it is to serve a more social goal of fending off poor food practices of lonely people, and for still others it is intended, as in England, to serve only those who are certified by a physican as physically unable to shop and prepare their own food.

My plea is that the goals and criteria for the various social services be determined and a national policy established which will result in the coordination of public and private agencies to achieve the ultimate goal of best meeting the needs of older people. The coordination of services is, I believe, more basic currently than is the invention of new services. We have far more knowledge about the services needed, their costs, and the way to deliver them than is being put to use. Expansion of services is needed if more older people are to be served, but such expansion should be on an orderly, systematic, and coordinated basis and should include only those models which have been proven outstandingly successful.

Dr. Donahue foresaw an occasion for "review and advance of firm guidelines" in the very near future. "If such steps could be taken prior to the proposed 1970 White House Conference on Aging," she said, "the Conference itself could serve to test and disseminate information about new and proposed national issues."

There is an obvious, pressing need for organized, comprehensive discussion of the goals and methods of delivering services to older Americans. A White House Conference on Aging—and the State conferences that would be held in preparation—offer an ideal opportunity for such discussion.

CHAPTER VIII

EMERGENCE OF A "RETIREMENT REVOLUTION"

Older Americans, though beset with a multitude of problems described elsewhere in this report, are nevertheless a "pioneer generation" in a largely unrecognized "retirement revolution" of such magnitude and significance that it deserves national attention and probably new directions in national policy.

Evidence for the conclusions reached above was made available during 1967 to this committee through hearings and studies of a new subcommittee,[1] by surveys now underway by Federal agencies, and by public statements that reflect a growing awareness of the need for more understanding of the institution of retirement itself, not only in its present forms but also in the shape it can and should take in the future.

I. MAGNITUDE OF RETIREMENT, PRESENT AND FUTURE

The National Institute of Child Health and Human Development—assigned the mission of improving "the quality of life for persons of all ages, principally by providing scientific information regarding development throughout the lifespan"[2]—turned its attention to research on retirement in 1967.

Soon after the Institute survey began, a NICHD interim report concluded that there is a dearth of information about retirement phases of life history because "only recently have there been significant numbers of persons in them."[3] The "pioneer generation" mentioned earlier are today's people of 62 through 65, "the first group to experience the increase of leisure"[4] on a scale large enough to have far-reaching social, economic, and psychological impact.

A. The Numbers and Their Meaning

Since 1900 the numbers of Americans 65 and over has increased sixfold—from 3 million to more than 19 million. In the next 15 to 20 years, there will be more than 25 million, and by the turn of the century more than 28 million.

These familiar statistics take on added meaning when we consider that years lived past 65 will increase markedly, too. A Social Security Administration study[5] submitted to the subcommittee shows that:

> A 20-year-old man in 1959 could expect about 49.7 years more of life, and a 20-year-old woman could expect about 55.6. Corresponding expectations in 1967–68 were 50.38 and 56.17.

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[1] The Subcommittee on Retirement and the Individual (Senator Walter F. Mondale, chairman), U.S. Senate Special Committee on Aging; hearings—Washington, D.C., June 7–8; Ann Arbor, Mich., July, 26 1967.

[2] Taken from "An Introduction to NICHD Conferences, Research on Retirement," by Frances M. Carp, Ph.D. Text appears on pp. 199–206, hearings cited, footnote 1.

[3] P. 200, hearings cited, footnote 1.

[4] P. 201, hearings cited, footnote 1.

[5] P. 180, hearings cited, footnote 1.

And by the year 2000 the 20-year-old man's will be 53.3 and the woman's about 58.5.

The above projections are, of course, based on present trends and cannot reflect the possible medical or biological discoveries that could increase the lifespan further.[6]

Worklife shortens.—As life expectancy increases, the average worklife decreases. Seymour Wolfbein, former Director of Federal manpower programs and now dean of the School of Business Administration at Temple University, submitted tables [7] showing that in 1900 a man spent only 16.1 years outside the labor force (for schooling and in retirement) during an average life expectancy of 48.2 years. In 1960—when the life expectancy was 66.6—average worklife expectancy was 41.4 years, with 25.2 years outside the labor force.

That 41.4-year worklife expectancy compares to 41.9 years in 1950, which is profoundly significant because, in Dean Wolfbein's words: "*For the first time in this century, the working life of men in the United States has declined.*"

One reason for the decline, discussed by Dean Wolfbein elsewhere,[8] is that postwar America has witnessed increased worker productivity at the rate of 3 percent a year, a rate which means that by 1970 output per man-hour will have doubled, even before "large-scale crossing of thresholds by computer-harnessed machines, satellite borne communication devices, nuclear power fuel and energy, and hundreds of other devices already proven to be operational.

* * * * *

> "*Already,*" observes Dean Wolfbein, "*we have become the only country in the world which deploys a majority of its labor force in the service-producing rather than the goods-producing sectors of the economy and where first place in the occupational standings has been taken over by the white collar workers, moving the blue collar workers into runner-up position.* (Emphasis added.) The economically active population contains an almost unbelievably small group which produces all the food, feed and fiber, steel, glass and concrete, highways and library buildings, autos and aircraft and the entire range of hardware which makes up our vaunted standard of living.

Increased productivity is almost certain to result in further reductions of the labor force needed by industries and farms, and more Americans will find that they have free time [9] on their hands.

The NICHD report summed up the situation in this way: "Our economy is changing from one in which a person normally produced

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[6] Dr. Augustus B. Kinzel, chief executive of the Salk Institute for Biological Studies, told the subcommittee (pp. 79-85, hearings cited p. 111, footnote 1) he firmly believes that recent advances in understanding of DNA molecules will lead to other breakthroughs that will make it possible that by 1980 a "man of 67 to 75 years of age who has availed himself of what is offered, will have the health and vigor necessary to productivity which he had at 45 to 55 years of age assuming he had then been healthy." Dr. Kinzel said his "speculative predictions" were based on the rate of progress thus far and the likelihood of accelerated discoveries. Dr. F. Marrott Sinex, chairman of the Biochemistry Department at Boston University School of Medicine, and president of the Board of Trustees for the Age Center of New England, said (p. 398, hearings cited) he agrees with Dr. Kinzel that "in the future our vigorous and productive years should extend well beyond what he calls statutory old age at 65." Dr. James E. Birren, director of the Rossmoore-Cortese Institute for the Study of Retirement and Aging, said he saw no "rational way of predicting any significant change in the health of the average person over the age of 65 over the decade," but that he shared "the open-ended optimism that we will make significant biological breakthroughs."

[7] P. 67, hearings cited p. 111, footnote 1.

[8] P. 460, "Long-Range Program and Research Needs in Aging and Related Fields," hearings before the U.S. Senate Special Committee on Aging, Washington, D.C., Dec. 5-6, 1967.

[9] See p. 32 of this report for an estimate by former Secretary of HEW John W. Gardner of the amount of free time already available.

until life's end, or very near it, to one in which he is a consumer for an increasing span of time after his economically productive years."

B. Extent of the New Free Time

Some potential forms of reductions in work lifetimes were discussed by Dr. Juanita Kreps,[10] professor of economics at Duke University.

One possible result of foreseeable economic growth is that new gains would be translated into increased leisure time. Our productivity is so potent that—as Dr. Kreps' tables show—within 17 years the Nation could have a workweek of 22 hours, or if we chose instead, a workyear of 27 weeks, or we could have a retirement age of approximately 38 years.

Dr. Kreps said:

> I realize, of course, that it is not likely that the economy would choose to take all of its growth potential in leisure time. * * * let's suppose that instead we continue approximately as we have during this century, taking one-third of the growth in leisure time and two-thirds in an increase in the output of goods and services. In such a case as this, we might have something such as the following: With two-thirds of the output growth in goods and services and one-third in leisure time, the per capita GNP would increase to more than $4,400 by 1980 and to about $5,000 by 1985. The leisure time which we could gain might be divided up in any one of several ways. Different people would put different priorities on the form in which they take their leisure time.
>
> If we conceded, for example, that part of the unemployment problem is due to some qualitative deficiencies in the labor force, we might want to take a large portion of this leisure time in the form of retraining. Therefore, we might start by saying that we would retrain a minimum of 1 percent of the labor force annually taking the necessary time from the growth and productivity.
>
> A second order of preference might be to increase vacation time at least until 1 more week per person is accomplished.

Of course, another possibility would be reduction of traditional retirement age from 65 to 60 or thereabouts. No matter what decisions are made, major social readjustments will have to be made.

> If it seems desirable * * * to allocate free time more heavily during worklife, society must then confront some difficult questions regarding work arrangements, part-time employment, changed vacation and workweek schedules, and so on, said Dr. Kreps.
>
> Alternatively, we could argue that a lengthened education period would better absorb the increases in productivity; or that frequent retraining throughout worklife would be a much more valuable use of leisure. The sabbatical plan, which is long recognized as the professor's strength and sometimes his sanity, may come to be equally useful for blue-collar workers as well.

[10] Pp. 52–62, hearings cited p. 111, footnote 1.

> But should society elect to push the retirement age down toward 60, the income maintenance arrangements then would have to be reconsidered to encompass this much longer period when earnings are small or nonexistent.[11]

Alternatives for the use of free time released by increased productivity are numerous and they are not likely to be considered in orderly fashion. Dr. Kreps, asked by Senator Mondale how "society is to develop a rational approach to make judgments of the options available to us," made this response:

> I am intrigued with the notion that such issues as these be given explicit attention. They are, of course, not altogether economic issues. They are questions of social priority which, in the absence of explicit attention, may result in a drift toward policies which do not necessarily reflect people's preferences. For example, I question whether early retirement is the most desired use of leisure time. But, where does such a question get considered in our course of affairs at present?

Senator Mondale, author of a bill[12] which would establish a Council of Social Advisers, described that bill as a means of bringing "to bear at the highest level on a Government-wide basis top social scientists to talk about a total spectrum" of major issues. Dr. Kreps said that the legislation might serve a useful purpose in much-needed deliberations on retirement policy, and added:

> * * * the whole question of priorities is a question of looking to the future, and it is in that context that we should focus the issues of retirement.

II. EMERGING PROBLEMS RELATED TO RETIREMENT

Some idea of the complexities of considerations related to retirement can be gathered from the official description of jurisdiction agreed to when the Subcommittee on Retirement and the Individual was established. The subcommittee is authorized:

> * * * to inquire into and report on the institution of retirement and its impact on the individual, especially as regards the problems of adjusting to a new role in life and his need for meaning and fulfillment in the retirement years. This shall include but not be limited to: nonmaterial or psychological needs of retirees, present and future dimensions and the nature of retirement, consequences of further reductions in retirement age, methods to promote constructive and meaningful use of retirement time, developing a viable concept of meaningful living and fulfillment so that loss of job and job status will not be a demoralizing and deteriorative experience, and adequacy of physical facilities for future retirement needs. Such studies will help to insure attainment of the objectives of the Older Americans Act of 1965.[13]

Although at this writing the subcommittee is less than a year old, it is apparently filling a void that had existed in earlier committee

[11] Additional discussion of long-term income maintenance by Dr. Kreps on pp. 4-6, ch. I.
[12] S. 843, *Full Opportunity and Social Accounting Act*, introduced Feb. 6, 1967.
[13] Agreed to by the U.S. Senate Special Committee on Aging, Mar. 9, 1967.

activities. Even before its first hearing in June, it received offers of help and study suggestions from nearly 200 organizations, State agencies, senior citizens groups, psychiatrists and psychologists, physicians, economists, and sociologists from throughout the Nation. Their observations, added to the record of the first hearing, are indicators of the widespread, scattered concern and study about retirement as an institution. Much the same is true of widespread responses incorporated into the record of the second hearing as part of an intensive discussion of early retirement and its consequences.

With several major fields of study not yet even begun, the subcommittee nevertheless has reached several interim findings and, in some cases, recommendations related to emerging problem areas.

A. Unreadiness for Retirement

Retirement comes upon most Americans as a surprise. They may have thought about it back in their early fifties. But, as one witness told the subcommittee,[14] "a year or 2 or 3 years away from retirement * * * a great many really would rather push the subject from their minds."

Part of the problem may well be that most ages set for retirement are arbitrary[15] and make no provisions for individual differences in ability, vitality, and interest in the job. As then Secretary of HEW John Gardner told the subcommittee:[16] "We all know people who retire psychologically when they are in their thirties or forties. They may continue working for another two or three decades, but psychologically speaking, they have turned in their uniforms. * * * In contrast, we all know people who at very advanced ages retain an incredible freshness, curiosity, interest, awareness, and enthusiasm."

The Secretary also discussed the onset of retirement as one of "life's toughest adjustments," and a physician[17] said that the adjustment is often so severe that it causes "retirement shock" caused by the "threat of leisure:"[18]

> At his work a man is at least maintaining communal contact with society, and its loss isolates him. Forced retirement may precipitate a severe emotional crisis.
>
> Enforced idleness due to lay-off or unemployment can hardly be classified as leisure, though they both may bring about the same unhappy results. There is a biological axiom that organisms, organs, and tissues tend to die when they no longer serve a useful purpose. An aimless existence is an intolerable one and nature will have none of it. The debilitating effects of advancing years cannot be laid entirely to changes in structure with time. The lost incentive, the loss

[14] P. 13, Hearings cited p. 111, footnote 1. Secretary Gardner.

[15] The American Medical Association has urged adoption of flexible retirement policies based on individual ability and desire to continue working. A report adopted by the AMA Board of Delegates in 1961 (cited p. 305, hearings) says: "The (AMA) Board of Trustees wishes to emphasize the need for implementation of our policy favoring flexible retirement of persons over 65. Considerable medical evidence is available to indicate that the sudden cessation of productive work and earning power of an individual caused by compulsory retirement at the chronological age of 65, often leads to physical and emotional illness and premature death.

"The American Medical Association for sound medical reasons urges industry and labor to arrange for the continued utilization of the work resources and experience available in our over-65-year-old group. Furthermore, the expected increase during the next 10 years of the population under 21 and over 65 relative to the group aged 21 to 65 accentuates the problem."

[16] P. 6, hearings cited p. 111, footnote 1.

[17] Edward L. Bortz, M.D., senior consultant in medicine, Lankenau Hospital.

[18] P. 126, hearings cited p. 111, footnote 1.

of driving power—that something which keeps an individual in tow and in tune with his fellow man—changes him from a contributing member to a parasitic member of the social group. Then he begins to look for signs of approaching decay. He studies his anatomy, and reviews one organ after another. The internal arrangements come into prominence. It is possible for an older man with nothing else to do to concentrate his attention upon some aspect of body function to such an extent that in a comparatively short time the parts become responsive to conscious thought. Minor derangement of the digestion, the heart action, or the kidneys come up for inspection. An idle person looks himself over for evidence of decay. In so doing he invites that process. Too much thinking and too much amateur anatomizing and self-purging, to which an old person can easily become addicted, start the train of circumstances for which the family doctor must be called. Of course, these complaints may not kill an individual, but they can make him very unhappy and sometimes somewhat of a nuisance. Roy Helton has pointed out that for any individual to retire to a parasitic life is for him to condemm himself to a position which is defenseless against nature. It does not matter whether a man becomes a charge upon his children or society, or upon the efforts of his own youth. If he is able of body and mind, and he is willing to be forced out of the useful area of life to become supported by society, as he withdraws from life he is inviting life to retire out of him * * *. Leisure becomes intolerable when an individual becomes useless.

Inadequacy of preretirement training.—To ward off such dangers and to provide practical advice on such matters as investments and suitable living quarters, some preretirement programs are now offered to employees in all income brackets.

Administration on Aging Commissioner William Bechill summarized both the extent and deficiencies of existing efforts in this area:

> * * * it is reasonable to assume that programs whose purpose is to help people prepare for retirement are helpful to obtaining a satisfactory, personal adjustment to retirement. Several major industries and governmental agencies now either conduct preretirement programs or, at the minimum, provide information to their employees on the various aspects of retirement. However, comparatively little is known at the present about the type of content or best methods for offering such programs. The Administration on Aging is now supporting a research and demonstration project in preretirement education at Drake University located in Des Moines, Iowa. The university is establishing a retirement opportunity center which will offer a program to some 500 persons who are within 5 years of retirement.[19]

He and Senator Mondale discussed the question of when such training should begin:

> Senator MONDALE. Is that the most desired time to begin preretirement counseling? Would it not be advisable to have

[19] P. 18, Hearings cited p. 111, footnote 1.

such a course adequately given much earlier in life? For example, insurance problems and other economic problems can be looked at; long-term adult education programs can be considered and carried out easily, consistent with family and occupational problems; this can be carried out while people are still insurable, and when plans can be carried out rather comfortably.

If you educate them this close to retirement, I wonder if there are not certain options that are already foregone.

Mr. BECHILL. Senator Mondale, I think the way the program is being set up, they are going to start with the group of people who are near retirement, but I do not think they intend to stay within this one period.

Senator MONDALE. When does this program actually start?

Mr. BECHILL. This will be starting next fall. It is one of the most recent grants that we have approved.

Senator MONDALE. I see.

Mr. BECHILL. I would say that the whole question of actual formal preparation-for-retirement education is a very open one at the moment. It does need to be evaluated and more information secured.

As to what are the best ages for information about retirement to be introduced into the mind and thinking of an individual, there are many people, for example, who believe and have wanted to see the information being developed on this period of life as early as the elementary and secondary curriculums, and there is some logic to this approach.

If you are going to think of retirement, or the older period of life, as a normal period of life, then in your educational process itself you could not ignore this period in whatever materials or items of information are presented.

A midcareer clinic.—Secretary Gardner also discussed preretirement training earlier in life than is now common. He said he would like to see the time come when many employing organizations will sponsor midcareer clinics to which men and women can go to reexamine the goals of the working life and "consider changes of direction." He added:[20]

Sometime during the middle years of life, preferably several years before retirement actually takes place—I would say perhaps as much as 10 or 15 years—every person should have access to effective preretirement information and education about some of the common problems and adjustments that are experienced in the retirement period.

This is simply not possible now, at least not on a broad scale. Educational programs of this type require well trained and experienced teachers. There is a risk involved in such efforts if the instruction given is superficial.

Here is a role that could be filled by mature or retired persons themselves who, with some intensive training, could counsel others on the problems of retirement. Some companies

[20] P. 7, hearings cited p. 111, footnote 1.

have recruited retired persons for just this purpose with excellent results.

Asked whether present preretirement education and counseling is now adequate, Secretary Gardner said: "There is certainly nothing on the scale that is needed, in my opinion."

He later informed the subcommittee that he had "asked the Office of Education, together with the Administration on Aging, to give greater attention to this subject" in order to "stimulate and encourage additional efforts by States, localities, and other extensions of preretirement training programs through adult education courses, university extension courses, the use of educational television, and other means."

Survey of Federal agencies.—Preretirement training programs for those in Federal service came under scrutiny in a report submitted to the subcommittee by William L. Mitchell, former Commissioner of the Social Security Administration. Now himself retired, Mr. Mitchell took major points from a study he conducted as consultant to the American Association of Retired Persons:

> I believe that there are about 430,000 employees in the Federal service 55 years of age and older. Of them, about 175,000 have acquired eligibility for a civil service annuity upon their retirement. These are 1966 figures. On the basis of preliminary estimates, *our study indicates that not more than one-third of these 175,000, the group most likely to profit from preretirement training, will get any more organized assistance prior to their retirement than some clerical help in the computation of their annuities or advice on the rules governing civil service retirement eligibility.* [Emphasis added.]
>
> Our survey has revealed also that there is no executive policy on preretirement service or training nor is there any uniformity of practice either within, or among, the Federal agencies.[21]
>
> * * * * *
>
> Preretirement training and counseling is a comparatively recent development in the Federal service. A few programs are 10 years old; one has been in existence for 16 years, but more than half have established their programs during the past 4 to 8 years. General counseling services for all employees, of course, are found quite frequently but those with a special orientation to the needs of the preretiree are relatively rare. The lecture and discussion group seems to be the device most frequently used to deal specifically with preretirees. A good many agencies use outside speakers or lecturers but some seem to rely exclusively on their own staff for lectures and for leadership in discussions. Very few agencies employ outside speakers or pay them for their services.

1. Agencies of the Federal Government can perform a valuable service by assuming leadership in the development of innovative and varied preretirement training programs that can serve as models for action by other levels of government and by private industry.

[21] Pp. 163-174, hearings cited p. 111, footnote 1.

Legislation should be enacted to provide specific authority and encouragement to establish preretirement programs within Federal agencies.

Discussion.—Mr. Mitchell reported to the subcommittee that without exception, Federal preretirement programs now in existence were established under general administrative policy, and that additional authority would be helpful.

"I would think," he added, "that the enactment of some sort of legislation, not only to provide such authority, but to require, certainly to encourage, the establishment of programs would be a great stimulus to getting them started and properly financed."

A Government-wide program need not be expensive, said Mr. Mitchell:

> A well-integrated program for most agencies could be given once a year, maybe on a 12-lecture basis, each lecture and discussion group relating to a different aspect of the retirement situation, and if it were done on a quality basis, prepared by professionally trained or experienced people, *I am confident that it would much more than pay for itself.* It would be very inexpensive, requiring only part-time personnel, but it should be taken seriously, I think, and it should have the backing of top management, which I do not believe it has now. The sponsorship really rarely goes beyond the sponsorship of the director of personnel and does not get into the administrative management itself. It is merely a permissive sort of thing. Now that I see it in hindsight, I was very deficient in this respect myself as an administrator. But again, on a hindsight basis it does seem to me that top administrators are losing a bet in not using retirement training as a contribution not only to the effective administration of their own organization, but as a contribution to public service generally. [Emphasis added.]

LEGISLATION INTRODUCED

Senator Mondale and Committee Chairman Williams adopted Mr. Mitchell's recommendations in S. 2295, introduced on August 15, 1967. The bill requires each Federal executive agency to make provision for preretirement counseling and assistance to employees who are eligible or approaching eligibility for retirement. The bill also requires the Administration on Aging to provide technical assistance and to develop preretirement training models that will be helpful to those executives in implementing their programs.

2. The Administration on Aging, in cooperation with Federal agencies and educational institutions, should encourage widespread discussion and the eventual development by Federal agencies of new work-life and study patterns, including phased retirement plans, new kinds of part-time work, and more widespread use of "sabbaticals."

Discussion.—As suggested in testimony already discussed, the traditional life pattern—schooling, career, full-time retirement—is becoming more and more unsatisfactory. The need for a "far-reaching funda-

mental reorganization of the life cycle of work" was discussed by Dr. Robert W. Butler, research psychiatrist and gerontologist, the Washington School of Psychiatry:[22]

> *Instead of "retirement" being condensed into one period of life, its concluding era, why not distribute work, education and leisure (or retirement) throughout the entire course of the life cycle?*
>
> Periodic "retirements" or "sabbaticals" could be used for such practical purposes as retraining and "updating" of our population ranging from our skilled workers to our professionals. Increasingly we see examples of such programs in industry as well as in the universities. These periods would also provide the opportunity for education in its highest sense—to pursue spiritual, personal, and contemplative goals.
>
> From the economic perspective, is it possible that the costs of pension programs, social security, retraining programs, to mention several, would support such a redistribution of work and retirement? Is it possible that the gains in human productivity and the elimination of the waste of the still capable retired would further contribute to the support of such a reorganization of the life of work and of the life of leisure? Finally, is it possible that the resulting continuing participation of our entire population in the mainstream of humanity would provide an inestimable gain in human dignity?

One compelling argument for readjusting "life phases," is the rapid obsolescence of education needed in today's businesses and professions Dr. James E. Birren, director of the Rossmoor-Cortese Institute at the University of Southern California, commented:[23]

> A dean of a medical school has said that a medical degree today is obsolete in 10 years. One shouldn't really practice medicine 10 years after receiving the degree without substantial reeducation. We therefore find that a degree which between the World Wars was good for a lifetime career is no longer able to carry one throughout a career. Our universities, which have up until now been educating the young, will likely have to become involved in the reeducation, retraining, of adults. This is a major role shift for the universities. The faculties aren't used to it. But this is another phenomenon of our times.

Walter Reuther recommended "phased retirement" as a method of facilitating the transition from work to retirement. He said:[24]

> This Nation, which has been a leader in technological developments and in medical scientific developments, has not done nearly as well in social innovation. It seems to me the time has come greatly to encourage the development of phased retirement programs in industry.
>
> Such programs were recommended by the President's Council on Aging in December of 1963. There continues to be

[22] P. 311, hearings cited p. 111, footnote 1.
[23] P. 144, hearings cited p. 111, footnote 1.
[24] P. 439, hearings cited p. 111, footnote 1.

> a good deal of interest in them and relatively little experimentation. Our experience in industry over a period of 30 years indicates that there is a great deal that commends itself in a voluntary tapering off of employment prior to retirement as a means of adjustment between full-time employment and full-time retirement. Such phasing out of the work experience can be invaluable from industry's point of view in that the worker can help train his replacement and from the worker's point of view enabling him and his family to adapt to a new way of life.

Changes of the kind described above are likely to occur only if management, labor unions, and government see the social value and necessity of such changes when they are applicable. Federal agencies, however, can take a leadership role by demonstrating a willingness to experiment. The Department of Health, Education, and Welfare already has done so.

A new program for part-time work was recently opened for persons with managerial or professional talent and experience. Initial response to the professional and executive corps was primarily from housewives who had suspended work activities and who wanted to put their knowledge and training to good use. Such a program, however, also is rich in promise for qualified retired persons. Similar efforts elsewhere, despite difficulties often encountered because of existing regulations and practices, could yield beneficial results if properly designed.

The Administration on Aging, working with other agencies, should encourage such programs, publicize them, and develop models for adaption elsewhere.

B. Misconceptions and Outdated Attitudes

Americans tend today to look upon retirement as a status rather than as one phase in their development as human beings. To retire is to depart from the realities of work and heavy responsibility.

Testimony taken by the subcommittee thus far strongly suggests that many Americans look upon retirement with mixed and even confused feelings. Even to attempt a definition [25] of the word is to invite an exchange of contradictory opinion.

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[25] The subcommittee asked the NICHD to provide a working definition and received the following: (p. 50, hearings cited p. 111, footnote 1.)

"There are a number of different definitions of retirement. Retirement can be viewed as an event, as a process, or as a status.

"Retirement as an event refers to the act itself. Some future anthropologist, studying the 20th century, may describe the retirement dinner as a typical rite-of-passage similar in function to puberty rites, et cetera, and marking for the individual and for society a turning point in his life history and a change in his status.

"Some studies view retirement as a process and investigate the characteristics of the person, the context of the retirement, and the adjustment of the individual to cessation of work over whatever period of time is necessary to make the transition and establish a new form of stability in the life pattern.

"Other studies are concerned with persons after they quit work or after they make the retirement adjustment, and their lives become stable again.

"Only confusion can result from failure to recognize that factors relevant to these different life-phases defined as 'retirement' are not the same. Conflicting results of various studies may reflect only differences in what was defined as 'retirement.' Research planning and interpretation with this in mind will advance and enrich understanding of retirement rather than confuse it.

"Different definitions of retirement are useful for different purposes. As our knowledge expands, new terminology will without doubt emerge. NICHD interest at present centers on *retirement-as-process* and is particularly focused on the period of transition in later maturity which no doubt has physiological, psychological, and social determinants in addition to that of exit from work."

Guilt feelings about leisure: Dr. Alexander Reid Martin [26] places much of the blame for guilt feelings about leisure on society's high esteem for work. He says:

> One particular outmoded belief that is responsible for a great deal of trouble is the belief that work was man's only salvation and in his free time he could not be left to his own resources because they were either nonexistent or destructive and this was expressed in the old saying—"Satan finds mischief for idle hands to do" and "Idle hands are the Devil's workshop."

The observations of over 2,300 persons over age 60 participating in Minnesota hearings disclosed other factors tending to downgrade leisure. Mrs. Walter W. Walker, chairman, Governor's Citizens Council on Aging, St. Paul, Minn., commented upon the hearings: [27]

> But emerging, too, out of these hearings were the confusion and frustration of having no identifiable role as a member of society, as a member of the local community and, also, a negative self-image of those very ones in their later years. These were both self-held by the individuals themselves and held by the public at large.

Attitudes: The high premium placed on work and activity by present-day society has a profound effect upon our attitudes, which tend to preclude the development of leisure interests and skills in the later years.

As Dr. Carp points out: [28]

> At present the social factors which define success in life and therefore provide a basis for the subjective experience of fulfillment are money, activity, and youth, and all are intimately bound up with work. Retirement reduces one's income, creates conditions conducive to inactivity, and confronts the person with loss of youth. Society offers nothing in their place.

Dr. Jack Weinberg, director, Illinois State Psychiatric Institute, associates loss of work with loss of identity: [29]

> The minute we meet someone we ask of him—after we get his name—"what do you do?" That immediately places him within a framework with which we can interact. But if you meet a man and ask him what he does and he says, "Nothing," you are stymied as if he seems to be nothing. So that work is part of the identifying data and in our society where so many people come to see the psychiatrist because of identity problems—because of difficulty in knowing who they are—this becomes an enormously cogent and important element in the human being's experience.

Government policy can have only limited effect on such attitudes, but it can contribute to their gradual change by actions already descibed, including experiments in phased retirements and "sabbati-

[26] Psychiatrist (New York City) and former chairman, Committee on Leisure Time and Its Uses, American Psychiatric Association. Also author of numerous publications on the nature of leisure. P. 88, hearings cited p. 111, footnote 1.

[27] P. 73, hearings cited p. 111, footnote 1.

[28] P. 202, hearings cited p. 111, footnote 1.

[29] P. 465, hearings cited p. 111, footnote 1.

cals" (not only for retraining but also for cultural interests). Research by national institutes can also be of assistance by exploring and publicizing the reasons for the persistence of attitudes that are destructive to the morale of those in retirement.

C. Early Retirement as a New Force

An earlier chapter dealing with income problems discusses the possible economic and social consequences that may result from the increasing number of workers who are retiring at ages earlier than 65 at reduced social security benefit levels. In this case, as a statement by Dr. Margaret Gordon makes clear,[30] "early retirement may cause far-reaching problems later on."

A different attitude toward early retirement was very much in evidence in testimony taken by the subcommittee from representatives of the United Auto Workers, AFL–CIO. Members of that union may now retire as early as age 55 and monthly retirement income could conceivably reach $400 through supplementation. At age 65, however, when social security benefits begin, the early retirement supplement is withdrawn and, in some cases, the reduction in income may be quite significant.

UAW President Walter Reuther, while praising the merits of early retirement and urging its widespread application, also called for additional social innovations:

> Our experience has convinced us that this early retirement program can and should be strengthened, particularly with regard to improving the benefit payments and building in adjustments for both improvements in the standard of living and increases in the cost of living * * *
>
> We seek to improve and extend these early retirement programs, for our older members by their actions have demonstrated their wish to use fully the opportunities for voluntary early retirement.

Changes recommended by Mr. Reuther needed to make early retirement more universally applicable:

> *Eliminate arbitrary age qualifications in government programs for retirees.*
>
> To achieve the objectives of a sound early retirement program for the country as a whole would require a number of modifications in public policy. Eligibility of the retired individual in respect to governmental benefits, medicare, or favorable tax treatment, should not be geared to an arbitrary age such as 65. This is an inheritance from Otto von Bismarck's concept of social security and social welfare. They are not particularly germane to the U.S. nor are the objectives he enunciated particularly acceptable to the American people.
>
> *Make available a new social security benefit for the technologically displaced.*
>
> Over the years the American people through their Congress have demonstrated humanitarian concern for the physically

[30] Excerpts from Dr. Gordon's statement on pp. 18–20 of this report.

disabled. This has been reflected in benefits provided in the social security program, as well as in negotiated pension programs such as those in which UAW members participate. The time has now come, I believe, to demonstrate equal concern for the technologically disabled and to provide equal protection against its hazards.

Provide for immediate improvements in cash benefits payable under social security.

If the opportunities for early retirement are to become rael for all elderly persons as they are beginning to be for UAW members who have negotiated pensions available to them, a number of immediate improvements must be made in social security benefits. Among them, three take the highest priority:

(1) A guaranteed minimum monthly benefit as follows:

(*a*) $100 for a worker retiring at age 65;

(*b*) $100 for a disabled worker or a technologically displaced worker;

(*c*) $150 for an elderly couple, both age 65 or over.

III. RESPONSE FROM THE AOA

Perhaps because the "retirement revolution" is unprecedented, efforts to formulate national policy in this area have been limited. Testimony taken from William Bechill, Commissioner of the Administration on Aging, indicates, however, that the Older Americans Act of 1965 can play a growing role in promoting understanding about nonmaterial needs related to retirement. Two of the objectives set forth in that act were described by the Commissioner as having special relevance to subjects under subcommittee study:[31]

> The first of these two objectives is "pursuit of meaningful activity within the widest range of civic, cultural, and recreational opportunities." The second is "retirement in health, honor, dignity—after years of contribution to the economy."
>
> These are broad objectives, and there is universal agreement as to their merit. For our agency they indicate that we must assign a high priority to the subject of free time in retirement.
>
> This is an important task since there has been a tremendous increase in leisure time during the last few decades, and additional gains seem assured with the lengthening of the retirement period. And, if this period of time is to be meaningful, it is clear that a range of opportunities must be available.
>
> Under the Older Americans Act today, we are stimulating a variety of roles in retirement that offer promise of making the retirement period more meaningful and satisfying. Our major tools are the three grant programs of the act, the foster grandparent program, which we administer under a contract with the Office of Economic Opportunity, and the resources which are being made available by the State agencies on aging in the 45 States and territories which have established them to date. As of June 1, there were 474 community projects approved

[31] P. 17, hearings cited p. 111, footnote 1.

by the States under title III of the act, 42 title IV demonstration and research projects, and 25 title V grants for training.

The Commissioner also described AOA-supported projects intended to broaden community participation roles and educational opportunities for retired persons. Two examples:

Community Service Society of New York, N.Y., 3-year project—"Older Volunteers in Community Service," $36,770.

The Community Service Society of New York is conducting a demonstration project on Staten Island to determine the feasibility of involving older volunteers in vital and challenging jobs at the Willowbrook School for the Mentally Retarded. Ways are being tested to recruit, train, place, and retain older people in volunteer jobs within the community. Because transportation is often a problem, CSS provides a bus to pick up volunteers each Monday at two points on the island. Within a few months, the corps of volunteers has mushroomed from 22 older men and women to 55 regular workers who are between 70 and 83 years of age. Their assignments are as varied as the individuals involved—occupational therapy, baby wards, teacher aides, et cetera. Many of the assignments have grown out of the volunteers' enthusiasm and willingness to see and respond to the needs of the patients and institution. The patients, many of whom rarely or never have visitors, receive them with warm anticipation.

* * * * *

Training Institute for Adult Education, 3-year project—Adult Education Association, USA, first year, $54,043.

Under this grant, the Adult Education Association will hold a national pilot institute in New England to bring together approximately 30 selected key adult educators with authority to establish new educational programs for older people within their organizations and agencies. The educators will be invited from university extensions, public schools, rural educational programs, libraries, and labor unions. The pilot institute will be held in cooperation with the University of New Hampshire and will draw its "trainees" from all the New England States. During the institute, the educators will develop specific plans for launching new programs and at the conclusion of the session will return to their organizations to begin the programs. A follow-up session will be held at a later date to allow them to evaluate their programs, share experiences, and help solve any problems encountered in starting or operating the new programs. The experience in New England is expected to lead to similar institutes in other parts of the country. Published materials, developed during the institute, will provide help for all those interested in furthering adult education for older people. In addition, the association will prepare an inventory of existing adult education programs for older people throughout the country and provide a directory of resources.

EDUCATIONAL TELEVISION

WITF–TV is a noncommercial, educational public television station based in Hershey, Pa. A title IV AOA grant is helping to support a

30-minute weekly television program intended to serve the retired and the preretirement community. Richard J. Lutz, assistant manager for programing at WITF, told the subcommittee that the program had, within less than a year, become established as a popular and helpful feature. But he said that the weekly program is merely one of several elements: [32]

> First, thorough and continuing liaison with interested individuals and organizations so that their needs may be known, so they may guide us in our efforts, and so that the spotlight of television may be focused upon the opportunities they provide to the aged.
>
> Second, to reinforce this, and to provide the project team with continuing feedback from this audience, an elderly area coordinator is in each of the nine counties we serve. These people are all over 65, one is 81, they are retired and they are respected members of their local communities looked up to by their fellow senior citizens for leadership.
>
> Third, the weekly program itself, "The Time of Our Lives."
>
> Fourth, continuing efforts to draw an audience of older Pennsylvanians.
>
> Fifth, as an integral part of the effort, extensive followup materials, offered free to older viewers who would write for them. To encourage this process of writing in, all elderly viewers who write us are supplied with postage-paid business reply cards on which they may simply circle preprinted numbers, as announced on the air, to request supplementary material on any subject treated in the telecasts as a basis for followup action by them.
>
> Sixth, and this is the last of the six items, the opportunity for any viewers to ask questions or describe situations which might benefit from professional attention, though the viewer may not himself be aware of which professionals will be most helpful, or how to contact them directly. All such questions are immediately referred for prompt action by counseling and welfare professionals, who have been immensely cooperative with us.
>
> The TV program itself is produced in a magazine format, so that something on almost every program will appeal to some segment of the retired population.

Mr. Lutz also said:

> * * * public television is anxious to serve the aging. We have a role to play, we think, in educating, preparing this target group for retirement and assisting them after retirement.

Experiments in the use of educational television are underway or contemplated in several other States, including Minnesota and Iowa.

3. Widespread experimentation in developing new roles for retired Americans while meeting their nonmaterial needs is already under way in programs supported and encouraged by the Administration on Aging, often working in conjunction with the Office of Education [33] and other agencies. Lessons

[32] P. 501, hearing cited p. 111, footnote 1.
[33] A report on Office of Education activities appears on pp. 265–267 of this report.

learned from such projects should receive widespread attention and—in the case of educational television, in particular—encouragement from all Federal agencies with a related interest.

IV. ADDITIONAL AREAS OF INQUIRY

Many additional subjects for subcommittee study were proposed in testimony and statements received by the subcommittee. Among the matters that will receive close attention are:

RESEARCH NEEDS: Proposals for research projects were made to the subcommittee in great number and variety by witnesses from scientific, economic, and sociological disciplines. Implicit in several of the proposals is that—even on matters related to major social objectives—there is very limited agreement or understanding of initial premises. The subcommittee will seek additional information on research related to retirement; and it will continue to seek opinions on whether a multiagency effort at the Federal level is needed to give direction and perspective to research efforts related to retirement. (Additional discussion of overall research needs appears in chapter IX.)

RURAL PROBLEMS: Retirement in predominately rural States takes on entirely different patterns than in more urban parts of the Nation. The subcommittee was informed, for example, that in Missouri, almost a third of the people over age 65 live in communities of 1,000 or less in population, and that there is a trend for older persons to move into small communities at the time of their retirement.

CAPACITY OF EDUCATIONAL RESOURCES: Many far-reaching proposals to provide educational or retraining opportunities for retired persons have been made to the subcommittee. An attempt will be made to determine, as far as is possible: (1) amount of interest by educators in such proposals, (2) methods to provide such opportunities, (3) whether existing educational facilities are capable of meeting such needs, and (4) the role of the elderly themselves in providing education to other elderly persons.

COMMUNITY PLANNING FOR AN INCREASING RETIREMENT POPULATION: Early inquiries indicate that such planning at present is minimal. It appears clear, however, that such planning is essential; and it should not be concerned only with the provision of institutions for the incapacitated, who comprise only a small proportion, now less than 5 percent, of all persons past 65.

CHAPTER IX

CONTINUING AND EMERGING AREAS OF CONCERN

I. REORGANIZATION AND THE ROLE OF AOA

Widespread concern about possible downgrading of the Administration on Aging arose with the announcement on August 17 of a major realinement of Federal welfare, rehabilitation, and social programs. John W. Gardner, then Secretary of the Department of Health, Education, and Welfare, said that the establishment of a new Social and Rehabilitation Service would join under a single leadership both our income support programs for needy Americans and the social service and rehabilitation programs that many families and individuals need.

Under the reorganization, the Administration on Aging became one of five major divisions within SRS. The other components are: Rehabilitation Services Administration, Children's Bureau, Medical Services Administration, and the Assistance Payments Administration.[1] The AOA Commissioner, who formerly reported directly to the Secretary, now reports to the Administrator of the Social and Rehabilitation Service.

Misgivings about the plan were based primarily on two major questions: (1) does the reorganization violate the intent expressed by the Congress when it passed the Older Americans Act of 1965, and (2) does the new AOA status reduce its potential leadership role in providing national visibility to vital public issues related to aging?

A. History of Legislation Related to AOA

Strong sentiment in favor of a Federal coordinating agency on aging developed early in this decade. The late Senator Pat McNamara, first chairman of this committee, introduced legislation calling for a U.S. Office of Aging headed by an assistant secretary of HEW. Another approach was suggested by the late Representative John Fogarty, whose initial bill asked for a Federal Commission on Aging independent of any individual department or agency. Delegates to the White House Conference on Aging in 1961 did not make a judgment on what approach was most promising but made it clear that they wanted a chief Federal working agency on aging that would (1) be granted statutory status and independent leadership, (2) have adequate operating funds * * * voted by Congress through a specific line item appropriation, (3) have the power to recommend legislative proposals to Congress, and (4) be directed to seek coordination among the various governmental programs and units working in behalf of older people.

[1] Details of the function of each agency may be found on pp. 271-278.

Even before the White House conference, the predecessor subcommittee [2] to the Senate Committee on Aging had declared that a major need of America's aged and aging is a central agency in the Federal establishment to represent them and their problems. This committee, in a report issued in 1963, made a fervent appeal for an independent Commission because it would lend (1) better and greater status, (2) balance, (3) strength, (4) continuity, and (5) visibility to Federal activities in aging.[3] As it finally emerged, however, the Older Americans Act took a compromise shape. Within HEW, the Administration on Aging was created in order to: [4]

1. Serve as a clearinghouse for information related to problems of the aged and aging;
2. Assist the Secretary in all matters pertaining to problems of the aged and aging;
3. Administer the grants provided by the act;
4. Develop plans, conduct and arrange for research and demonstration programs in the field of aging;
5. Provide technical assistance and consultation to States and political subdivisions thereof with respect to programs for the aged and aging;
6. Prepare, publish, and disseminate educational materials dealing with the welfare of older persons;
7. Gather statistics in the field of aging which other Federal agencies are not collecting; and
8. Stimulate more effective use of existing resources and available services for the aged and aging.

Senator McNamara and Representative Fogarty had made it clear, at hearings and in floor discussion, that they expected the AOA to be a strong, independent agency, totally independent of agencies which provide welfare assistance or services.

They emphatically wanted it free of domination by any agency, and to have direct access to the Secretary. Testimony from other legislators and from national organizations had been similarly confident about the status of the AOA, and the intent of Congress had been spelled out clearly in House of Representatives Report No. 145, 89th Congress, in the section on the need for the legislation. The document states:

> The Administration on Aging, headed by a Commissioner appointed by the President subject to confirmation by the Senate, *would have coequal status with the Social Security and Welfare Administrations*. Thus the older population would be meaningfully represented in the upper echelons of the Federal Government, [Emphasis added.]

In 1967, the Congress reaffirmed its support of the Older Americans Act by passing, just 7 weeks before the HEW reorganization was announced, an extension of the program. Authorizations for fiscal years 1968 and 1969 were substantially increased.[5] Thus Congress recognized that the AOA is performing valuable functions worthy of increased appropriations.

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[2] P. 9. "The Aged and Aging in the United States, A National Problem," report by the Subcommittee on Problems of the Aged and Aging, Senate Committee on Labor and Public Welfare, Feb. 23, 1960.

[3] P. 168. "Developments in Aging," 1953 to 1963, Senate Report No. 8, 88th Congress.

[4] Sec. 202, Public Law 89-73, July 14, 1965.

[5] Details of the Older Americans Act Amendments of 1967 appear on pp. 172.

B. Reasons Given for the Reorganization

Secretary Gardner, responding to a letter from Chairman Williams [6] of this committee, said:

> The whole thrust of the new Social and Rehabilitation Service is to bring about a more concerted effort in providing basic opportunities and services to people whom it is our Department's responsibility to serve, including the older population, the disabled, children, and families. The three key features of the organization have this overriding purpose in mind. First, in the new Social and Rehabilitation Service, under the leadership of Mary Switzer, we have brought together the various services of the Department that are concerned with particular groups in our population so that they can work more effectively together in innovative and united ways to improve the organization and delivery of necessary services to all.
>
> Second, we have taken a significant step of separating out the cash payment and service functions in our public assistance programs. I want to see that greater opportunities for rehabilitation and self-support are made available in these programs and am determined that this be done. The Administration on Aging, the Children's Bureau, and the Rehabilitation Services Administration have demonstrated under their past experience a real ability to promote and provide these services. Their experience and expertise will now be applied fully as part of their new responsibilities.
>
> Third, I believe that there is no more pressing need facing the Department at the present time than facilitating our relationships with States and local communities. With the growth of all of the Department's programs in recent years, it has become a paramount issue, particularly in the fields of public assistance, rehabilitation, aging, and child welfare services. The establishment of a Social and Rehabilitation Service Commissioner in each of our regions, with authority and responsibility to supervise all programs now located in the new agency, should make our present relationships to States and communities much more effective.

Miss Switzer, the new SRS Administrator, testified [7] soon after the reorganization and said:

> The Administration on Aging is only one of several formerly independent parts of the Department that used to report directly to the Secretary. The Secretary had two or three primary motivations and reasons behind reorganization. The scope of the programs in the Department of Health, Education, and Welfare is very broad, and the Secretary it seems to me, as one who has been with the Department since its creation, must have some flexibility in arranging his administrative responsibilities in a manner which he feels would

[6] Letter by Senator Williams and response by Mr. Gardner appears on pp. 17-20 of hearings cited in footnote 7.

[7] P. 22-23, hearing on "Older Americans Community Service Program" before the Special Subcommittee on Aging (Sen. Edward M. Kennedy, chairman), U.S. Senate Committee on Labor and Public Welfare, Washington, D.C. Sept. 18-19, 1967.

merit the greatest opportunity to give the programs what Congress intended them to have.

But the primary reason for this reorganization goes to the spectacle that all of us are conscious of, and those of us who have been in the business of trying to get community programs more efficient and more effective in their rendering of service, and that is somehow or other to get a better and more unified approach where the service is given, and I feel that the Administration on Aging is going to have very, very great opportunity to be fully effective and more effective in this situation than it would be as an independent unit.

After all, I didn't build the vocational rehabilitation program over the last 15 or 16 years, and concur in its coming in under this umbrella, and I would never have done it if I had felt that it was going to diminish its effectiveness in serving handicapped citizens. I firmly believe that we can all gain from this, and there is no reason why the constituency, interested primarily in the older American, needs to lose anything. In fact, they have much to gain by the joining of the constituency, and by having the Administration, the Commissioner on Aging, privy to the resources that could be much more effectively used in the present reorganization.

C. Reasons for Concern

Despite arguments advanced by HEW representatives—and with many expressions of admiration for Miss Switzer's prior record of accomplishment—individual legislators and representatives of national organizations spoke out against the reorganization at a hearing in mid-September. Although that hearing was called to consider another matter,[8] much of the testimony was devoted to the reorganization. The most common complaint was that the reorganization had been implemented without any prior discussion with leaders in the field of aging or even with members of the Advisory Committee on Aging.[9] Among those who expressed concern was John Edelman, president of the National Council of Senior Citizens:

> The most obvious error we find in this merger is the fundamental psychological fact, which is so generally unrecognized, so generally overlooked, and it is the psychological problem which you are confronted with in dealing with the vast majority of the elderly in America; that is their terrific resentment and distress over being identified as welfare recipients, although many of them do have to finally accept public assistance of one kind or another. The greatest appeal about the social security approach is that payments under a social insurance system are made as a matter of right and do not include a means test.

[8] Hearing cited p. 130, footnote 7.

[9] See testimony by James C. O'Brien, representing the National Council of Senior Citizens, p. 58, and testimony of William Fitch, p. 166, hearing cited p. 130, footnote 7.

Now we link the Administration on Aging with a series of agencies within HEW, whose fundamental concern is with welfare. By doing so you impair the effectiveness in a very definite psychological sense of the Administration on Aging, simply because it is linked in the minds of millions of older people with other departments concerned with reaching the needs of those who can only be helped by some type of public assistance. I think this is unfortunate.[10]

Mrs. Eone Harger, president of the National Association of State Units on Aging:[11]

Testimony given in 1963 prior to passage of the Older Americans Act urged the creation of a Commission on Aging within the Executive Office of the President. It was felt that only there could sufficient prestige and visibility be achieved to counteract the problems created for an increasing number of older people by our national stereotypes of age. Supporters of the Commission on Aging accepted grudgingly and with grave doubts the substitution of an Administration on Aging in the Department of Health, Education, and Welfare because it was offered as the "only politically achievable arrangement."

There were three main doubts in regard to the placement of the Administration on Aging in the Department of Health, Education, and Welfare. There were doubts because the proposed Administration on Aging did not carry the same operating responsibility as other administrations in the Department of Health, Education, and Welfare, so would be difficult to equate with them. There were doubts as to the ability of an Administration on Aging, from within the Department of Health, Education, and Welfare, to give leadership and carry out the intended coordination of programs related to aging within the Federal Establishment. There were doubts as to the impact on State organizations for aging, most of which were independent commissions that provided the vitality, flexibility, leadership, and working relationships with multiple agencies and organizations on which progress in the total field of aging was based.

These doubts appear to have been well founded in light of the recent reorganization of the Department of Health, Education, and Welfare * * *.

William Fitch, then executive director of the National Retired Teachers Association and the American Association of Retired Persons:[12]

As you recall, in the reorganization, the responsibility for aging was put under welfare, where we did not believe it belonged, because we thought that many older persons did not belong in that category. We felt it was a disservice when it was put within the Welfare Agency, and I think many of us have that same feeling that, if we are not very careful

[10] P. 58, hearings cited p. 130, footnote 7.
[11] P. 118, hearings cited p. 130, footnote 7.
[12] P. 167, hearings cited p. 130, footnote 7.

in the administration of the new program, that we are going to give the impression that older people now are all in need of rehabilitation. The emphasis has been on that, rather than the fact that, just as your testimony has shown here, that this is a very dynamic group.

Many of them have much to give. Some of them need to be served, but I think there are more older people who are ready to serve. I am not quite sure that this focus does not get lost in a social and rehabilitation agency, no matter how sincere the administrators may be; I do not think we have reached the point yet where we should have lost the independent focus that we were able to put on the older person through the Older Americans Act.

A statement submitted later by Dr. Ewald Busse, president of the American Gerontological Society of America, also took issue with the reorganization:

In my opinion, the Administration on Aging has lost much of its distinct visibility as well as its advantageous position so that it could influence the wide variety of governmental agencies, departments, and private organizations that are concerned with the aging and the aged * * *. It is my belief that the elderly and their representatives are constantly confronted with prejudicial barriers. The field requires not only well-intentioned leadership, but responsibility and strength so that it can educate and favorably influence individuals and organizations.

Senator Edward Kennedy, who conducted the hearing, reacted to Miss Switzer's testimony by saying:

It is not easy to challenge such worthy intentions, but here again I have a lingering misgiving. We have seen in the past that programs for the elderly can disappear or weaken when they are merged with others.[13]

Senator Williams called for the Department of Health, Education, and Welfare to:

Provide a forum for extensive discussion of the reorganization plan.[14]

Information received by this committee since the hearing indicates that some consultation with individual organizations has since taken place, and that plans are under way for a major conference at which the reorganization will be discussed at length.

The HEW reorganization, and its effect upon the role of the Administration on Aging, raises serious questions that should be explored by HEW in extensive consultation with national organizations and knowledgeable individuals at the earliest possible date. In addition, a proposed White House Conference on Aging could serve as a forum for discussion of more fundamental issues related to coordination of policies and programs within other departments that, in varying degrees, deal with matters related to the elderly.

[13] P. 210, hearings cited p. 130, footnote 7.
[14] P. 209, hearings cited p. 130, footnote 7.

Discussion.—The HEW reorganization plan is a major, comprehensive effort to deal with many longstanding administrative problems. Its advantages should be thoroughly explored—and its critics should be heard—at a full-dress HEW conference, lasting for one or more days, in the near future. If additional congressional action then seems appropriate, it should be taken.

The committee has also noted a growing number of units related to the elderly in other Federal departments. The need for coordination is becoming more and more apparent, raising questions so complex that they would require a concentration of thought and discussion that could find best expression at a White House Conference on Aging and in State preparations for that conference.

II. THE WAR ON POVERTY AND THE ELDERLY

During 1965, soon after the war on poverty was launched, the committee began a study and investigation to determine whether it was serving older Americans as it should. After several hearings, the committee issued a report [15] offering recommendations, several of which were subsequently adopted. Perhaps the most significant of these was an amendment [16] to the Economic Opportunity Amendments of 1966 which authorized the appointment by the President of an Assistant Director of the Office of Economic Opportunity to be responsible for programs for the elderly poor.

A. 1967 Activities of Office of Economic Opportunity

The President on March 5, 1967, appointed Miss Genevieve Blatt, former Secretary of Internal Affairs of the Commonwealth of Pennsylvania, to serve as Assistant Director of OEO in charge of programs for older persons. Her appointment was confirmed by the Senate on March 23. Miss Blatt's efforts in behalf of the elderly poor during 1967 were reflected in a report issued by OEO Director Sargent Shriver to this committee.[17] Mr. Shriver, pointing out that 8 million persons 55 years of age or older are poor, discussed new programs implemented by OEO, including the training of 2,000 persons past age 45 as home health aides.

While this and other information provided in the reports indicate a good beginning, it must be borne in mind that it is only a beginning toward making the war on poverty effective for the elderly poor and that there remains vast potential for meeting the needs of this age group through the war on poverty.

B. Congressional Call for More Action

OEO programs received careful scrutiny during 1967 in a full-scale Senate study of purposes and methods.[18] One deficiency pointed out forcefully in testimony and field inspections was the need for additional attention to the elderly poor. The Senate Committee on Labor and Public Welfare responded to such calls for action when it con-

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[15] "The War on Poverty as It Affects Older Americans," Senate Report 1287, 89th Cong., 2d sess., 1966.
[16] Sec. 601(a), Public Law 89-794 (Nov. 8, 1966), 80 Stat. 1468.
[17] Text on p. 259.
[18] "Examination of the War on Poverty," Subcommittee on Employment, Manpower, and Poverty of the Senate Committee on Labor and Public Welfare, 90th Cong., 1st sess. (1967).

sidered S. 2388, the bill incorporating the Economic Opportunity Amendments of 1967. The report on that bill commented: [19]

> The older poor are one of the most neglected groups of the war on poverty, in spite of repeated congressional urging for action * * * Once again the committee must report an inadequate performance in programs for the elderly and urges OEO to take immediate steps to remedy this deficiency.

The bill, as finally signed into law,[20] contained the following provisions [21] on behalf of the elderly:

1. A new section 126 requires that the Director of OEO provide that programs conducted under the "Work and Training for Youth and Adults" authorization be designed to deal with the incidence of long-term unemployment among persons 55 and older, and that the Director encourage the employment of such persons as regular, part-time, and short-term staff in component programs.

2. "Senior Opportunities and Services" (SOS) was authorized as one of eight types of "special programs" to be emphasized. This program will be designed to identify and meet the needs of older, poor persons above the age of 60.

3. The Director was required to encourage the employment of those age 55 and older as regular, part-time, and short-term staff in component programs of "senior opportunities and services" and the other seven special programs.

4. The Director was authorized to make loans up to $3,500 for as long as 15 years to low-income rural families where, in his judgment, such loans have a reasonable possibility of contributing to the improvement of the living or housing conditions of the elderly.

5. The new law strengthens section 610 of the act, which, since 1965, has declared the intention of Congress that whenever feasible the special problems of the elderly poor shall be considered in the development, conduct, and administration of Economic Opportunity programs. In addition to the duties previously given the Director of OEO with reference to the elderly poor, the 1967 amendments direct him to:

a. Carry out a plan for the participation of the elderly poor in Economic Opportunity programs;
b. Broaden his activities regarding the elderly poor to include "other services and activities which assist the elderly poor to achieve self-sufficiency";
c. Maintain a constant review of all programs under the act to assure that the needs of the elderly poor are given adequate consideration;
d. Initiate and maintain interagency liaison with all other appropriate Federal agencies to achieve a coordinated national approach to the needs of the elderly poor;
e. Cooperate with the Commissioner of Aging in exercising the Director's responsibilities under this section; and
f. Describe the ways in which this section has been implemented in the Director's annual report.

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[19] P. 44, Senate Report 563, 90th Cong., 1st sess., Sept. 12, 1967.
[20] Public Law 90-222 (Dec. 23, 1967).
[21] Provisions discussed in this summary are reproduced verbatim in the appendix, beginning on p. 260.

6. A new section 832 requires the Director to take necessary steps, including the development of special projects where appropriate, to encourage the fullest participation of older persons and older persons membership groups as volunteers and participant agencies in the various programs and activities of VISTA (Volunteers in Service to America) and other domestic volunteer service programs. The new section also directs the encouragement of a variety of volunteer services to older persons, including special projects, to assure that they are served in proportion to their need.

The intent of Congress, as clearly expressed in the 1967 amendments to the Economic Opportunity Act, is that attention should be paid to the needs of the elderly poor, on a scale large enough to accelerate the noteworthy, but limited, progress already achieved in this area by the Office of Economic Opportunity.

Congressional units and the OEO should remain in close communication on steps needed for full implementation of the amendments.[22]

III. USEFULNESS OF FEDERAL PROGRAMS TO MINORITIES

Still at the early stages of a study intended to explore this subject in some detail, the committee has already received weighty and disquieting statements[23] to the effect that inadequacies in present Federal actions on behalf of older Americans cause their worst personal and social damage among elderly members of minority groups. Occasionally, Federal efforts are misdirected or inappropriate; innovation and greater awareness of the problems of being among "a minority within a minority" are called for.

A. "Double Jeopardy" Plight Worsens

The single most striking statement made to the committee at a recent discussion of the Negro elderly was related to a publication called "Double Jeopardy" issued by the National Urban League in 1964. That study drew a portrait of older Negroes "who bring to their older years a whole lifetime of economic and social indignities, a lifetime of struggle to get and keep a job, more often than not at unskilled hard labor, a lifetime of overcrowded substandard housing in slum neighborhoods, of inadequate medical care, of unequal opportunities for education and the cultural and social activities that nourish the spirit, a lifetime of second-class citizenship, a lifetime of watching their children learn the high cost of being a Negro in America."

And yet, although the 1964 findings drew a grim picture of the elderly Negro, a witness told the committee, "The plight of the elderly Negro has worsened since the publication of 'Double Jeopardy.'"[24] The

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[22] Early in 1968, Committee Chairman Harrison Williams and Senator Edward Kennedy expressed concern about reports that OEO programs for the elderly would be cut back, not increased. Later, word came that four members of the OEO Advisory Committee on Older Persons Programs had resigned because they regarded OEO commitment to such programs as too limited. Some congressional demands for earmarking of funds for such purposes were heard as this report neared completion.

[23] "Long-Range Program and Research Needs in Aging and Related Fields," hearings before U.S. Senate Committee on Aging, Washington, D.C., Dec. 5-6, 1967.

[24] P. 126, hearings cited, footnote 23.

witness, Mr. Hobart Jackson, said that his estimate was based "on the fact that the plight of the Negro generally has worsened, I think, in the country with reference to the closing of the gap between whites and Negroes in economic terms * * * Very little has been done in terms of improving the income maintenance situation * * * Very little has been done to improve their housing, their health and other services, their educations, and opportunities for fullfillment during leisure hours." [25]

Mr. Jackson described current programs as so fragmentary or pauperized "that they hardly amount even to a tokenistic resolution of the problems involved." Giving some of the reasons for those problems, he said:

> We must recognize that a majority of the current generation of elderly Negroes came from rural, southern backgrounds. They were born in the latter part of the 19th century and the early part of the 20th century and were greatly conditioned by the culture prevalent during that era. They cannot be expected to exercise initiative in the enunciation of their rights and needs. They are in many ways still invisible and undemanding.
>
> I think the greatest and most expeditious help that could be provided the elderly Negro is in the area of income maintenance.
>
> Increases in the coverage and minimum dollar provisions of social security could be used to immediately improve the life and living of more than 1½ million older Negroes. Doing away with old-age assistance and placing all the elderly on social security at a minimum income much higher than the present level could achieve this. This proposal is similar to a negative income tax for this group or guaranteed annual income.
>
> My feeling is that the current increases being proposed for social security do not go far enough in helping those who need help the most. A hundred dollars a month minimum and coverage of all persons over 65 would begin to make a real dent into the income aspect of the problem.
>
> If each State continues to make its own rules, there will continue to be wide variations in the determination of who is eligible to receive old-age assistance and the amount to be received. The amount in most States is grossly inadequate in terms of minimum standards of health and decency.
>
> Many elderly eligible for this help aren't aware of their benefits because of the way our welfare system operates, even benefits that are at starvation levels.[26]

Mr. Jackson also called for more outreach efforts similar to Project FIND,[27] multipurpose centers designed to serve special needs, "strong interpretation of the public accommodation nature of homes for the aged and nursing homes with great emphasis on the need to make such an interpretation generally known," and adequate representation of Negroes at a proposed White House Conference on Aging.

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[25] P. 135, hearings cited, p. 136, footnote 23.
[26] P. 127, hearings cited p. 136, footnote 23.
[27] See p. 105.

Miss Jeweldean Jones, associate director of the National Urban League, gave this picture of the economic and social disadvantage:[28]

> The data show that it is bad enough to be black in our society. It is also bad to be old in a youth-oriented culture. But to be old and black is indeed to be in double jeopardy.
>
> The pitifully low incomes of elderly people, especially elderly Negroes, is reflected in terms of daily bread and medical care. The $3,010 minimum annual income set by the Bureau of Labor Statistics as a modest but adequate budget for an elderly couple provides not quite an egg a day per person, about a half pound of meat and no provision for a special diet or the expensive kinds of medical care all too often associated with the terminal illnesses that strike one in 10 aged couples every year.
>
> Seven out of every 10 elderly Negro couples have less than $3,000 a year; one in two couples, less than $2,000; and one couple in 10 must live on less than $1,000 a year.
>
> The older Negro man or woman who lives alone faces a daily existence even more bleak than that of married couples; $1,800 is the figure set by the BLS for a minimum sustenance budget for the lone elderly person, a budget which does not cover such basic items as medical care, carfare to the clinic, replacement of wornout clothing.
>
> Yet, 76.6 percent of the older Negro men and 96.5 percent of the women have less than $2,000 a year; 45.7 percent of these men and 68.5 percent of lone older Negro women must try to get along on less than $1,000 a year.
>
> Moreover, there are more older Negroes who are alone than white men and women because of the higher broken marriage rate and the shorter life expectancy among Negroes: 44 percent of the older men and 75 percent of the women are alone.

Among other findings presented by Miss Jones:

1. Aging Negroes receive less income from social security benefits because only in recent years have the bulk of Negro workers been brought under the OASDI provision of the Social Security Act.
2. Three times as many Negroes as white people need old-age assistance.
3. More Negro men than white men "retire" early, many for health reasons, but "a substantial number are actually forced out because of company or union policy * * *."
4. A "wide gamut of services" must be thrown open to older Negroes, with special efforts made to involve them in such services.

Basically, Miss Jones called for a "coalition of conscience between those people who are concerned about the aged and those who are concerned about the Negro."

Dr. Lionel Swan, president of the National Medical Association, described health service shortages of special consequence to the elderly Negro. He made several suggestions for action:[29]

[28] P. 137, hearings cited p. 136, footnote 23.
[29] P. 150, hearings cited p. 136, footnote 23.

No. 1. We must begin to meet the health needs of the aged Negro at birth and continue throughout his lifetime. Statistics have been given, and I have some here, but there is no point in reading them, about the higher mortality, the lower life expectancy of the Negro. These things should be corrected so that by the time the man gets to be 65 he has not accumulated all these inadequacies.

We cannot expect to overcome decades of relative neglect when the Negro reaches 65.

No. 2. We should develop an outreach program that actually informs Negroes of all ages of available programs and facilities. Some have been mentioned such as service centers, but again this withdrawn man in a dinky house in the ghetto is not likely to know about this and he is not likely to seek information. That point was very well brought out here. He must be reached and he must be encouraged.

Such a program must inform the elderly of the available health and social services and aid him in finding recreational facilities to overcome what is one of the greatest single perils of old age, loneliness. It occurs to me that we must eliminate the deductible and coinsurance [30] features of medicare. I think we should pay the whole thing. It is a little ridiculous to put a person of 28 or 29 on medicaid and have his bill covered, whatever it might be—I am speaking of even the minimum of $5 or $6 or $8—that would be paid for by medicaid. Whereas the man on medicare has to pay this $8, himself, until he will have paid $50. Then if it is $8 he pays 20 percent of whatever it is.

No. 4. We must raise the benefit levels under social security. That has been mentioned. The present revisions are a step in the right direction, but we feel they have not gone far enough.

No. 5. We should extend the benefits of medicare to include drugs, prostheses, and other appliances.

No. 6. We should extend inducements to private capital to invest more money in health care and housing facilities. Similarly we should eliminate some of the present obstacles to the formation of efficient group medical practice * * *.

No. 7. More doctors and health service professionals must be trained through scholarship and other public support, particularly from the minority groups themselves. The shortage of Negro physicians is almost at the crisis level. We are short of physicians generally throughout the country, but especially in minority groups it is true. We also need to train many, many more social workers.

No. 8. New emphasis must be placed in the field of geriatrics through a combination of medical care, recreation facilities and continued training in useful activity in order to make the retiree's life more meaningful.

One of the tragedies of the people I see is that the man feels so useless. He says—I think it was mentioned here by Senator Young, I believe—he is a man, vigorous, may feel very well, "I am 70 years of age, but I have no job. There is not a thing for me to do."

[30] See pp. 43-45 for additional discussion of deductible and coinsurance.

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> No. 9. New means of meeting the health needs of the aged community must be found. For example, expanded housing for the aged, perhaps combined with health care facilities, might improve the quality of both.[31]

The committee has also been informed of another serious deficiency in matters related to the Negro aged. Dr. Jacquelyne J. Jackson, of the Duke University Center for the Study of Aging and Human Development recently completed an intensive review of research sources in this field and reported the following: [32]

> Insofar as Negro aged are concerned, my most important finding is that *almost nothing is known about Negro aged*. Most of the few data available pertain to their objective socioeconomic conditions, as measured by such indices as income, education, and housing. As you well know, a majority of them can readily be classified as being at or below the poverty level by the current Federal guidelines. One implication of a finding regarding their objective socioeconomic conditions and those who will become aged within the next several decades, however, is that aged Negroes in very low-income situations will also have fewer rural persons. It appears as if aged Negroes in poverty-level conditions need more public assistance in urban than in rural areas. If this is so, then the Federal Government will have a much larger proportion of aged Negroes depending upon it for assistance.
>
> A more important implication of my general finding regarding the paucity of data on Negro aged as it relates to the value of federally assisted programs to older Negroes is that the lack of much needed data prevents the most efficient planning and utilization of resources. Therefore, the most urgent need which may confront a special committee on aging might be the undertaking of or support of a research study designed to at least (1) identify the significant homogeneous sub-groups of Negro aged; (2) specify their objective and subjective conditions as they relate to their age and to the various societal institutions affecting them; (3) determine their *perception* of their problems, needs, and desires; and (4) evaluate the services provided by currently available federally assisted programs for these aged. Special attention should be given to the isolated, urban aged Negro male. It may also be necessary to examine certain kinds of changes which may be taking place in the types of instrumental assistance which adult children may be able to provide for their parents when both occupy extremely low income levels.

Initial research and discussion thus indicates that the committee has a broad and urgent area of study intended to promote greater public understanding—and greater Federal commitment—relative

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[31] Several of the proposals made by Dr. Swan are incorporated in a pilot health and housing project for Washington, D.C., announced by President Johnson on Jan. 20, 1968. The Secretaries of HEW and HUD are working with Dr. Swan and the National Medical Association in order "to provide new types of nursing home and other care for the elderly and the poor in the inner city." Initial plans called for: an extended-care facility in the vicinity of Howard University, a medical building equipped for group medical practice, a skilled nursing home, social care institutions, new housing, and a neighborhood service center.

[32] P. 337, hearings cited p. 136, footnote 23.

to the unique problems and inequities encountered by the elderly Negroes of this Nation.

B. The Mexican Americans

Committee Chairman Williams announced on December 5 that Senator Ralph Yarborough, a member of the Senate Committee on Aging, will conduct for the committee inquiries into problems faced by the elderly of another minority group, the Mexican Americans. Among matters to be studied are: the apparent reluctance of elderly Mexican Americans in some cities to become tenants in high-rise public housing, suitability of some social services to their needs, and gaps in social security coverage. Senator Yarborough, commenting on the study, said: [33]

> Surely we must pay special attention to the unique problems faced by our minority groups. They stand in need of the greatest help, the greatest understanding. In the case of the Mexican Americans, they also appear to stand isolated from the services and programs meant to be of help to the elderly, especially the low-income elderly.
>
> A study of relocating the dispossessed elderly in the Rosa Verde section of San Antonio, for example, showed that much public housing attractive to the "Anglo" population there had very little appeal for the Spanish-speaking elders who want to hold on to a way of life they understand.
>
> The same study showed that lifetimes of inadequate income reach bitter fruition in old age. I will read for a moment from the report:
>
> > Even among those who worked, many receive neither social security nor private pensions. Company and Government pensions are unobtainable for all but a few. Many of the elderly worked for individuals rather than companies, and thus, hardly ever received social security coverage. Since they were unskilled, they have not been employed at jobs which furnish pensions.

C. The "Extreme Deprivation . . . of the Indian"

The National Council on the Aging and some Federal agencies have attempted within recent months to promote greater understanding of factors that intensify among the elderly, "the extreme social and economic deprivation of the Indian and Alaskan native." Dr. E. S. Rabeau, Director of the Division of Indian Health, at the Department of Health, Education, and Welfare responded to a preliminary committee inquiry and gave these suggestions for dealing with at least a few of the most common problems: [34]

> Services which are presently needed for the older Indian and Alaska native and which will be needed increasingly in succeeding years include:
>
> (a) Public health nursing follow-up of the chronically ill and aged. This would require additional staff and

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[33] P. 5, hearings cited p. 136, footnote 23.
[34] P. 363, hearings cited p. 136, footnote 23.

vehicles in each of the Division's service units.

(b) Social evaluation of homes where older patients reside to determine family relationships and attitudes toward the elderly to assess the preventive and medical social services required. Where needed, staff should encourage the elderly who have feelings of dependency or anxiety or fear of rejection to request and use available services, and should provide personal guidance and counseling to help the elderly care for themselves to the extent of their capabilities.

(c) Physical and occupational therapy by the few therapists now employed by the Division serve primarily the high volume of crippled children, tuberculosis patients and young adults. There is not sufficient staff to meet the total needs of elderly patients with strokes, fractures, arthritis, et cetera.

(d) Environmental health assistance including adequate housing, running water, heat, and lighting.

(e) Homemaker services, provision of prostheses, and transportation to and from clinic facilities.

Other staff expansion needed to meet the health needs of the increasing numbers of elderly beneficiaries include physician-nurse-social worker teams, nutritionists, health educators, speech therapists, health aides, and supervisory personnel.

It is estimated that 600 nursing-home beds will be needed by 1970, largely for the elderly. Additional financial assistance also is required to provide and maintain dignity and comfort for the individual in his later life.

With the reduction of infant mortality and infectious diseases to infants and young children, the life expectancy of Indians has been increasing. More people are living long enough to reach the older age groups and, as a consequence, chronic diseases are becoming more frequent. These diseases represent a significant workload in inpatient and outpatient services because of the necessity for long-term care, rehabilitation, and followup.

IV. TRAINING AND PERSONNEL NEEDS

This committee has long recognized that the shortage of trained personnel is one of the most serious bottlenecks in launching and expanding programs and services for older Americans.

In recognition of the need for a special effort toward meeting the need for trained personnel, title V of the Older Americans Act of 1965 authorized a program of grants and contracts "for the specialized training of persons employed or preparing for employment in carrying out programs related to the purposes of this act." [35] Authorizations and appropriations for this purpose have been modest, but the Congress acted last year to broaden current efforts by including the following provision in the Older Americans Act Amendments of 1967:

[35] Sec. 501, Public Law 89-73, the Older Americans Act of 1965.

SEC. 503. (a) The Secretary is authorized to undertake, directly or by grant or contract, a study and evaluation of the immediate and foreseeable need for trained personnel to carry out programs related to the objectives of this act, and of the availability and adequacy of the educational and training resources for persons preparing to work in such programs. On or before March 31, 1968, he shall make a report to the President and to the Congress of his findings and recommendations resulting from such study, including whatever specific proposals including legislative proposals, he deems will assist in insuring that the need for such trained specialists will be met.

To submit the report thus requested, the Administration on Aging entered into contracts with Surveys and Research Corp., National Recreation & Park Association, and National Association of Housing & Redevelopment Officials to assist with the report, which will be filed in the near future.

Despite efforts in this area by AOA and others with responsibility for meeting training needs in the field of aging, there are strong indications that much more needs to be done.

Recently Dr. Wilma Donahue, director of Gerontology, University of Michigan, testified before our committee as follows: [36]

Last June, in testimony before the Special Subcommittee on Aging of the U.S. Senate Committee on Labor and Public Welfare, I called attention to the critical manpower shortages of professional and technical personnel trained in aging and equipped to administer the newly developing programs. I also pointed out that paralleling the scarcity of trained personnel was the scarcity of university-based career training in aging and of substantial inservice training programs to improve the skills of those already employed in agencies in serving older people.

At that time, the title V training grant program of the Older Americans Act, being administered by the Administration on Aging, had constituted a new source of funds which were stimulating development of new curriculums in social gerontology. I predicted that in time this grant program would help make up for the failure of universities to take earlier action in providing instruction in gerontology.

This prediction held at least some essence of truth, for beginning with the 1967–68 fall term, seven major universities introduced new career training programs in one or more phases of applied social gerontology in which 89 students enrolled for advanced graduate degrees with specialization in aging. In a market as tight as that for trained personnel in aging, 89 new trained recruits will indeed seem a bonanza to employers who now can seldom find even a single trained candidate to interview. The Administration on Aging is to be complimented for its diligence and success in stimulating these universities to take action. It seems obvious that the only limiting factor to similar developments at other universities will be that of sufficient funds to pay part of the

[36] P. 187, hearings cited p. 136, footnote 23.

cost of such new programs. The need to increase the appropriation for the training of personnel to insure that the investment of other funds in services to the aging give maximum returns cannot be too strongly emphasized. The momentum created by the Administration on Aging among universities should not be allowed to diminish.

Of this fall's 89 new career students, 17 of them received traineeships from the University of Michigan-Wayne State University Institute of Gerontology, which was funded by a title V grant from the Administration of Aging. They are enrolled in a 2-year graduate program in public administration with specialization in gerontology. These students will be prepared to administer public programs in aging or in senior citizen housing.

In a statement submitted to the committee, Dr. Seymour L. Wolfbein, dean of the School of Business Administration, Temple University, observed:[37]

> There is today a substantial and significant nationwide shortage of most professional, technical, and skilled personnel.
>
> There is today, specifically a nationwide shortage of trained persons in the gerontological field which will continue for the foreseeable future.

From these statements and other information reaching the committee, it appears that a shortage of trained personnel handicaps programs and services for the elderly and that allocation of additional funds for training would be a good investment in meeting the needs of the Nation's elderly.

V. FEDERAL SUPPORT FOR RESEARCH RELATED TO AGING

A new summing up of a chronic problem[38] was offered to the committee in 1967:

> * * * research in aging, while it is not getting a lot of money, is getting money from a lot of places. This may be one of the reasons why it is not getting sufficient money. Because every one has a verbal commitment to at least a minimal program in aging. Since problems of the aged and aging are so rampant, agency heads feel the need to respond to the public concern and take the posture: "You see, I have an aging program, we are giving out this much money in aging." No one is willing to admit that we would be better off saying, "No, we don't function in aging at all," because this would mean that they are somehow not doing their job. What I am calling for is a more clear specification of what jobs we want done in aging and at least some kind of survey in terms of who is best equipped to do it.

Dr. Carl Eisdorfer, chairman of the research committee of the Gerontological Society of America, made those observations at the

[37] P. 460, hearings cited p. 136, footnote 23.

[38] A call for an organized research effort on aging was made at the White House Conference on Aging, in 1961, and in a report issued by the committee in 1963.

beginning of a new committee inquiry [39] into the status of federally supported programs on research related to aging. Giving his personal reactions to a study he conducted for the Society, Dr. Eisdorfer selected a few major examples of agency activity.

A. Survey of Major Agencies

National Institutes of Health: "aging grants received a lower priority and fared much less well than grants in other areas" in fiscal years 1964, 1965, and 1966. Dr. Eisdorfer added:

> These findings may reflect that research proposals in aging are not up to the caliber of other proposals, or indeed as most of us feel, that while the review was being conducted by a body of eminent scientists, these men were typically not familiar with the area of aging.

He added:

> In dollar amounts, the National Institute of Child Health and Human Development of the NIH awarded grants totaling $5,322,912 for fiscal 1967 in its programs of adult development and aging. Of this total, $3,233,799 was for research, representing approximately 8.79 percent of the total NICHD research budget—this is my calculation rather than theirs from data available to me—and less than .03 percent of the NIH budget.

Dr Eisdorfer, who is associate professor of medical psychology and psychiatry at Duke University, cited studies showing high rates of the elderly in mental hospitals and that psychiatric impairment affects an increasingly greater proportion of the population as age advances.

Even so, " * * * there is now only one professional person in the National Institute of Mental Health charged with the responsibility for the development of programs for the aged. In fact, the NIMH has expressed a real desire to develop and sustain programs in aging. At this time, however, it is attempting to recruit a first-rate psychiatrist into this program at a salary approximately 50 percent of the contemporary wage scale."

The Administration on Aging.—"The * * * title IV research and demonstration grant program under the Older Americans Act of 1965 supported 55 grant projects for a total of $2.5 million through fiscal 1967. Its primary objectives involve comprehensive coordinated services for the aged, senior centers, retirement planning, voluntary and social employment, recreational and leisure activities, the evaluation of living arrangement, and special services to the aged. For this monumental set of tasks, the agency has available to it approximately $2 million in fiscal 1968. It has an additional $2 million to develop programs in nutrition. The Administration on Aging is presently funding programs ranging from demonstration geriatric psychiatric units and teacher aides programs through recreational and coordinated community health, housing, and social services. This agency serves primarily to fill the gap in programs of action and demonstration of services for the aged and has accepted a broad mandate, but clearly it is not in a position to undertake support of major programs of

[39] P. 312, hearings cited p. 136, footnote 23.

basic research. Much of its funds are directed to community councils, social agencies, and aging centers, in an effort to stimulate program development and improved conditions for the aged throughout the country."

Office of Education.—"The Office of Education indicated in February of this year that no specific portion of its funds were earmarked for research in adult and continuing education. It has two sources of funds which it does—or could—use for such support. The Vocational Educational Act, section 4(c), had $17 million appropriated in fiscal 1966 and a $10 million total in 1967 and the Elementary and Secondary Education Act Title IV had $70 million for 1966 and again for 1967. During the 2½ years through February 1967, a total of 120 proposals in adult and vocational training were received and, approximately one of every three funded."

Recent cutbacks in federal research funds have contributed to the overall problem, along with the fact "that it becomes more difficult for the scientist outside of the Federal establishment to develop clear distinctions in his own mind as to appropriate sources of fundings and the guidelines for each source."

B. The Biology of Aging

A growing number of scientists have informed the committee that they believe a unified research effort could well result in major discoveries that would finally provide better understanding of the biological reasons for the aging process, which is—as one witness told the committee—"a reality that sooner or later affects each of us and limits the days and hours which we spend on this engrossing globe." [40]

The case for a "systems approach" to research on biological aging was put to the committee by Dr. Bernard Strehler, Professor of Biology at the University of Southern California.[41]

His major points:

1. The last decade has been a period of unparalleled achievement in two central areas of biology, genetics and biochemistry.
2. Attention will probably now turn from the detailed descriptions of mechanisms underlying cell behavior to more difficult and complex problems including the origin and mechanisms of senescence.
3. Even though the White House Conference on Aging called for a major research commitment in this area, "the present . . . effort is nevertheless substantially less than at the time of the . . . Conference." Part of the reason, in Dr. Strehler's opinion, is that the "NIH leadership has repeatedly stressed a lack of sympathy for a comprehensive approach."

Dr. Strehler submitted several immediate recommendations to serve as a beginning for a 10-year program:

1. Establishment of a National Institute for Aging Research, which he considers the most important step that can be taken;
2. Setting up a study section on the biology of aging within the National Institutes of Health; and
3. Appropriation to National Institute of Health or Atomic Energy Commission of a substantial amount of grant or contract funds

[40] P. 397, hearings cited p. 136, footnote 23.
[41] Testimony on pp. 190–200, hearings cited p. 136, footnote 23

specifically allocated to extramural research on the biology of aging. An initial additional appropriation of $6,000,000 per annum, specifically earmarked for basic research, is needed. This would about double the research budget now available.

Dr. Strehler's long-range recommendations:

1. Establish and fund the "International Gerontological Quinquennium" for the period 1970–1975. The proposed budget for the quinquennium is about $230,000,000. An intensive research approach and effort would be launched and carried out to define in detail the causes of the process of aging. An adaptation of the systems approach would seem appropriate, since it has served well in various other types of scientific endeavors.
2. Establishment of an agency to implement the quinquennium Dr. Shrehler presented three hypotheses which could be explored if an adequate effort were launched:

   (a) That cells may "lose the ability to translate certain code words as they age or mature, which might restrict the synthetic abilities of cells to the utilization of those messages which contain only translatable words."

   (b) That aging might be ascribed to the accumulation of "age pigments" which occur in ever increasing amounts, particularly in heart and brain, with advancing age.

   (c) That warm-blooded animals, like cold-blooded animals, age more slowly at reduced body temperatures than at more elevated ones.

C. Additional Suggestions for Research

Suggestions for additional research related to aging were offered at practically every committee or subcommittee hearing conducted in 1967. The Subcommittee on Retirement and the Individual, for example, received this list of proposals from one witness:[42]

1. More study of the changing length and patterns of our working lives, particularly:
   - The role of part-time work.
   - Differential experience among different industries and occupations.
   - The role of voluntary and service work.
   - Future projections of human service occupations, their relation to new public programs, their needs by age classification.
2. In this connection, I commend to you the ongoing work in the Labor Department, which is carrying out a longitudinal study of the labor force. This is just about the best way of getting some good intelligence about how different people fare in the labor force, especially in their preretirement years.
3. Then there are a whole series of specific questions on some of the assumptions we all have been using without any real documentation. For example:

[42] Dr. Seymour Wolfbein, pp. 70–71. The Subcommittee on Retirement and the Individual (Sen. Walter F. Mondale, chairman), U.S. Senate Special Committee on Aging. Hearings, Washington, D.C., June 7–8, 1967; July 26, 1967.

Do preretirement programs of counseling, gradual reduction in workload, et cetera, really make a difference to "successful retirement?"

(I might add, parenthetically, that I have found it pretty difficult to get much agreement on what is even meant by "successful retirement.")

What difference does income size really make in retirement, after some minimum amount?

What difference does it really make to a retiree if he does or does not work? How does this differ with different groups?

What are the relationships between health and retirement?

What differences exist between those people who retire voluntarily and those who have been compulsorily retired?

4. We ought to begin to assess the potential impact of the burgeoning number of women workers. They are responsible for a major piece of the increase in family income in postwar America. Doesn't this portend a similar development for future couples in retirement?
5. I would recommend, too, as a final note, that most—if not just about all—policies and programs relating to this field are set up by experts. It might be an enormously revealing operation to ask the retirees and potential retirees themselves about some of the alternatives we have talked about.

Hearings on consumer interests of the elderly also yielded many more suggestions for research, as did testimony on housing and minority groups. At a hearing on long-range service needs of older Americans, Dean Walter Beattie of the Syracuse University School of Social Work, proposed establishment of "regional multidisciplinary centers for training, service, and research in aging." Dr. Beattie's "action research" proposal has as a major objective "closing the gap between research findings and the utilization of such findings."

The large number of suggestions for research suggests that a major reappraisal of both research needs and federal resources for the support of research related to aging is called for. Proposals for a coordinated, comprehensive research effort related to the biological process of aging appear to have considerable merit and some urgency. The committee will continue its studies in this area and will ask federal agencies for additional information beyond that already provided.[43]

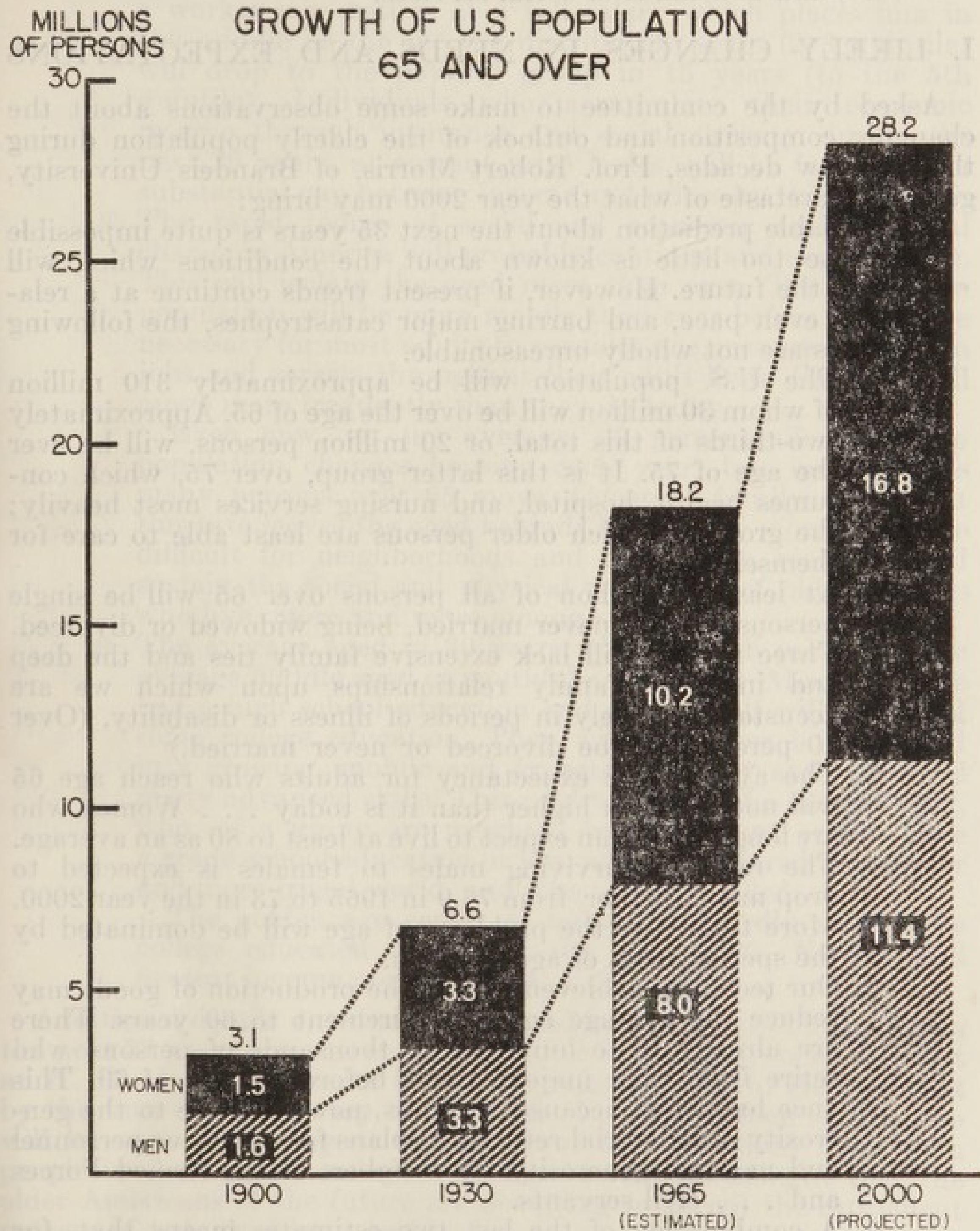
[43] See pp. 216, 264, 265, 278, and 284 for reports from directors of Federal research projects related to aging.

CHAPTER X

A LONG-RANGE LOOK AT THE FUTURE

Population projections about future generations of older Americans tell only part of the story of vast social and economic change that can be expected within the next three decades, as more Americans reach retirement age than ever before, and as those Americans live additional years in retirement.

In terms of sheer numbers, the picture is this:



To explore the ramifications of such growth, the Committee on Aging called "a convocation of experts" in December 1967.[1] Two major conclusions emerged from those deliberations:

1. Tomorrow's population of older Americans will be far different in needs and expectations from today's.
2. To prepare for great changes ahead, authoritative and comprehensive projections of future requirements should be made in such areas as retirement income, housing and other shelter needs including nursing homes and alternatives, health facilities and care, and new kinds of social services.

I. LIKELY CHANGES IN NEEDS AND EXPECTATIONS

Asked by the committee to make some observations about the changing composition and outlook of the elderly population during the next few decades, Prof. Robert Morris, of Brandeis University, gave this foretaste of what the year 2000 may bring:

> Reliable prediction about the next 35 years is quite impossible because too little is known about the conditions which will shape the future. However, if present trends continue at a relatively even pace, and barring major catastrophes, the following guesses are not wholly unreasonable.
>
> 1. The U.S. population will be approximately 310 million of whom 30 million will be over the age of 65. Approximately two-thirds of this total, or 20 million persons, will be over the age of 75. It is this latter group, over 75, which consumes health, hospital, and nursing services most heavily; the group in which older persons are least able to care for themselves.
> 2. At least 16 million of all persons over 65 will be single persons, having never married, being widowed or divorced. Three million will lack extensive family ties and the deep and intensive family relationships upon which we are accustomed to rely in periods of illness or disability. (Over 10 percent will be divorced or never married.)
> 3. The average life expectancy for adults who reach age 65 will not be much higher than it is today . . . Women who are longer lived can expect to live at least to 80 as an average.
> 4. The ratio of surviving males to females is expected to drop much further, from 76.9 in 1965 to 73 in the year 2000. More than ever the problems of age will be dominated by the special needs of aged women.
> 5. Our technical achievements in the production of goods may reduce the average age for retirement to 60 years. There are already some hundreds of thousands of persons who retire from their major careers before the age of 60. This once happened because of illness, now it is due to the generosity of industrial retirement plans for executive personnel and national generosity for members of the Armed Forces and . . . civil servants.
> 6. A combination of the last two estimates means that, for the average American, between 15–20 years of human life—

[1] "Long-Range Program and Research Needs in Aging and Related Fields," hearings before the U.S. Senate Special Committee on Aging, Washington, D.C., Dec. 5 and 6, 1967.

and more likely 20 than 15 years—one-fourth of man's time on earth—becomes "free time" detached from goods-producing labor. Twenty years of time, for the average human being, who must decide what he shall do with his life, rather than having a brief span at the end of a working career to ask "what *have* I done with my life?"

7. The price level will be 50 percent higher than it is today, given a non-inflationary cycle and the recent rate of "creeping inflation." By one conservative estimate (Froomkin) a worker who retires at a full salary which places him in the middle of the income distribution scale (2–3 quintile) will drop to the poverty group in 15 years (to the 5th quintile). Individuals who accumulate their economic reserve through insurance and social security during the next 30 years, at current price levles, will be faced with a substantial gap between income and prices by the year 2000.
8. The rapid tempo of social and economic and technical change in America will probably continue and ever increase. This will isolate the aged more than ever. The American population will be more mobile than ever before. It will be necessary for most adults to consider one or more changes in jobs and careers throughout their adult lives. Families will move more frequently than they do today.

   Even now, on the average, 20 percent of the urban population changes housing each year, but only half as many persons over 65 move. Constant family moving at this rate leaves the aged behind: It becomes more and more difficult for neighborhoods and families to maintain and sustain the social and physical well-being of older persons who live, more and more among strangers.
9. The average aged in 30 years will be much more like the average middle aged or youthful adult today. Most will have had a high school education and almost half will have had some college education. They will be native born, reared in a growing, mobile and expectant society and will have many advanced skills. This contrasts with the present aged, who, as a group are weighted by immigrant origin, have a grade school education or less, who were reared in a slower and more frugal world, and who are less skilled.

   The golden age center of today will hardly satisfy the college educated oldster of the year 2000. Neither will present income nor a lifetime of inactivity.

Additional details on educational attainment by the elderly within the next 32 years were given by Dr. Harold Sheppard, social scientist at W. E. Upjohn Institute for Employment Research. He said that by the turn of the century the number of people in their sixties who will have a college degree will be about 9 to 10 times more than people in their sixties today. Like Dr. Morris, he thought that the older Americans of the future are not going to accept the retirement pattern of today's elderly people: [2]

> With higher educational achievement—this is my main point—and health consciousness and the effective acceptance

[2] P. 106, hearings cited p. 150, footnote 1.

of a democratic ideology of equality, I doubt very strongly that the aged in the year 2000 will passively tolerate conditions resulting from the stereotypes and attitudes toward the aged that the young today themselves entertain toward the aged. They will not want to be treated in the year 2000 the way they treat the aged of today. That is the point.

Dr. Sheppard also discussed the effects of increasing longevity upon younger generations: [3]

> From the standpoint of having wage and salary earners as potential sources of financial and other support, there will be increasing numbers of aged persons whose children and other so-called younger relatives will themselves be of retirement age . . . thus, with limited financial means under our present public policy and with certain kinds of problems all their own. Let me be very concrete.
>
> You will find in 1960 there were 34 persons aged 80 and over for every 100 persons aged 60 to 64; 34 persons aged 80 and over for every 100 people aged 60 to 64. The projections indicate that by the year 2000 there won't be 34 of these very old, old people but 67 people for every 100 persons aged 60 to 64 when the new century rolls around.

II. THE NEED FOR PROJECTIONS OF FUTURE REQUIREMENTS

"The future is not an overarching leap into the distance; it begins in the present."

With that quotation, Dean Walter Beattie of the Syracuse School of Social Work called for "identification of the central issues and directions of our day" in order to create a "framework for social planning and service provisions, as well as for problem solving, as we move toward the future."

The National Council on the Aging, which has already begun its own studies of future need, was even more emphatic in requesting an organized, far-reaching effort to estimate what the future can and should bring. Milton Shapp, chairman of the Public Policy Committee for the NCOA, put the case for systematic projections: [4]

> Heretofore, we have tackled the job piecemeal, and to do so was perhaps wise and even necessary to get a program started. The time has now come to establish some national standards and goals for the elderly in certain crucial areas—(1) to measure the need, (2) to define ways of meeting the need, (3) to estimate the cost, and (4) to establish target dates.
>
> Similar methods have brought results in war efforts, in space exploration, in public highway construction, and—to an extent—in public education. We can do no less with regard to human goals for the older people of the Nation.
>
> Last year, the staff of the National Council on the Aging undertook an assessment of progress in the field of aging

[3] P. 105, hearings cited p. 150, footnote 1.
[4] P. 11, hearings cited p. 150, footnote 1.

> since 1950, as background material for our annual meeting, which was on the subject of "Developing Public Policy." In many respects, this was a rewarding experience, but it was a sobering one also. We were forced to conclude that, in spite of all our efforts, life in these United States has not changed much in the past 20 years for the great mass of older people.
>
> * * * * *
>
> * * * It (the NCOA report) did, we believe, point the way to a much more complete study which, taken together with certain minimum standards as national goals, would provide a basis for a national policy for all older people—as distinguished from isolated demonstration programs which at best benefit only a few.

Strong support was given by Mr. Shapp and other witnesses at the December 5–6 hearings for legislation[5] calling for a White House Conference on Aging in 1970. They saw the proposed Conference as a vehicle not only for making the kind of projections requested by Mr. Shapp, but also as an opportunity to reexamine progress made since the last White House Conference in 1961. The American Association of Retired Persons/National Retired Teachers Association, for example, had these suggestions:[6]

1. Matters discussed at the first Conference which require further consideration.

(*a*) The role of older people in today's world, including employment, training, and group leadership for volunteer and professional community organization and for churches.

(*b*) The study of State programs in relation to age discrimination, opportunities for employment, leisure time activities, suitable housing and living conditions, and adequate health care facilities for older persons.

(*c*) Up-to-date reports from States on their research in health, psychology and social science.

(*d*) Opportunities for preretirement counseling and planning.

2. Suggestions for improvement of the 1970 Conference over the 1961 Conference.

(*a*) Inclusion of older people in Conference planning, deliberations and participation. This is vital to success. One of the criticisms of the 1961 Conference was that it was *for* not *with* older people, an almost fatal omission.

(*b*) Explanation by the States of the programs they have developed in the area of aging. Many of the States embarked on new programs for older persons. Although some States have not carried their programs through, many have developed brilliant programs in several areas.

3. Suggestions by the members of the legislative council of our two associations after discussion with people in their own areas. Following are the subjects which occurred most

[5] Senate Joint Resolution 117, introduced by Sen. Harrison A. Williams and 19 cosponsors on Oct. 18, 1967, The resolution was the subject of hearings by the Special Subcommittee on Aging (Edward M. Kennedy, chairman), U.S. Senate Committee on Labor and Public Welfare, on Mar. 5-6, 1968.

[6] P. 242, hearings cited p. 150, footnote 1.

often in their letters. These are the matters we would like to call to your attention and perhaps explore in greater depth in the future.

Retirement income of all older people.
Home visitation and health aid.
Supplementation of pension laws. Advisory service to older people.
More and better housing for lower income groups.
Implementation of Fair Packaging Act.
Up-dating of social security earnings limitation.
Need for prescription drugs at more reasonable prices.
Effect of inflation on persons with fixed incomes.
Job discrimination affecting the aging.
Improvement in health insurance policies.
Federal minimum standards for teacher retirement pensions.
Federal, State and local property tax treatment of persons age 65 and over.
More uniform probate laws.
Use of the knowledge, training and experience of retired persons who are still capable of giving constructive service to all phases of our economic, political and social life.

The committee has received many other suggestions for matters to be discussed and methods for planning and conducting the State and White House conferences. Interest is already at a high pitch, and there is good reason to believe that it will increase if Congress acts in time for State and Federal officials to plan adequately.

The committee supports the proposal calling for a White House conference on aging some time in 1970, and it suggests that the conference, together with all preparations for it, serve as the means for developing comprehensive projections of long-range need that may be expected as the population of older Americans continues to increase.

MINORITY VIEWS

MINORITY VIEWS OF MESSRS. DIRKSEN, CARLSON, PROUTY, FONG, MILLER, MORTON, AND HANSEN

INTRODUCTION

Previous minority reports of the Special Committee on Aging have all endorsed (a) improvements in old-age, survivors, and disability insurance under the social security system, (b) Federal support of special services to the aged where needed, (c) better Federal-State economic assistance to the elderly in greatest need, (d) removal of older people as far as possible from treatment as public welfare cases, (e) stimulation of private efforts to improve the social and economic situation among senior citizens, and (f) effective Federal executive and legislative action to cut the devastating losses by older Americans through inflation.

Underlying these minority policy positions has always been a deep and abiding concern for older persons. We reaffirm now our belief that older Americans should be given full opportunity to share in America's bounty with dignity and independence.

While a recapitulation of earlier minority recommendations appears elsewhere in this statement, for most it hardly seems necessary to repeat our previously published detailed comments. We have elected instead to concentrate on three major points.

Nothing in this decision should be interpreted as changing any of our previous positions. We urge as a matter of priority now, however, that special and most serious consideration be given to:

1. **Immediate development and implementation of effective Federal fiscal policies to stop the accelerating inflation—the most common source of trouble for older Americans;**
2. **Provision of automatic social security benefit increases based on escalation in living costs; and**
3. **Initiation of a comprehensive nonpartisan review in depth of the social security system, private pensions, tax laws, employment opportunities, and related elements in the economy of aging to the ends that—**
   - **(a) no older American shall suffer want or loss of dignity;**
   - **(b) the social security system's integrity shall be reassured for the benefit of both present and future generations;**
   - **(c) necessary burdens on the young for support of the old will be compatible with principles of fairness and and social justice; and**
   - **(d) any inequities in public and private efforts to provide decent retirement income will be corrected in the most intelligent possible manner with minimum delay.**

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As in the past, we continue our view that while special services to meet a variety of unique needs among the Nation's older population deserve support, the most serious problems of older Americans are economic and are related to achievement and preservation of adequate income.

INFLATION—ECONOMIC PUBLIC ENEMY NO. 1

Minority members of this committee have repeatedly taken the lead in recognizing that the most serious sources of problems among all older Americans is the massive loss of real income through inflation.

We maintain, with wide support from economic experts, that control of inflation can only be achieved through Federal policies which are fiscally sound, and by rollcall votes of Members of Congress which are consistent with such policies.

The record of the Republican membership measures up to these requirements.

We have emphasized that a sound dollar demands cuts in unnecessary and wasteful expenditures which have characterized recent Democratic-controlled Congresses and the present national adminstration. Further priorities for spending programs must be established—a basic principle of good government which has been absent under the present administration.

We are compelled to reiterate our concern for reduction in and postponement of unjustifiable or low-priority Federal expenditures. It is absolutely necessary to put an end to rising public deficits and debt, which lay the foundation for inflation and high-interest rates.

The record since our last report has already shown increasing erosion of the dollar's value. It has become commonplace to speak of today's U.S. money as a 40-cent dollar.

There is no place in this serious problem for levity, but we cannot help but agree with the late and venerable comedian, Ed Wynn, who said, "What this country needs is a good 5-cent nickel."

The danger is that, unless those in control of our Federal Government live up to economic policies which include a stable dollar, we may some day come to a 5-cent dollar.

Almost all citizens are hurt by rising costs of living. Only the very wealthy escape. No single group suffers more, however, than older Americans.

While some employed persons derive some relief through wage increases, there are many who do not. A high percentage of the over 3 million employed persons over 65 are to be found in the latter group. Even when increases do occur, their delay often makes it impossible to recoup the inflation-created losses.

Farmers, of course, have been confronted with falling prices for their products while prices of goods and materials they must buy have risen sharply. This has special significance to a discussion of inflation's impact on the aging because so many of our Nation's farms are operated by persons in the older age brackets. It should be remembered that half the Nation's poor live in rural areas.

In earlier minority reports of this committee, we made estimates of possible inflation-created losses to older people in terms of probable percentages and total dollar reductions in purchasing power. Our predictions of substantial losses have been confirmed. Much to our

regret, indeed, actual injury to older people far exceeded our predictions.

Cost-of-living inflation during the past year amounted to nearly 4 percent. Virtually no economist expects a lower rate of inflation during the next 12 months. Most experts predict a greater loss in dollar values, ranging to as much as 5 percent or more.

The record of $10 billion cost-of-living inflation during the first 3 months of 1968 bears out these predictions.

Based on an estimated 1968 annual purchasing power of over $40 billion among persons past 65, a 4-percent inflation would produce purchasing power loss to these citizens of roughly $1.6 billion per year. A 5-percent inflation would cost them over $2 billion per year.

When these losses are translated into individual personal terms, they become even more significant. Living standard prospects for the person now 65, with roughly 14 years of life expectancy, become dim if this inflationary spiral is not stopped.

The greatest injury is suffered by people with the lowest incomes. The bulk of these persons are to be found among the most elderly and among single and widowed women who often must face life alone.

Even the present national administration, whose own policies have contributed so severely to losses in dollar values, has begun to express alarm at current and future threats of greater inflation. Regretably these words of alarm have yet to be followed by meaningful deeds.

In the face of our Vietnam problem, which may yet impose even more serious demands on the Nation, it hardly appears enough to simply call for an increase in taxes.

There must be some real belt tightening with reference to lowest priority expenditures and vigorous efforts to eliminate unnecessary expenditures and waste.

Lipservice to these needs is not enough. Nor are "budget cuts" which are little more than promises against budget increases. There must be action now—and it must aim at eliminating all the fat in our governmental programs.

An example of national administration attitudes is afforded by what has happened since the "freeze" on the number of Federal civilian employees. Since 1966, when the "freeze" became effective, the number of Federal civilian employees has risen by almost 200,000. The national administration's budget for next year requests a further addition of 55,600 Federal employees.

The Democratic-controlled Congress and national administration cannot divest themselves of responsibility for this, which, in itself, has been a substantial factor in the inflationary spiral.

We recognize the vast responsibilities the Federal Government has toward its citizens and their special needs. We have supported and will support programs which effectively address themselves to such needs. We insist, however, that sensible priorities must be set within the context of sound fiscal policies.

We take this position in the interest of all the people. As members of the Committee on Aging, however, we feel a special need to protect the economic security of older Americans. Inflation is the No. 1 enemy of such security. It must be brought under control at the Federal level, not through words, but through action.

While a stable dollar is the major long-range need to protect older Americans and others who must depend on relatively fixed incomes, we feel immediate action is required to provide help to these persons against ravages of inflation.

Adoption of our proposal to provide automatic increases in social security benefits equal to rises in living costs would be a major step in that direction.

As introduced and supported by scores of minority Members in the House and Senate during the 89th and 90th Congresses, such an amendment to social security would provide that whenever the Consumer Price Index goes up by a specified percentage, then old-age, survivors, and disability insurance benefits would be increased in an equal percentage. This proposal has strong endorsement by the Republican National Coordinating Committee.

This improvement in the Social Security Act recommends itself on several counts.

Its implementation would require no increase in social security tax rates. We believe, as we think most older Americans do, that social security taxes, which fall primarily on the young and middle aged, should not become an unbearable burden.

Our concern for the tax level is only in part related to immediate needs of workers—with responsibility for rearing and educating youngsters on whom our Nation's future depends. It also relates to our desire for preservation of OASDI as an effective instrument which will stand the test of time.

Economists and other students of social insurance have voiced the opinion that a point can be reached when the burdens of social security taxes might jeopardize the whole system. We do not choose to be a party to such a misfortune. Experience in other countries suggests that such fears may have justification in fact.

The most important argument for automatic cost-of-living increases in social security benefits, of course, is the help it would give to older people.

Most older Americans are relatively defenseless against higher living costs produced by the inflationary spiral. The Federal Government's actions have been the primary source of this problem. It appears equitable and fair that that Government should provide at least some relief to persons who are victims of its fiscal policies.

That such help should be available to the retiree as soon as he is hit by the dollar value loss appears equally appropriate. He should not have to wait 1, 2, or 5 years for such relief through general amendments to the Social Security Act. This is especially so when such increases often fail to compensate fully for changes in living costs anyway.

It is regrettable, but true, that many of the elderly simply cannot wait. Some are of most advanced age and may not even live to get the benefit of increase "promises." A high percentage of these extremely old people are ones with lowest resources.

We believe that compassion, equity, and commonsense demand that we stop making older people wait until some future Congress chooses to compensate them for social security benefit losses created by inflation.

This is the most compelling reason for our support of the automatic adjustment in OASDI benefits based on consumer price levels.

It is also true, however, that such an automatic provision would tend to reassure the worker, whose taxes now support the program, that he will not be shortchanged when he reaches retirement age.

Adoption of social security cost-of-living increases on an automatic basis is by no means offered by us as a sole answer to the problems of older people. Other improvements in the social security system, many of which we have discussed in previous minority reports, also deserve action.

It should be noted further that such a social security amendment cannot meet the basic problems created by inflation. After all, less than one-third of the money income received by persons past 65 is derived from OASDI payments. This underscores the absolute necessity of effective action to stop inflation across the board.

NONPARTISAN ECONOMICS OF AGING STUDY

Old Americans' incomes are derived from a variety of sources, each of which must be considered in developing national policies to assure income adequacy in later years. This is one of the several major reasons that prompt us to urge most strongly that a comprehensive study in depth of the whole economics of aging be made as soon as possible.

Such a study should be conducted in a maner completely removed from partisan politics.

It should involve, in addition to a balanced team of qualified economists, representatives from other social and scientific disciplines with knowledge of the elderly's problems. Included among such experts undoubtedly would be many who qualify as "senior citizens."

The scope of such a study should be comprehensive and should be related to both long-range opportunities and needs and to immediate problems among our older population.

The study should try to determine realistically the probable budgetary requirements of older persons now and in the future. Related to this must be consideration of health, medical, and educational progress which may create an older population in the future as different from today's as today's is different from the elderly of 1900.

A meaningful economic survey most certainly would direct careful attention to the contributory social security system, private pensions, Government pensions, old-age assistance programs, employment opportunities, and all other sources of income for older Americans.

It is our hope that the study would provide a sound base for formulation of national policies which would achieve our common goal of decent living standards with dignity for every elderly person.

Ideally, the study should be undertaken by a recognized economic research institution or bureau, of which there are several. Preferably it would be financed by one of the large, independent foundations now dedicated to impartial improvements in our society.

Should such a privately sponsored study appear impractical, an alternative approach could be created by Congress of a bipartisan commission similar to the successful Hoover Commission, created during the Truman administration, to develop recommendations for improvements in Federal Government operations.

It has been 30 years since full operation of the social security system began. At no time since has there been a thorough reexamination of its purposes, operation, and total effect on the American people. We believe such an examination is needed to make certain that social security serves our people as they want and deserve.

No one would deny, least of all Members of Congress most deeply involved with such legislation, that we have seen 30 years of patching, shoring up, and expansion of social security in a piecemeal fashion. How much of its purpose and function has changed would be a primary concern of the study we propose. So also would be answers to questions about its future scope and character.

Questions have been raised as to the financial soundness of Federal old-age, survivors, and disability insurance (OASDI). We who have supported recent amendments to the system are confident that its obligations will be honored. At the same time, however, some of us have become disturbed about solvency of the Federal civil service pension system. We do not want to see either of these fine programs put in jeopardy.

Questions have risen as to the best ways to finance OASDI. Questions have been raised as to whether the young will get a fair return in later years for the social security tax contributions they are making now. Impartial, factual answers are needed.

We, in previous reports of this committee, have raised a number of questions regarding inequities in social security, including treatment given:

1. Widows who receive only 82½ percent of primary benefits payable to their husbands.
2. Married couples both of whom work yet receive benefits only on contributions by the major wage earner.
3. Persons who continue working past 65, continue paying social security taxes, and yet do not get equitable increases in benefits.
4. Eligibile persons who lose social security benefits because of employment when even the combination of benefits received and earned income give them too little on which to live in reasonable comfort.

To these could be added many more inequities, real or fancied, which have been brought to the attention of individual Members of the Congress.

What should be the minimum primary OASDI benefit? Should it be $55, $75, $100? Should it be some other figure plucked out of a hat? Or should it be a minimum based on a thoroughgoing study of unmet needs among the aged? Is there an alternative method, apart from old-age assistance, to finance the elderly whom the present public and private system is failing to serve?

How closely should OASDI benefits be related to wage-based tax contributions made over the years by the beneficiary? Are social security taxes equitable on employed persons and self-employed, respectively?

The study we propose could well address itself to such questions and countless more related to the Social Security Act.

We believe members of the House Committee on Ways and Means and the Senate Finance Committee, charged with responsibility for social security legislation—but also for much other extremely import-

ant legislative business—would welcome an unbiased analysis and pertinent recommendations.

We do not believe a study for this purpose initiated and directed by the Social Security Administration or other division in the Federal executive department could produce the objective analysis and recommendations that are needed.

The executive branch can be and has been the source of much valuable data. It has many highly competent people involved in administration of programs affecting the elderly. Their primary responsibility, however, is administration and not policy development. Administrative bias, indeed, can lead and, in the past, has led to policies not in the country's best interests.

Another reason for keeping the study independent and nonpartisan is the fact that it must go far beyond a review of social security and other publicly financed programs for older people.

It is approximately 20 years since our Nation's private pension system began its real growth. A study of the economics of aging which failed to take into account the contribution, largely unique to America, by this approach to needs of older people would have relatively little meaning. Attention to income-producing savings of all other types would also be necessary.

All of these private efforts to develop retirement incomes have made great strides since the end of World War II.

As with social security, however, many questions are pertinent to our goal of adequate income for older Americans. This is particularly so with regard to organized private pension programs.

What is the potential of private pensions? How can this potential be realized and expanded through both private and Government initiative? How effective are current laws designed to stimulate their growth?

In a mobile society, with frequent changes of employment by millions of individuals during their working years, what are the best ways to protect their stake in various private pension programs to which they may have access? To what extent is vesting and portability of pension rights practical and desirable? Are there special problems in vesting and portability which must be resolved if they are to work? Is there danger that overzealous legislative requirements in these areas might impede development of new pension programs?

Other questions relate to how entire groups of employees may have assurance that their reliance on private programs is justified. What is the proportion of insured pension plans? What are the trends in marketing of new plans? Are new laws or regulations necessary to protect interests of members in union-operated plans? In employer-operated plans?

At least as important as these examples, perhaps, is the question of interrelationships of social security, private pensions, and other retirement income programs. To what extent have these intermixed to achieve the current median annual income of $1,433 for single older individuals and $3,645 for couples over 65?

Beyond this is a question with both immediate and long-range implications: How many Americans may reasonably be expected to participate in private plans? Those who cannot also deserve decent living when they grow old. How can this goal best be achieved?

We believe public assistance casework treatment of the aged whose only handicap is financial cannot be justified on the same basis as with the younger relief recipient. How can we best provide help with dignity to the several million aged in this category?

Another factor in the economics of aging is employment. A large number of people past 65, especially men, choose to continue employment. Many, on retirement from one job, move to another—some full time, some part time.

Is there need in our society for the skills of senior citizens? Do social security or private pension regulations discourage those who want to work in later years from doing so? How many private pension plans are designed to close the employment door on competent older workers? How can this problem be resolved?

How great an effort should be made by private business to offer employment opportunities suitable to needs and skills of older people? How can Government encourage such effort?

A splendid beginning in developing answers to questions of the type cited above has been made by the Subcommittee on Fiscal Policy of the Joint Economic Committee in its six-volume compendium of papers on "Old Age Income Assurance" written by distinguished economic experts. This compendium includes numerous questions other than those we have raised in this statement. They also deserve attention. Some are extremely important. The excellent material developed by the Joint Economic Committee, however, only serves to emphasize the importance of a major study such as we propose. Time and again contributing experts, commenting on areas in which they have greatest knowledge, say: "A further study needs to be made."

It is perhaps fitting to comment at this point on bipartisan proposals for a White House Conference on Aging in 1970. We are in full sympathy with what we believe would be the objectives of such a conference. We note that administration witnesses testifying on such legislation have recommended deferring such a conference until 1971 because of the magnitude of such an undertaking.

Whatever may be the best time for such a conference, we believe it would be greatly strengthened if the study we have proposed is completed, or at least well underway. A White House Conference on Aging which fails to meet the No. 1 problem, which is economic, head on, could not do full justice to senior citizens of our Nation. We, therefore, urge maximum speed in implementation of our economic study recommendation.

PREVIOUS MINORITY RECOMMENDATIONS

In the opening paragraphs of these minority views, it was noted that a recapitulation, without elaboration, of recommendations we have made in previous reports would be made to complete the record of our position in aging. It goes without saying that enumeration of last year's recommendations reflects our continuing attitude toward older people and solution of their problems. At that time we urged:

1. Automatic upward adjustments in OASDI benefits equal to increases in living costs;
2. Across-the-board increases to all OASDI beneficiaries;
3. Higher minimum OASDI payments;
4. One hundred percent of primary OASDI benefits to older widows (instead of the present 82½ percent of the amount payable to surviving husbands);

5. Permitting OASDI beneficiaries to earn at least $2,100 a year without penalty;
6. Upward adjustments in benefits for married couples both of whom work and thus often pay dual social security taxes without receiving higher payments when they become beneficiaries of OASDI;
7. Upward adjustments in OASDI benefits for persons who do not retire at age 65, but who now receive no recognition for their added years of contributions to social security and to society;
8. Extension of OASDI to more people on an adequately funded basis;
9. Vigorous efforts to expand and improve America's unique private pension system;
10. Preservation and development of appropriate tax relief measures for older Americans at all levels of government;
11. More liberal income tax considerations for persons who contribute substantially to the support of needy older relatives;
12. Assurance of adequate old-age assistance programs;
13. Expansion of job opportunities, full time and part time, for older persons desiring employment;
14. Effective "sheltered care" programs for the aged whose infirmities require such service;
15. More effective State and local programs for older people such as were envisioned when the Congress gave almost unanimous support to enactment of the Older Americans Act of 1965.

On some of these recommendations, the Nation has made progress; others remain to be done in their entirety. We hope that time will soon be at hand.

CONCLUSION

The thrust of these minority views reflects our conviction that top priority to our current three major recommendations, including the call for a nonpartisan economic study in depth, is necessary if our Nation is to attain an enduring posture in the field of aging which will:

1. Provide ample opportunity for all Americans to achieve decent living standards for their later years;

2. Achieve adequate income with dignity for those who are unable to do so through their own efforts;

3. Maintain the purchasing power of such incomes once they are attained;

4. Develop the most workable and equitable combinations of private and public efforts toward these ends; and

5. Hold necessary tax burdens on the worker for these purposes at levels as reasonable as possible.

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APPENDIXES

Appendix 1

AID FOR THE AGED

MESSAGE FROM THE PRESIDENT OF THE UNITED STATES TRANSMITTING A REVIEW OF MEASURES TAKEN TO AID THE OLDER AMERICANS AND RECOMMENDATIONS FOR LEGISLATION TO PROVIDE FURTHER AID

JANUARY 23, 1967

To the Congress of the United States:

America is a young nation. But each year a larger proportion of our population joins the ranks of the senior citizens. Today, over 19 million Americans are 65 or older—a number equal to the combined populations of 20 States. One out of every 10 citizens is in this age group—more than twice as many as a half century ago.

These figures represent a national triumph. The American born in 1900 could expect to reach his 47th birthday. The American born today has a life expectancy of 70 years. Tomorrow, the miracles of man's knowledge will stretch the lifespan even further.

These figures also represent a national challenge. One of the tests of a great civilization is the compassion and respect shown to its elders. Too many of our senior citizens have been left behind by the progress they worked most of their lives to create. Too often the wisdom and experience of our senior citizens is lost or ignored. Many who are able and willing to work suffer the bitter rebuff of arbitrary and unjust job discrimination.

In this busy and productive Nation, the elderly are too frequently destined to lead empty, neglected lives:

5.3 million older Americans have yearly incomes below the poverty level.

Only one out of five has a job, often at low wages.

Over 2 million elderly citizens are on welfare.

Nearly 40 percent of our single older citizens have total assets of less than $1,000.

Countless numbers dwell in city and rural slums, lonely and forgotten, isolated from the invigorating spirit of the American community. They suffer a disproportionate burden of bad housing, poor health facilities, inferior recreation and rehabilitation services.

THE FEDERAL ROLE

The historic Social Security Act of 1935, sponsored by that great President, Franklin D. Roosevelt, first proclaimed a Federal role in the task of creating a life of dignity for the older American. By 1951, the number of our senior citizens who had earned and received social security benefits exceeded the number on public welfare. Today, more than 15 million Americans over 65 draw social security, while only 2 million remain on the welfare rolls.

We in the executive branch and you in the Congress have extended the Federal role in other ways:

The last eight Housing Acts contain special public housing provisions for the elderly and special assistance for them when they rent, buy, or modernize their own homes.

The Hill-Burton hospital program seeks to expand and improve nursing homes and other long-term care facilities.

Public welfare provides programs to help restore older people to self-support and self-care.

The manpower development and training programs direct special efforts at the problems of the middle-aged and older Americans.

The National Institutes of Health have established programs of research on aging.

In 1965, the Congress enacted and I signed into law two landmark measures for older Americans:

Medicare, to ease the burden of hospital and doctor bills.

The Older Americans Act, to develop community services to put more meaning into the lives of the senior citizens.

When he signed the 1935 Social Security Act, President Franklin Roosevelt said, "This law * * * represents a cornerstone in a structure which is being built but is by no means complete." President Truman in 1950 and President Kennedy in 1961 proposed and the Congress passed legislation to improve the social security system.

The time has come to build on the solid foundations provided by the work of Congress and the executive branch over the last three decades. Last summer, I declared a Bill of Rights for Older Americans—to fix as our Nation's goal an adequate income, a decent home, and a meaningful retirement for each senior citizen.

Now we must take steps to move closer toward that goal.

Let us raise social security benefits to a level which will better meet today's needs.

Let us improve and extend the health care available to the elderly.

Let us attack the roots of unjust job discrimination.

Let us renew and expand our programs to help bring fulfillment and meaning to retirement years.

TOWARD AN ADEQUATE INCOME

Social security benefits today are grossly inadequate.

Almost 2½ million individuals receive benefits based on the minimum of $44 a month. The average monthly benefit is only $84.

Although social security benefits keep 5½ million aged persons above the poverty line, more than 5 million still live in poverty.

A great nation cannot tolerate these conditions. I propose social security legislation which will bring the greatest improvement in living standards for the elderly since the act was passed in 1935.

I recommend effective July 1, 1967:

1. *A 20-percent overall increase in social security payments.*
2. *An increase of 59 percent for the 2.5 million people now receiving minimum benefits—to $70 for an individual and $105 for a married couple.*
3. *An increase of at least 15 percent for the remaining 20.5 million beneficiaries.*
4. *An increase to $150 in the monthly minimum benefit for a retired couple with 25 years of coverage—to $100 a month for an individual.*
5. *An increase in the special benefits paid to more than 900,000 persons 72 or over, who have made little or no social security contribution—from $35 to $50 monthly for an individual; from $52.50 to $75 for a couple.*
6. *Special benefits for an additional 200,000 persons 72 or over, who have never received benefits before.*

During the first year, additional payments would total $4.1 billion—almost five times greater than the major increase enacted in 1950, almost six times greater than the increase of 1961. These proposals will take 1.4 million Americans out of poverty this year—a major step toward our goal that every elderly citizen have an adequate income and a meaningful retirement.

The time has also come to make other improvements in the act.

The present social security system leaves 70,000 severely disabled widows under age 62 without protection.

The limits on the income that retired workers can earn and still receive benefits are so low that they discourage those who are able and willing to work from seeking jobs.

Some farmworkers qualify for only minimum social security benefits. Others fail to qualify at all. As a result, many farmworkers must go on the welfare rolls in their old age.

Federal employees in the civil service and Foreign Service retirement systems are now excluded from social security coverage. Those having less than 5 years' service receive no benefits if they die, become disabled, or leave Federal employment. Those who leave after longer service lose survivor and disability protection.

I propose legislation to eliminate these inequities and close these loopholes.

I recommend that—

Social security benefits be extended to severely disabled widows under 62.

The earnings exemption be increased by 12 percent, from $125 to $140 a month, from $1,500 to $1,680 a year.

The amount above $1,680 a year up to which a beneficiary can retain $1 in payments for each $2 in earnings be increased from $2,700 to $2,880.

One-half million additional farmworkers be given social security coverage.

Federal service be applied as social security credit for those employees who are not eligible for civil service benefits when they retire, become disabled, or die.

Social security financing must continue on an actuarially sound basis. This will require future adjustments both in the amounts of annual earnings credited toward benefits and in the contribution rate of employers and employees.

I recommend—

A three-step increase in the amount of annual earnings credited toward benefits—to $7,800 in 1968; to $9,000 in 1971; and $10,800 in 1974.

That the scheduled rate increase to 4.4 percent in 1969 be revised to 4.5 percent; and that the increase to 4.85 percent in 1973 be revised to 5 percent.

Public Assistance

Despite these improvements in social security, many elderly Americans will continue to depend on public assistance payments for the essentials of life. Yet these welfare programs are far behind the times. While many States have recently improved their eligibility standards for medical assistance, their regular welfare standards are woefully inadequate.

In nine States, the average amounts paid for old-age assistance are as low as $50 a month, or less.

Twenty-seven States do not even meet their own minimum standards for welfare payments.

The Federal Old-Age Assistance Act allows the States to provide special incentives to encourage older persons on welfare to seek employment. But almost half the States have not taken advantage of this provision.

To make vitally needed changes in public assistance laws, I recommend legislation to provide that—

State welfare agencies be required to raise cash payments to welfare recipients to the level the State itself sets as the minimum for subsistence;

State agencies be required to bring these minimum standards up to date annually;

Each State maintain its welfare subsistence standards at not less than two-thirds the level set for medical assistance;

State welfare programs be required to establish a work-incentive provision for old-age assistance recipients.

Tax Reform for Senior Citizens

Our Federal income tax laws today unfairly discriminate against older taxpayers with low incomes who continue to work after 65. The system of deductions, credits, and exemptions is so complex that many senior citizens are unable to understand them and thus do not receive the full benefits to which they are entitled.

I recommend that—

The tax structure for senior citizens be completely overhauled, simplified, and made fairer.

Existing tax discrimination against the older Americans who are willing and able to work be eliminated.

Under this proposal, taxes will be reduced for almost 3 million older Americans—two out of every three who now pay taxes. Nearly 500,000 of these Americans will no longer have to pay taxes. There will be some increases for those in the upper tax brackets—those best able to afford them.

The Success—and the Future—of Medicare

During the long wait for medicare, many older Americans needlessly suffered and died because they could not afford proper health care. Nearly half had no health insurance protection. For most, coverage was grossly inadequate. As a result, men and women spent their later years overburdened by health care costs. Many were forced to turn to public assistance. Others had to impose financial hardship on their relatives. Still others went without necessary medical care.

Since medicare went into effect just over 6 months ago—

More than 2½ million older Americans have received hospital care.

Hospitals have received nearly $1 billion in payments.

More than 3½ million Americans have been treated by doctors under the voluntary coverage of medicare.

130,000 people have received home health services, and medicare paid the bills.

6,700 hospitals, with more than 98 percent of the general hospital beds in the Nation, have become partners in medicare.

High standards set by medicare will raise the level of health care for all citizens—not just the aged. Compliance with title VI of the Civil Rights Act has hastened the end of racial discrimination in hospitals and has brought good medical care to many who were previously denied it.

Medicare is an unqualified success. Nevertheless, there are improvements which can be made and shortcomings which need prompt attention.

The 1.5 million seriously disabled Americans under 65 who receive social security and railroad retirement benefits should be included under medicare. The typical member of this group is over 50. He finds himself in much the same plight as the elderly. He is dependent on social security benefits to support himself and his family. He is plagued by high medical expenses and poor insurance protection.

I recommend that medicare be extended to the 1.5 million disabled Americans under 65 now covered by the social security and railroad retirement systems.

Certain types of podiatry services are important to the health of the elderly. Yet, these services are excluded under present law. *I recommend that foot treatment, other than routine care, be covered under medicare whether performed by podiatrists or physicians.*

Finally, medicare does not cover prescription drugs for a patient outside the hospital. We recognize that many practical difficulties remain unresolved concerning the cost and quality of such drugs. This matter deserves our prompt attention. *I am directing the Secretary of Health, Education, and Welfare to undertake immediately a comprehensive study of the problems of including the cost of prescription drugs under medicare.*

Nursing and Health Care

Medicare and the medical assistance program have removed major financial barriers to health services. Federally assisted programs are developing health facilities, manpower, and services—many targeted to the needs of older Americans.

We have made progress, but serious problems remain. Although the number of agencies that provide health services to individuals in their own homes has grown to more than 1,400 throughout the country, their services are often limited in scope and quality. Many communities still have no such services available.

The great majority of nursing homes are ill equipped to provide services required for medicare and medical assistance patients. Of the 20,000 nursing homes in the country, only 3,000 have qualified for medicare. Of the 850,000 beds in nursing homes, less than half—415,000—meet Hill-Burton standards for long-term care. Many do not even meet minimum fire and safety standards.

Expenditures for nursing home care have increased by 400 percent in the past decade. They now exceed $1.2 billion annually. Federal, State, and local governments pay more than a third of these costs—and the government share is rising rapidly.

We have learned that there is no single answer to the problem of providing the highest quality health care to the elderly. Just as their needs vary, so must the approach.

Some senior citizens can be treated in their homes, where they can be close to their families and friends. Others may need once-a-week care at a nearby out-

patient clinic. When serious illness strikes, extended hospitalization may be required. When chronic disease is involved, care in a nursing home may be needed. And when postoperative care for short durations is necessary, specialized facilities may be essential.

Thus, we must pursue a wide range of community programs and services to meet the needs of the elderly—to allow them freedom to choose the right services at the right time and in the right place.

To move toward our health goal for the elderly, I propose to—

Extend the partnership for health legislation to improve State and local health planning for the elderly.

Launch special pilot projects to bring comprehensive medical and rehabilitation services to the aged.

Begin an extensive research effort to develop the best means of organizing, delivering, and financing health services needed by the aged.

Expand visiting nurses and other home health services.

I am requesting funds for more health facilities and better health care institutions for the aged, including:

The full authorization of $280 million for construction under the Hill-Burton program to provide new beds and to modernize existing facilities.

Mortgage guarantees and loans to construct nursing homes for the aged.

Infirmaries and nursing units in senior citizens' housing projects.

Intensive research to find new approaches in design and operation of hospitals, nursing homes, extended care facilities, and other health institutions.

Job Opportunities for the Older American

In our Nation, there are thousands of retired teachers, lawyers, businessmen, social workers and recreation specialists, physicians, nurses, and others, who possess skills which the country badly needs.

Hundreds of thousands not yet old, not yet voluntarily retired, find themselves jobless because of arbitrary age discrimination. Despite our present low rate of unemployment, there has been a persistent average of 850,000 people age 45 and over who are unemployed.

Today, more than three-quarters of a billion dollars in unemployment insurance is paid each year to workers who are 45 or over. They comprise 27 percent of all the unemployed—and 40 percent of the long-term unemployed. In 1965, the Secretary of Labor reported to the Congress and the President that approximately half of all private job openings were barred to applicants over 55; a quarter were closed to applicants over 45.

In economic terms, this is a serious—and senseless—loss to a nation on the move. But the greater loss is the cruel sacrifice in happiness and well-being which joblessness imposes on these citizens and their families.

Opportunity must be opened to the many Americans over 45 who are qualified and willing to work. We must end arbitrary age limits on hiring. Though 23 States have already enacted laws to prohibit discriminatory practices, the problem is one of national concern and magnitude.

I recommend that—

The Congress enact a law prohibiting arbitrary and unjust discrimination in employment because of a person's age.

The law cover workers 45 to 65 years old.

The law provide for conciliation and, if necessary, enforcement through cease-and-desist orders, with court review.

The law provide an exception for special situations where age is a reasonable occupational qualification, where an employee is discharged for good cause, or where the employee is separated under a regular retirement system.

Educational and research programs on age discrimination be strengthened.

Employment opportunities for older workers cannot be increased solely by measures eliminating discrimination. Today's high standards of education training, and mobility often favor the younger worker. Many older men and women are unemployed because they are not fitted for the jobs of modern technology; because they live where there are no longer any jobs, or because they are seeking the jobs of a bygone era.

We have already expanded training and education for all Americans. But older workers have not been able to take full advantage of these programs. In many State employment offices, there is need for additional counselors, trained to deal with the special problems of older workers.

I am directing the Secretary of Labor to establish a more comprehensive program of information, counseling, and placement service for older workers through the Federal-State system of employment services.

Enriching the Later Years

Old age is too often a time of lonely sadness, when it should be a time for service and continued self-development. For many, later life can offer a second career. It can mean new opportunities for community service. It can be a time to develop new interests, acquire new knowledge, find new ways to use leisure hours.

Our goal is not merely to prolong our citizens' lives, but to enrich them.

Congress overwhelmingly endorsed this goal, when it passed the Older Americans Act. As a result, we have launched a new partnership at all levels of government, and among voluntary and private organizations. We have established a new agency and a new impetus to promote this partnership.

Forty-one States, the District of Columbia, and Puerto Rico—where more than 91 percent of our older persons live—are now engaged in providing special services for senior citizens. Two hundred and seventy community programs have already been started. Several hundred more will begin in the next few months.

We are helping States and communities to—

Establish central information and referral sevices so that our older citizens can learn about and receive all the benefits to which they are entitled.

Begin or expand services in more than 65 more senior citizens centers.

Increase volunteer-service opportunities for older people.

Offer preretirement courses and information about retirement.

Support services which help older people remain in their homes and neighborhoods.

To carry forward this partnership, I recommend that—

The Older Americans Act be extended and its funding levels be increased.

Appropriations under the neighborhood facilities program be increased to construct multipurpose centers to serve senior citizens with a wide range of educational, recreational, and health services, and to provide information about housing and employment opportunities.

A pilot program be started to provide nutritional meals in senior citizen centers.

Decent housing plays an important role in promoting self-respect and dignity in the later years. In the past 3 years, the total Federal investment in special housing programs for the elderly has doubled—to over $2.5 billion.

Rental housing for the elderly is one of our most successful housing programs. We have made commitments for about 187,000 units to house more than 280,000 persons. Direct loan and grant programs assist many senior citizens to improve their homes in urban renewal areas, and in areas of concentrated code enforcement where blight is worst. The new rent supplement program, enacted in 1965, promises to help thousands of low income older citizens to have good housing at reasonable rents.

I recommend that these housing programs be continued and that the full amount authorized for the 1968 rent supplement program be provided. I am directing the Secretary of Housing and Urban Development to make certain that the model cities program gives special attention to the needs of older people in poor housing and decaying neighborhoods.

The talents of elderly Americans must not lie fallow. For most Americans, the most enriching moments of life are those spent helping their fellow man. I have asked the Director of the Office of Economic Opportunity to initiate and expand programs to make a wider range of volunteer activities available to older citizens:

To enlist them in searching out isolated and incapacitated older people.

To build on the success of the foster grandparent and medicare alert programs by using public-spirited older Americans as tutors and classroom aides in Headstart and other programs.

To organize older citizens as VISTA volunteers in a variety of community efforts.

Our Obligation

These are my major recommendations to the first session of the 90th Congress on behalf of older Americans. But this message does not end our quest, as a nation, for a better life for these citizens.

I believe that these new measures, together with programs already enacted, will bring us closer to fulfilling the goals set forth in our Bill of Rights for Older Americans.

We should look upon the growing number of older citizens not as a problem or a burden for our democracy, but as an opportunity to enrich their lives and, through them, the lives of all of us.

LYNDON B. JOHNSON.

THE WHITE HOUSE, *January 23, 1967.*

92-654—68——13

Appendix 2

MATTERS RELATED TO THE ADMINISTRATION ON AGING* AND THE PRESIDENT'S COUNCIL ON AGING

ITEM 1: SUMMARY, OLDER AMERICANS ACT AMENDMENTS OF 1967

Responding to President Johnson's call for extension of the Older Americans Act and an increase in its funding levels [1] the Congress acted in 1967 to provide the Administration on Aging with new means for carrying out its mission.

Senator Harrison Williams, Jr., of New Jersey, Chairman of the Senate Special Committee on Aging, introduced S. 951 on February 9, 1967, to implement the President's recommendation, with the cosponsorship of Senators Church, Kennedy of Massachusetts, Long of Missouri, Miller, Morse, Moss, Muskie, Randolph, Smathers, Yarborough, and Young of Ohio, all of whom are members of the Special Committee on Aging. An identical bill, H.R. 4261, was introduced in the House of Representatives by Chairman Carl D. Perkins, of the House Education and Labor Committee.

There was a hearing on June 12, 1967 on the Williams bill before the Special Subcommittee on Aging of the Senate Committee on Labor and Public Welfare, the chairman of which is Senator Edward M. Kennedy of Massachusetts. Hearings on the Perkins bill were held on May 10, 11, and 16 and on June 1, 1967, before the Select Subcommittee on Education (Hon. Dominick V. Daniels, chairman) of the House Committee on Education and Labor.

As the result of the House subcommittee hearings, a clean bill, H.R. 10730, was introduced and reported favorably by the Education and Labor Committee. It passed the House unanimously (331–0) under suspension of rules on June 19. To expedite consideration of this legislation, the House bill was substituted for S. 951 within the Senate Committee on Labor and Public Welfare, and reported, amended, to the Senate on June 27. It passed the Senate unanimously (83–0) on June 28. The House agreed to the Senate amendments on June 29, and the bill became Public Law 90–42 when the President signed it on July 1, 1967.

As enacted, Public Law 90–42 provided:

1. A 2-year extension of the grant programs authorized under the Older Americans Act of 1965, through fiscal year 1972;

2. Increased authorizations for fiscal years 1968 and 1969, as follows:

Grant program	Fiscal 1968	Fiscal 1969
Title III, community planning, services, and training	$10, 550, 000	$16, 000, 000
Title IV (research and development projects), and title V (training projects)	6, 400, 000	10, 000, 000

3. Authorizations for the fiscal years 1970, 1971, and 1972 of "such sums * * * as the Congress may hereafter authorize by law."

4. For the Secretary of the Department of Health, Education, and Welfare to undertake a study of forseeable needs for trained personnel in the field of aging, and of the availability and adequacy of the educational and training resources for persons preparing to work in programs related to the objectives of the act.

5. For making available (for paying up to one-half of the costs of a State agency in administering the State plan) of 10 percent of that State's title III

*See chs. VII and IX for discussion of new responsibilities assigned to the Administration on Aging in 1967.

[1] Full text of President's message on aid appears in app. 1 of this report.

allotment or $25,000, whichever is larger. (Under the Older Americans Act, as originally passed, the limitation was 10 percent or $15,000.)

6. Other minor and technical amendments to clarify the act and improve its workability.

Before enactment of this public law, there was no specific authorization for the Older Americans Act for the year beginning July 1, 1967. For this reason, no appropriation for this purpose could be included in H.R. 10196, the appropriation bill for the Departments of Labor and Health, Education, and Welfare for this fiscal year, when that bill passed the House on May 25. However, when the new public law was signed on July 1, this appropriation bill was pending in the Senate Appropriations Committee, and that committee inserted an Older Americans Act appropriation in the full amount authorized. This item remained in this appropriation bill when it was passed by the Senate, resolved in conference, and signed by the President. This fiscal year 1968 appropriation consists of the following:

Title III	$10,550,000
Titles IV and V	6,400,000
Administration	1,500,000
Total	18,450,000

ITEM 2: REPORT BY THE ADMINISTRATION ON AGING—1967*

The passage of the Older Americans Act of 1965 symbolized a growing national awareness of the need for full participation of older citizens in our society. It created a partnership between the Federal Government, the States and their localities, and voluntary organizations designed to improve the lives of older people. It recognized their material needs—for adequate income, good housing, improved health—and their nonmaterial needs for a place and a role in society.

The Administration on Aging continued, in 1967, to work toward the objectives of the Older Americans Act—fuller opportunities and a range of alternatives for older people—through its three grant programs and through activities with other Federal agencies and with private organizations.

Grants for Community Planning, Services, and Training

Title III of the Older Americans Act provides for allotments to the States for (1) community planning and coordination of programs in aging; (2) demonstration of new programs or activities beneficial to older people; (3) training of special personnel to carry out such programs; and (4) establishment of new or expansion of existing programs including senior centers. The grants are intended to strengthen State and community services to the aging and to stimulate new interest and commitment on the part of the States and communities to their older residents.

In order to participate in the title III program, the Governor of each State must designate a single State agency to coordinate programs for the aging throughout the State and a State plan for the aged must be approved. The State in turn makes grants to local public and nonprofit, private agencies.

Four more State plans were approved during the year for a total of 46 States with approved plans. Forty-four States now have operational programs. During 1967, over 400 new projects were funded. In total, over 640 projects have been funded since the program began. Another 189 new projects and 480 continuations are expected at the increased authorization levels of fiscal year 1968.

The largest number (227) of title III grants during this period was awarded to multipurpose senior centers. The senior center is available to older people who wish to participate in a varied program under leadership of trained personnel. For the individual older person, it offers meaningful relationships, a chance to learn new skills, a chance for community service and a community role.

The specific services most often found in a senior center are: information and referral, personal counseling, recreational facilities, educational opportunities, volunteer programs, and health and employment services. The Administration

*The committee received this report on the work of the Administration on Aging during 1967 from Hon. William D. Bechill, Commissioner of Aging on Dec. 29, 1967.

on Aging has been encouraging the development of multipurpose senior centers which provide a central location for a range of services and activities.

About 145 title III grants went for planning and development of services for older persons at the community level. Many communities are unaware of the actual needs of older persons, particularly those individuals who have become isolated. Most planning and development grants have made it possible for communities to structure a planning body which is sensitive to the urgency of determining where the older persons are, what the most pressing needs are and what resources can be mobilized to meet these needs. Older persons themselves are involved in the planning and implementation of programs which enable the elderly to maintain independent living. Some examples of planning programs undertaken include:

—A project in Utah in which university personnel are developing standardized data-gathering procedures is permitting a number of communities in the State to survey the needs of older persons through personal interviews in which standard forms are used. The responses are fed into a computer system. As a result, the State will have accurate and consistent data to strengthen planning at both the State and community levels.

—In Texas, the Agricultural Extension Service has expanded its program of establishing local committees on aging, and providing leadership in the development of local programs of services and activities for older persons. Seventy-five percent of the counties of the State now have local committees organized or are beginning organizational procedures. Ninety percent of all persons over 65 in the State live in these 189 counties. Over 200 county extension agents have been actively involved with local committees in the planning and initiating of activities and services to meet local needs. The extension agents have played an advisory role successfully encouraging initiative and leadership from the committee members.

—A project in West Virginia in a community which had virtually no community-based service programs is providing a central information and referral service, counseling, and a friendly visiting program. The State agency provided consultation in the planning of this project. As a result of its success. a senior citizens group was organized to develop service centers. The first has been established and others are planned throughout the country.

Over 70 title III grants were for training programs which prepare older people as volunteers to train and help others in problems of aging. Fifty grants were for information and referral services which answer the questions of older people about availability of services and activities and offer direction to such services. The remaining title III grants were for a variety of services such as educational programs, volunteer programs, homemaker services, and friendly visitor services. Specific services include:

—A preretirement training course, prepared a 74-year-old retired community leader and designed to train 30 other leaders in the methodology of conducting programs for preretirees.

—A senior volunteer service which recruits and orients older persons and encourages and prepares them to take their place with other age groups in community organizations and service programs. The project has proved a great manpower resource for the community.

—A demonstration of unlimited transportation on regularly scheduled city buses for a small monthly fee for those over 65 and those over 60 who are social security beneficiaries or are disabled. The project stimulated inquiries from cities across the country and other such projects have been initiated as a result.

State agencies continue to strengthen their administrative roles; to provide technical assistance and consultation to communities and project grantees; and to carry out effectively their responsibility for comprehensiveness and coordination of services. In Michigan, for example, cooperation between the Commission on Aging and the State department of public health led to a multiphasic, health-screening program for rural communities and senior centers. Cooperation with the State department of education resulted in new educational opportunities for older people.

Over 400,000 older persons have been served directly by title III programs. The impact of these programs is being felt at the local community level where the older person finds new services and activities and at the State level where there is increasing concern for the State's older population.

Research and Demonstration Grants

The title IV grant program of the Older Americans Act authorizes grants for research on patterns and conditions of living of older people, for demonstration and development of new approaches and programs in meeting the needs of older people, and for achieving or improving coordination of community services.

In 1967, 22 grants and contracts and two continuation grants were awarded under title IV bringing the total to 58 grants and contracts.

The objectives of the programs are to analyze, develop, and demonstrate:

—Various ways of administering and delivering a full range of needed services in an effective and efficient manner wherever older people live;

—New roles and meaningful activities for older persons;

—Improved patterns of retirement and preparation for it;

—Opportunities for employment and sources of supplemental income for older persons;

—Housing and living arrangements conducive to the well-being of older persons;

—Means of preventing personal disability among older persons and, when needed, providing rehabilitative procedures.

The largest proportions of title IV grants went to demonstration in senior centers and to development of comprehensive coordinated services. Other priorities of the program are in the areas of: nutritional programs; retirement planning and preparation; voluntary and social employment; improved ways of using leisure; evaluation of living arrangements; and special service programs.

Examples of title IV projects funded included:

—In St. Paul, Minn., a demonstration of extensive cooperation between the State agency on aging and educational television is being conducted to develop a broad-gaged statewide program of services and activities in aging. Weekly programs for, about, and by older persons are coordinated with a field staff of six older persons employed as regional representatives to work with and through 42 planning committees and more than 500 golden age clubs in the State.

—In Chicago, Ill., a senior center on wheels takes activities and services into the homes and neighborhoods of formerly isolated older persons; also, a mobile van transports older persons from their homes to the sites of health, leisure, social, and recreational services.

—The University of Oregon in Eugene, Oreg., is conducting a project to analyze the interrelationships among: (*a*) success in adjustments to retirement; (*b*) preretirement counseling; (*c*) retirement benefits; and (*d*) the sociological, psychological, and economic characteristics of the individual.

—The Winnetka Public Schools in Winnetka, Ill., are demonstrating, recruiting, organizing, training, and using older adults as volunteers to enrich the curriculum and motivate underachievers in public schools.

The Older Americans Act Amendments of 1967 authorized expanded levels of funding for the title IV program for more comprehensive research and demonstration programs in 1968 and 1969. This authorization will fund a major pilot program of food and nutrition for older persons whose nutritional problems are severe either because of lack of money or lack of motivation. The purpose of the food and nutrition project is to gain new knowledge of the dietary needs of older persons, and to develop a flexible program of providing an adequate diet through facilitating the purchase of food, assistance in meal planning, education in nutrition, and the development of group dining programs. Approaches to be demonstrated include: central dining facilities operated by senior centers, dining clubs, and other organizations; a program of cooperative purchasing of food for meal preparations at home; and a program of delivered meals for the homebound.

Grants for Training

Title V of the Older Americans Act authorizes grants for training professional, technical, and lay personnel to plan for and serve older people in programs related to the broad purposes of the act.

In 1967, 18 new grants were awarded, for a total of 33 grants since operations began. About 2,000 persons had received short- and long-term training by the end of the year.

The Administration on Aging training program is focusing on areas within which there is desperate need for personnel and for which existing support is

inadequate or lacking. Training in several professions is being offered for the first time. Priorities in training are as follows:

—Broad planning and administration in aging for work at Federal, State, and local levels.
—Planning, administrative, and management training in the field of retirement housing, villages, and homes for the aged.
—Planning, administration, and program supervision for personnel of multiservice centers for older people.
—Training for specialists in aging within such professions as recreation, religion, adult education, architecture, and retirement preparation.
—Preparation of faculty personnel and preparation of specialists in aging within established professions.
—Leadership training for members of State and community committees on aging and for older adults who wish to become active in their communities.
—Training for semiprofessional and technical personnel to serve under professional direction as library and recreation aides; aides in housing projects, senior centers, homes for the aged, and institutions; in homemaking and meal services, and in other ways.

Over one-half of the projects funded by the Administration on Aging, by December 1967, were for short-term training; about one-quarter were for long-term, career preparation courses; and another 20 percent were for development by universities of curriculums in aging.

The impact of title V is just beginning to be measured: in new ideas stemming from trained people; in the implementation of better center programs and program planning; and in changed attitudes and outlooks of young and older trainees on the needs and the roles of the aging and aged.

The Older Americans Act Amendments of 1967 expanded authorizations for the training grant program in fiscal year 1968. This will provide for a substantial increase in the number of training programs and trained personnel. The amendments also authorized the Secretary of Health, Education, and Welfare to undertake a study and evaluation of the existing and foreseeable need for trained personnel in various programs and services related to the objectives of the Older Americans Act and to report his findings to the President on or before March 31, 1968.

The Senate report on the amendments, in noting the need for this study, stated: "The comprehensiveness of legislative programs for older people has created a tremendous need for a pool of professional and technical personnel possessing knowledge about the consequences of aging and equipped to administer the newly developing programs, to serve older people directly, and to train others for the many new career opportunities in the field. According to expert testimony received by the committee, this pool of manpower is currently nonexistent, for so great is the number of job openings that every available trained person is already employed. To improve the situation, an immediate all-out effort on the part of Government and educational institutions is required."

The Administration on Aging began preparations for the study in July of 1967. Projections were made on the numbers of older people in 1970 and 1980, their incomes, life expectancies, participation in the labor force and other aspects of the older population. These will be used by all contractors for the survey. Contracts have been made for inventory of training needs in housing management and recreation and for an "umbrella" agency to place the various parts into the whole study.

Activities With Voluntary and Religious Organizations

Consultation and technical assistance to voluntary and religious organizations and groups is carried on by the Administration on Aging staff in both the Washington office and in the field. Close working relationships are maintained with those groups which represent older people or have aging divisions such as: the National Council of Senior Citizens, the National Council on the Aging, the American Association of Retired Persons, the American Public Welfare Association, the National Farmers Union, and the Gerontological Society.

Special efforts have been made to enlist the cooperation of organizations whose community affiliates represent a source of leadership for local programs for older people. The YWCA, the YMCA, health and welfare councils, and the service clubs are sponsoring or cooperating in many projects under the Older Americans Act. The Girl Scouts of America celebrated Senior Citizens Month in 1967 with

special programs featuring youngsters and older people working together for a common objective. Working relationships continued in 1967, with the American Library Association, the Adult Education Association, and the National Recreation and Parks Association, all of whom are working toward increased educational and recreational opportunities for older people.

The interest and concern of religious organizations for the needs of older people have increased greatly in the past few years and the Administration on Aging is continuing to further the movement. There is a discernible trend toward broader based, better integrated and coordinated programs in both the national denominational structure and in the local parish, with much more emphasis on services to people in their own homes; on opportunities for educational and creative pursuits; and on volunteer opportunities.

Religious organizations were included among the recipients of project grants under the Older Americans Act in 1967. Nine representatives of major faiths are serving voluntarily and at their own expense on an advisory panel to consult and advise the Commissioner on Aging in the preparation of materials and other activities relating to religious organizations.

Activities With Other Agencies

The Administration on Aging maintains formal and informal liaison with all Federal agencies which have programs affecting the aging, including agencies represented on the President's Council on Aging. Through these activities, it attempts to stimulate more effective use of existing resources and the planning of new programs to fill areas of gap in services.

During 1967 the Administration on Aging worked with the Department of Housing and Urban Development to assure continued consideration of older people in programs such as neighborhood facilities and the model cities programs.

A joint State letter with the Bureau of Outdoor Recreation was issued to State agencies to encourage recreation programs for older people and the preparation of a pamphlet on outdoor recreation planning was begun. The Administration on Aging cooperated on Project Moneywise-Senior with the Bureau of Federal Credit Unions, worked with the Federal Trade Commission on problems affecting the older consumer such as sales frauds and charity rackets; consulted with the Census Bureau on items of special interest to the aging to be included in the census questionnaires; encouraged special tabulation and analysis of aspects of the older worker problems of the Department of Labor; and maintained contact with the Department of Transportation on consideration of older people in the planning of that Department. In addition, the Administration on Aging continued to administer the foster grandparent program in cooperation with the Office of Economic Opportunity.

The Administration on Aging also maintains contact with private citizens through the Advisory Committee on Older Americans, a group of 15 public experts in the field of aging. Through this mechanism, representatives from all interested segments of society furnish the Secretary of Health, Education, and Welfare and the Commission on Aging with recommendations based on their own experience.

Informational Activities

During 1967 the Administration on Aging handled nearly 12,000 inquiries from Members of Congress, from public and private organizations, and from members of the public, including older people themselves. These individuals and organizations requested a variety of information ranging from how to start and maintain programs for older people to personal questions involving family relationships.

The Administration on Aging started a new series this year entitled "Designs for Action for Older Americans." These publications provide brief descriptions of successful programs being carried out by communities and organizations throughout the United States. They contain sufficient information to permit local communities and agencies to determine whether similar programs can be undertaken locally.

Another series of documents entitled "Federal Financial Assistance for Projects in Aging" describes Federal grant programs which offer support to communities and agencies in developing programs for older people. At the end of 1967, six of these had been published and another seven were in process.

A periodic summary of major Federal legislation concerning older people in a series entitled "Highlights of Legislation on Aging" was also issued. Another AOA series, "Useful Facts," provides a coordinated, analytical approach to pertinent data on the characteristics and conditions of the older population. Twenty-six issues were distributed in 1967.

The Administration on Aging also publishes a monthly news magazine, Aging, which reports on programs and activities on aging from Federal, State, and local levels, and goes to over 16,000 individuals and organizations in the United States and overseas.

In cooperation with the President's Council on Aging, the Administration on Aging conducts the annual observance of Senior Citizens Month. During the 1967 observance of Senior Citizens Month, news media across the country cooperated by reporting on both the needs of older people and some of the accomplishments of programs being conducted under the Older Americans Act. Over a million pieces of material were distributed to individuals, organizations and news media for the 1967 observance.

Consumer Information Program

The Administration on Aging works through its titles III and IV grant programs and through direct relations with the President's Committee on Consumer Interests to provide consumer information to older people.

Over half of the senior activity centers funded under title III of the Older Americans Act—as well as one out of six of all other title III projects—have an element of education in their services. Almost all of these education programs include an aspect of consumer information—money management, economy food purchasing, sound nutrition and avoidance of fraudulent practices.

In October 1967, the Administration on Aging participated in a conference on consumer problems of older people, held by the Hudson Guild-Fulton Center. The conference was part of a continuing consumer education program conducted by the Center under an Older Americans Act title III grant. The objectives of the program were to draw together various disciplines concerned with consumer problems of the elderly; to involve business and local agencies; to interest older people themselves; and to make recommendations to government agencies on encouraging comprehensive consumer programs. Speakers, panels and workshops discussed various aspects of the consumer problem and focused attention on consumer action for the coming year.

Under two title IV demonstrations, in several senior centers, a nutrition program is being established which includes educational programs in consumer education. Specialists are brought into the centers and films are used to provide the necessary information. These demonstrations are located in Temple, Tex., and Miami, Fla.

The Older Americans Act Amendments of 1967 provided $2 million for a major new demonstration program in nutritional services to be carried out under title IV of the act during the next year. The Administration on Aging is cooperating with the Public Health Service and other agencies concerned with nutrition to develop new approaches and information about food services to be presented through this program.

Project Moneywise-Senior

(Details on p. 94 of this report.)

The Foster Grandparent Program

The foster grandparent program, which is administered by the Administration on Aging, recruits, trains, and employs low-income men and women over 60 years of age to serve as foster grandparents to children in institutional and community settings. "Grandparents" provide 2 hours of individual attention daily to each of two children and usually work 4 hours a day, 5 days a week. Their salary is equal to the Federal minimum hourly wage, and, in most cases, transportation is provided.

The program, which is operated under contract with the Office of Economic Opportunity, began in the fall of 1965. As of December 1967, the program had expanded from 37 grants in 1966 to 63 project grants in 38 States and Puerto Rico. About 8,000 children in 155 institutional and community settings are served

by 3,927 foster grandparents. Over 120 communities are affected by the program which is supported by over $8.3 million in Federal funds. As knowledge of the program expands, more communities are expressing an interest in developing a foster grandparent project. During the past 6 months, over 100 additional communities and institutions have asked for information to assist them in developing a project. Limited funds make it impossible to further expand the program at this time.

Foster grandparents serve a variety of dependent, neglected, and otherwise needy children in many institutional and community settings. These settings include institutions for the mentally retarded, dependent and neglected, the emotionally disturbed, and physically handicapped; day care centers; foundling hospitals and pediatric wards of general hospitals. Some experimental programs are continuing in which foster grandparents serve children in correctional settings, special classes for the retarded, and in Headstart homes.

Foster grandparents is a double-edged program from which two needy groups gain. It provides the grandparent with the dignity of a much needed income while making a meaningful contribution to the community. Foster grandparents have demonstrated through this program that the love, understanding, and maturity developed in many years of living add an ingredient to the lives of children for which there is no substitute.

This program has proved that older people are eager to help themselves through employment when the opportunity is available to them. There have been more than eight applications for each available foster grandparent position. Some projects with a full complement of foster grandparents have more eligible applicants on the waiting list than positions authorized. For example, one project with 114 foster grandparents authorized has over 450 on the waiting list.

Local financial support of the program is also increasing. In Iowa, 25 foster grandparents are employed through State funds. In Illinois, 68 foster grandparents have been employed with State funds. Within 1 year, the total cost of the project in New York will be provided from local funds. The States of Pennsylvania and Iowa are considering the possibility of expanding the program throughout their States. This further confirms the viability of the program and the enthusiastic support of the organizations and institutions involved.

New Responsibilities of the Administration on Aging

As a result of the organization of the Social and Rehabilitation Service, the administrative functions of the Administration on Aging were broadened to include responsibilities for the public social services to eligible older persons covered under the provisions of titles I, XVI, and XIX of the Social Security Act and certain other related responsibilities.

These include services for recipients of old-age assistance and medical assistance to the aged and services for former recipients and potential applicants who are aged persons.

The broad range of services to be provided are designed to improve, restore, or retain the older individual's capacities for personal and social functioning. Direct services provided include: (1) the activities of caseworkers who provide counseling and guidance or secure other services or facilities to meet the needs of individuals and families; and (2) the activities of other social work staff such as medical and psychiatric social workers and volunteers who work directly with the individual. Enabling services provided include consultation on social, legal, educational, medical, psychiatric, psychological, or other problems of the older person. Complementary services provided include homemaker services, foster family care for adults, volunteer services, and social rehabilitation services.

Responsibilities to public assistance recipients also include cooperation with communities in developing resources to serve low-income groups and the development of alternative plans of care for older people who would otherwise require care in mental institutions.

In discharging these responsibilities, the Social and Rehabilitation Service will give particular emphasis to cooperative relationships between the State agencies administering the public assistance programs, the State agencies administering title III of the Older Americans Act, and the State agencies administering vocational rehabilitation services.

ITEM 3: REPORT ON THE PRESIDENT'S COUNCIL ON AGING

DECEMBER 20, 1967.

Hon. HARRISON A. WILLIAMS, Jr.,
U.S. Senate,
Washington, D.C.

DEAR SENATOR WILLIAMS: This is in response to your letter of December 11, 1967, requesting information on the activities of the President's Council on Aging during 1967.

The Executive Committee of the President's Council on Aging, chaired by the Commissioner on Aging, Mr. William D. Bechill, met five times during 1967 to plan how Federal activities relating to older Americans could be more closely coordinated. Their discussions gained added importance on October 17 when Executive Order 11022 was amended to make the Secretary of Transportation and the Director of the Office of Economic Opportunity members of the Council (Executive Order 11376).

Working together, the departments represented on the Council observed Senior Citizens Month in May 1967, through launching a public information program designed to spotlight attention on the needs of the Nation's older citizens—for work, for increased retirement benefits, for continued education, for retraining, for recreation, for suitable housing, for health care, for friendship, and for an opportunity to serve others. As one part of the Senior Citizens Month activities, the President's Council on Aging, in cooperation with the Administration on Aging, published a booklet, "Meeting the Challenge of the Later Years—Guide to Community Action," as a tool for leaders in aging programs in government, unions, business and professional associations, and private and voluntary organizations.

During the year, discussions by the full Executive Committee centered around the need for data on the older poor; preretirement programs; a Department of Transportation study on the aged and handicapped; the Department of Health, Education, and Welfare's plan for coordinated services for the elderly; and a study of the need for trained personnel in the field of aging.

In addition, two standing committees were formed to explore in more depth particularly serious problems of older people. A Committee on Income Maintenance, chaired by the representative of the Department of Treasury is planning to make a study of State and local tax laws and structures and their effect on the economic situation of the elderly. The second standing committee, chaired by the representative of the Department of Housing and Urban Development and including representatives of the Department of Agriculture, the Veterans' Administration, the Administration on Aging, and the Public Health Service, will consider living arrangements for older people.

Through the mechanism of the Council, special meetings have also been held by representatives of the Department of Housing and Urban Development, the Administration on Aging, and the Veterans' Administration to discuss a series of proposals presented by the Veterans' Administration for cooperative efforts in behalf of older people.

Overall, the major efforts of the Council during the year have centered around the preparation of a report to the President which will be released early in 1968. This report includes comprehensive descriptions of the many Federal programs serving older people.

Sincerely,

WILBUR J. COHEN,
Acting Secretary.

Appendix 3

MATERIAL RELATED TO RETIREMENT INCOME*

ITEM 1: THE SOCIAL SECURITY AMENDMENTS OF 1967: SUMMARY OF MAJOR PROVISIONS[1]

OLD-AGE, SURVIVORS, DISABILITY AND HEALTH INSURANCE

1. *Benefit increase.*—The 1967 amendments provide for a 13-percent increase in benefit payments for persons currently receiving benefits. The minimum benefit (payable when benefits start at age 65) is increased from $44 a month to $55. The amount of earnings subject to tax and also used in the computation of benefits is increased from $6,600 to $7,800 in 1968.

The legislation provides for the increased benefit to be first payable for the month of February 1968. It is estimated that 22.9 million people are to receive the increase in benefits and that $3 billion in additional benefits are to be paid in the first 12 months under this provision.

2. *Special benefits for persons age 72.*—The amount of the special payment which is made to persons age 72 and over who are uninsured is increased from $35 to $40 a month for a single person and from $52.50 to $60 a month for a couple. The increased amount is first payable for February 1968. It is estimated that 900,000 people will get new or increased benefits under this provision.

3. *Retirement test.*—There is an increase from $1,500 to $1,680 in the amount of annual earnings a beneficiary under age 72 can have without having any benefits withheld. Provision is made for an increase from $125 to $140 in the amount of monthly earnings a person can have and still get a benefit for the month. One dollar in benefits will be withheld for each $2 in earnings between $1,680 and $2,880, and $1 in benefits for each $1 in earnings above that amount. The provision is effective for earnings in 1968. It is estimated that about 760,000 people will receive approximately $175 million in additional benefits in 1968.

4. *Benefits for disabled widows and widowers.*—The amendments provide for reduced monthly benefits for certain disabled widows and widowers of deceased workers who are between the ages of 50 and 62. A widow or widower would be considered disabled only if the disability is one that would preclude any gainful activity. Benefits are payable beginning February 1968. It is estimated that about 65,000 people will be made eligible for benefits and about $60 million in benefits will be paid during the first 12 months.

5. *Additional disability insurance provisions.*—The amendments provide for a more detailed definition of disability than is in present law; they liberalize the definition of blindness; they liberalize the insured status provisions for workers who become disabled before the age of 31.

6. *Coverage provisions.*—Clergymen are permitted to elect not to be covered if they are opposed to coverage on the basis of conscience or religious principle; coverage is extended to some employment of a parent in the home of a son or daughter; other provisions affect the coverage of certain State and local employees.

7. *Medicare—title XVIII.*—In addition to certain administrative and operational changes, the amendments provide for a lifetime reserve of 60 days of hospital care after the 90 days covered in a spell of illness have been exhausted, with a $20-a-day coinsurance provision; payment of full reasonable charges for

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*See ch. I for discussion of matters related to this appendix.

[1] Prepared by Margaret Malone, Education and Public Welfare Division, Legislative Reference Service, Library of Congress, and issued on Dec. 18, 1967.

radiological and pathological services to hospital inpatients; payment for diagnostic X-rays made in a patient's home or in a nursing home; payment for services in nonparticipating hospitals under certain conditions; payment for physical therapy services furnished by physical therapists under the direction of hospitals or other approved agencies. The Secretary of Health, Education, and Welfare is directed to study a proposal which would provide coverage of prescription drugs under medicare and a proposal to establish, through a formulary committee, quality and cost control standards for drugs provided under various programs of the Social Security Act. The amendments provide for a number of additional miscellaneous changes in the medicare program.

Public Welfare

1. *Work incentive program for AFDC recipients.*—State welfare agencies are to refer appropriate adult members of families (with certain exceptions) who are receiving aid to families with dependent children to work and training programs operated by the Department of Labor. The Department of Labor, through the U.S. employment offices, will meet the employment needs of persons referred to it by three approaches. In the first instance, all those who are immediately employable will be moved into regular employment. Secondly, those who need training will be given suitable training and will then be referred to regular employment. Thirdly, the employment office will make arrangements for special work projects to employ those for whom no jobs can be found in the regular economy or for whom training is not suitable. The projects must be arranged by the employment office with public agencies or nonprofit private agencies organized for a public service purpose. Persons working in these projects must receive at least the minimum wage if the work they perform is covered under a minimum wage statute. Workers will be guaranteed amounts at least equal to their welfare grants plus 20 percent of their wages. Day care (under standards established by the Children's Bureau) must be provided to working mothers. The Federal Government will pay 80 percent of the cost of training under the program, and the States will pay 20 percent in cash or in kind.

2. *Earnings exemption.*—The amendments provide for excluding the first $30 of earned income plus one-third of the remainder in computing a family's income for purposes of determining payments under the aid to families with dependent children program. Earned income of child recipients who are full-time students or who are part-time students not working full time are also excluded.

3. *Aid to families with dependent children of unemployed fathers.*—The amendments provide for a Federal definition of unemployment for States which have AFDC–UF programs.

4. *Limit on Federal matching for AFDC.*—The amendments provide that for purposes of Federal matching the proportion of all children under age 18 who are receiving AFDC payments on the basis of a parent's absence from the home in each State as of January 1, 1968, cannot be exceeded after June 30, 1968.

5. *Emergency assistance.*—Provision is made for Federal matching for up to 30 days of emergency assistance during a 12-month period to a child and his family. This assistance can be extended to migrant families.

6. *Home repairs.*—Federal matching is allowed for repairs (up to $500) to homes of cash assistance recipients if such repair will assure the recipient the continued use of his home and provide housing at less cost than rent for suitable accommodations.

7. *Services for children.*—Child welfare services and services to children receiving AFDC are to be provided by the same organizational unit at the State

and local level with certain exceptions for existing arrangements. The authorization for child welfare services is increased from $55 million to $100 million for fiscal year 1969, and from $60 million to $110 million for later years.

8. "*Pass along*" *provision.*—States have the option of exempting up to $7.50 a month of any type of income for the aged, blind, and the disabled in determining eligibility and the amount of assistance under the cash assistance programs.

9. *Medicaid.*—States are limited in setting income levels for Federal matching purposes to 133⅓ percent of the AFDC payment level. For those States with programs already in effect the percentage is 150 for the period July–December 1968 and 140 for calendar year 1969. This limit does not affect persons who are receiving or are eligible for cash welfare assistance. Other medicaid amendments relate to the coordination of medicaid and the supplementary medical insurance program under medicare, free choice of medical practitioners and facilities for medicaid recipients, choice of services which the States may provide under medicaid, provision for deductibles or cost sharing under State programs, and other miscellaneous provisions.

10. *Standards for skilled nursing homes under medicaid.*—The amendments require the States to place medicaid recipients only in those licensed nursing homes which meet specified standards. The States are also required to have a professional medical audit program under which periodic medical evaluations will be made of the appropriateness of the care provided to medicaid patients in nursing homes, mental hospitals, and other institutions. Effective July 1, 1970, States which provide skilled nursing-home care will also have to provide home health care services to medicaid recipients.

11. *Federal matching for intermediate care services.*—Provision is made for Federal matching for vendor payments in behalf of persons who qualify for old-age assistance, aid to the blind, or aid to the permanently and totally disabled, and who are living in facilities which provide care which is more than that of boardinghouses, but less than in a skilled nursing home. The rate of Federal sharing is at the same rate as under medicaid.

12. *Licensing of nursing home administrators under medicaid.*—States must license administrators of nursing homes in order to qualify for Federal matching under medicaid.

13. *Maternal and child health.*—There is a single authorization for child health programs, increasing from $250 million in 1969 to $350 million in 1973 and thereafter. An earmarking of 6 percent is made for family planning services. Special project grants are authorized to (*a*) reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with childbearing, (*b*) promote the health of children and youth of school and preschool age, and (*c*) provide dental care and services to children. Responsibility for these projects will be transferred to the States after July 1972.

14. *Social work manpower.*—The amendments authorize $5 million for 4 years for grants to public or nonprofit private colleges and universities and accredited graduate schools of social work, or associations of such schools, to meet part of the costs of improvement or expansion of social work programs and the training of personnel.

15. *Other public welfare provisions.*—The amendments also have provisions relating to the AFDC program as to the location of absent parents, family planning, foster-home care for dependent children, protective or vendor payments, and others.

TABLE 1.—COMPARISON OF MONTHLY CASH BENEFITS UNDER PRESENT LAW AND UNDER H.R. 12080 AS AGREED TO BY THE CONFERENCE COMMITTEE

Average monthly earnings after 1950	$67 or less		$150		$250		$300		$350		$400		$550		$650 [1]
	Present law	H.R. 12080	Present law	H.R. 12080	Present law	H.R. 12080	Present law	H.R. 12080	Present law	H.R. 12080	Present law	H.R. 12080	Present law	H.R. 12080	H.R. 12080
1. Retirement at 65 or disability benefit	$44.50	$55.00	$78.20	$88.40	$101.70	$115.00	$112.40	$127.10	$124.20	$140.40	$135.90	$153.60	$168.00	$189.90	$218.00
2. Retirement at 62	35.20	44.00	62.60	70.80	81.40	92.00	90.00	101.70	99.40	112.40	108.80	122.90	134.40	152.00	174.40
3. Wife's benefit at 65 or with child in her care	22.00	27.50	39.10	44.20	50.90	57.50	56.20	63.60	62.10	70.20	68.00	76.80	84.00	95.00	[2] 105.00
4. Wife's benefit at 62	16.50	20.70	29.40	33.20	38.20	43.20	42.20	47.70	46.60	52.70	51.00	57.60	63.00	71.30	78.80
5. 1 child of retired or disabled worker	22.00	27.50	39.10	44.20	50.90	57.50	56.20	63.60	62.10	70.20	68.00	76.80	84.00	95.00	109.00
6. Widow 62 or older	44.00	55.00	64.60	73.00	84.00	94.90	92.80	104.90	102.50	115.90	112.20	126.80	138.60	156.70	179.90
7. Widow at 60, no child	38.20	47.70	56.00	63.30	72.80	82.30	80.50	91.00	88.90	100.50	97.30	109.90	120.20	135.90	156.00
8. Disabled widow at age 50		33.40		44.50		57.60		63.60		70.30		76.90		95.00	109.10
9. Widow under 62 and 1 child	66.00	82.50	117.40	132.60	152.60	172.60	168.60	190.80	186.40	210.60	204.00	230.40	252.00	285.00	327.00
10. Widow under 62 and 2 children	66.00	82.50	102.00	132.60	202.40	202.40	240.00	240.00	279.60	280.80	303.00	322.40	358.00	395.60	434.40
11. 1 surviving child	44.00	55.00	58.70	66.30	76.30	86.30	84.30	95.40	93.20	105.30	102.00	115.20	126.00	142.50	163.50
12. 2 surviving children	66.00	82.50	117.40	132.60	152.60	172.60	168.60	190.80	186.40	210.60	204.00	230.40	252.00	285.00	327.00
13. Maximum family benefit	66.00	82.50	120.00	132.60	202.40	202.40	240.00	240.00	280.80	280.80	309.20	322.40	368.00	395.60	434.40
14. Maximum lump-sum death payment	132.00	165.00	234.60	255.00	255.00	255.00	255.00	255.00	255.00	255.00	255.00	255.00	255.00	255.00	255.00

[1] Maximum AME under H.R. 12080.
[2] Maximum wife's benefit.

Source: Social Security Administration.

TABLE 2.—MAXIMUM CONTRIBUTION AMOUNTS UNDER AMENDMENTS—OLD-AGE, SURVIVORS, DISABILITY, AND HOSPITAL INSURANCE

Calendar year	OASDI		Health insurance		Total	
	Previous law	1967 amendments	Previous law	1967 amendments	Previous law	1967 amendments
			Employee			
1967	$257.40	$257.40	$33.00	$33.00	$290.40	$290.40
1968	257.40	296.40	33.00	46.80	290.40	343.20
1969-70	290.40	327.60	33.00	46.80	323.40	374.40
1971-72	290.40	358.80	33.00	46.80	323.40	405.60
1973-75	320.10	390.00	36.30	50.70	356.40	440.70
1987 and after	320.10	390.00	52.80	70.20	372.90	460.20
			Self-employed			
1967	$389.40	$389.40	$33.00	$33.00	$422.40	$422.40
1968	389.40	452.40	33.00	46.80	422.40	499.20
1969-70	435.60	491.40	33.00	46.80	468.60	538.20
1971-72	435.60	538.20	33.00	46.80	468.60	585.00
1973-75	462.00	546.00	36.30	50.70	498.30	596.70
1987 and after	462.00	546.00	52.80	70.20	514.80	616.20

Source: Chief Actuary, Social Security Administration.

TABLE 3.—ESTIMATED ADDITIONAL OASDI BENEFIT PAYMENTS IN CALENDAR YEARS 1968, 1969, AND 1972 UNDER AMENDMENTS

[In millions of dollars]

Item	1968	1969	1972
General benefit increase	2,529	3,190	3,604
Benefit increase for transitional insured	6	7	5
Benefit increase for transitional noninsured	43	43	25
Liberalized benefits with respect to women workers	73	90	101
Special disability insured status under age 31	60	72	77
Disabled widow's benefits at age 50	50	63	73
Earnings test liberalization	140	221	244
Total	2,901	3,686	4,129

Source: Chief Actuary, Social Security Administration.

TABLE 4.—COMPARISON OF CONTRIBUTION INCOME AND BENEFIT OUTGO UNDER PRESENT LAW AND UNDER AMENDMENTS, OLD-AGE, SURVIVORS, DISABILITY, AND HOSPITAL INSURANCE

[In billions of dollars]

Calendar year	Contribution income	Benefit outgo	Excess of contributions over benefits
		Present law	
1967	28.5	24.2	4.3
1968	29.6	25.5	4.1
1969	33.7	26.9	6.8
1970	35.2	28.2	7.0
1971	36.2	29.4	6.8
1972	37.2	30.8	6.4
		Amendments	
1968	31.0	28.3	2.7
1969	35.2	30.4	4.8
1970	36.8	31.8	5.0
1971	40.8	33.3	7.5
1972	42.5	34.7	7.8

Source: Chief Actuary, Social Security Administration.

TABLE 5.—DETAIL OF PUBLIC WELFARE AND CHILD HEALTH COSTS AGREED TO BY THE CONFERENCE COMMITTEE

[In millions of dollars]

	Fiscal year 1968	Fiscal year 1969	Fiscal year 1970	Fiscal year 1971	Fiscal year 1972
Public assistance:					
AFDC costs if there is no change in present law [1]	1,462.0	1,555.0	1,647.0	1,741.0	1,837.0
Title XIX costs if there is no change in present law [2]	1,391.0	1,913.0	2,289.0	2,690.0	3,118.0
All other public assistance costs if there is no change in present law [3]	1,647.0	1,700.0	1,725.0	1,750.0	1,776.0
Subtotal, present law	4,500.0	5,168.0	5,661.0	6,181.0	6,731.0
Increases in the bill:					
Day care		35.0	80.0	160.0	350.0
Other social services		35.0	70.0	100.0	125.0
Earnings exemptions		20.0	25.0	30.0	35.0
Work training	30.0	129.0	165.0	209.0	308.0
Foster care		10.0	20.0	33.0	40.0
Emergency assistance		10.0	20.0	35.0	35.0
Puerto Rico, et al		7.8	11.0	14.2	17.5
Demonstration projects		2.0	2.0	2.0	2.0
Additional child health requirements in title XIX			30.0	40.0	50.0
OAA, AB, APTD spouses under medicaid		14.0	15.0	16.0	17.0
Medical review program for nursing homes		2.5	5.0	7.5	10.0
Subtotal, increases	[4] 50.0	265.3	443.0	646.7	989.5
Decreases in the bill:					
AFDC limitation					
AFDC reductions for persons trained		−11.0	−63.0	−145.0	−257.0
Restrictions on title XIX		−329.0	−678.0	−1,037.0	−1,.540
Decreases in public assistance due to social security benefit increase	−15.0	−65.0	−70.0	−75.0	−7.500
Federal participation in cost on care in "intermediate care facilities"		−10.0	−20.0	−29.0	−29.0
Subtotal, decreases	−15.0	−415.0	−831.0	−1,286.0	−1,766.0
Net cost of savings due to public assistance amendments	35.0	−149.7	−388.0	−639.3	−766.5
Total, public assistance as amended by bill	4,535.0	5,018.3	5,237.0	5,541.7	5,954.5
Child welfare:					
Present law	55.0	55.0	60.0	60.0	60.0
Increase for child welfare services		45.0	50.0	50.0	50.0
Increase for child welfare research		5.0	10.0	15.0	15.0
Subtotal, increases		50.0	60.0	65.0	65.0
Social work manpower		5.0	5.0	5.0	5.0
Net public welfare cost or savings in bill	35.0	−94.7	−323.0	−569.3	−706.5
Child health:					
Authorizations in bill	203.0	250.0	275.0	300.0	325.0
Authorization in present law	198.0	210.5	225.5	225.5	225.5
Increase in bill	5.0	39.5	49.5	74.5	99.5

[1] Assumes annual increase in the rolls of about 200,000 based on the experience of the past several years; allows increase of $1 each year in the average monthly payment per recipient, in line with recent experience.

[2] Includes all medical vendor payments; assumes 5-percent annual increase in unit costs after 1968.

[3] Assumes continued decline in number of old-age assistance and aid to the blind recipients, and continued increase in aid to the permanently and totally disabled, based on experience; allows increases for average payments.

[4] 1968 cost of $20,000,000 related to these items undistributed.

Note: Costs are based on 1968 prices except as noted in assumptions.

Source: U.S. Department of Health, Education, and Welfare.

TABLE 6.—WORK TRAINING IMPACT OF WORK INCENTIVE PROGRAM

Fiscal year	Work training expenses (millions)	Federal AFDC reduction due to training (millions)	Trainees (thousands)[1]	Full-time job placements after training (thousands)
1968	$30		27	
1969	[2] 129	−$11	110	13
1970	165	−63	150	55
1971	209	−145	190	75
1972	308	−257	280	95
Total	841	−476	757	250

[1] Does not include recipients on priority III work projects.
[2] Includes $8,000,000 1-year cost for priority III work projects (for public agencies).

Source: U.S. Department of Labor.

ITEM 2: MEMORANDUM AND REPORT TO THE PRESIDENT FROM THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

MEMORANDUM FOR THE PRESIDENT—JANUARY 3, 1968

From: John W. Gardner.
Subject: Report on major advances in social security and medicare under the 1965, 1966, and 1967 amendments.

With your approval of the Social Security Amedments of 1967, Social Security benefits will be increased the largest dollar amount in the history of the program.

One million individuals will be lifted above the poverty line when the benefits are paid in March.

The accomplishments of the three social security laws you have approved in the past 30 months are remarkable in many additional ways.

The enclosed information summarizes the major accomplishments of the 1965, 1966, and 1967 legislation.

MAJOR ADVANCES IN SOCIAL SECURITY AND MEDICARE UNDER THE 1965, 1966, 1967 AMENDMENTS

1. Medicare—hospital insurance protection extended to 19 million, and supplementary medical insurance to 17.6 million people age 65 and older. They received:
   - —$3.1 billion for inpatient and outpatient hospital services for 5.3 million hospital admissions.
   - —$1.18 billion for physicians' bills and other medical services.
   - —$275 million for the 400,000 admissions to skilled nursing homes providing extended services.
   - —$40 million for services rendered by the 250,000 home health care plans.

The numbers of medical facilities rendering services under the medicare program greatly increased during the year:
   - —221 hospitals were certified to participate in 1967 in the program, bringing to 6,888 the total of medicare certified hospitals.
   - —4,353 extended care facilities were certified to give skilled posthospital care starting January 1, 1967.
   - —481 home health agencies were certified, bringing to 1,880 the number of agencies in the program.

2. Cash benefits to aged persons, widows, orphans, and the disabled were increased on the average of 23 percent—over 7 percent in 1965 and 16 percent in 1967.

The total annual cash benefits in social security this year were $21.4 billion—$1.4 billion more than 1966. Monthly benefits are now going to 23,600,000—some 800,000 more than a year ago at this time. The social security rolls now consist of almost 16 million retired workers and their dependents, over 5½ million widows and orphans, and over 2 million disabled workers and their wives and children.

3. Average value of benefits, when account is taken of addition of medicare, increased 35 percent: cash benefits of 23 percent and 12 percent for medicare.

4. Minimum cash benefit payable at age 65 and to the disabled increased 37.5 percent—from $40 a month in 1965 to $55 in 1967 legislation.

5. Annual earnings not causing the withholding of benefit checks because of a beneficiary's work increased 40 percent—from $1,200 to $1,680 a year. Total people who get benefits as a result of the 1965 retirement test amendment, 190,000; total people who will get benefits as a result of the 1967 retirement test amendment, 50,000.

6. Annual earnings creditable for social security benefit and contribution purposes increased 63 percent—from $4,800 to $7,800 a year.

7. Ultimate maximum cash benefit for people contributing on basis of higher creditable earnings increased 72 percent—from $127 to $218 a month.

8. Eleven additional groups of beneficiaries have been included, increasing the number of beneficiaries by 1,883,000 persons—including students age 18 to 22, disabled widows and widowers at age 50, and certain people age 72 and older. Total people in the categories added by the 1965 and 1966 amendments, 1,468,000; total people in the categories added as a result of the 1967 amendments, 415,000; grand total, 1,883,000.

Provisions	*Number*
A. Number of additional people who now get cash benefits as a result of the 1965 amendments:	
1. Reduced benefits for widows, aged 60–61	121, 000
2. Benefits to people aged 72 and older with limited amounts of social security coverage	124, 000
3. Benefits under broadened definitions of child	20, 000
4. Benefits for children aged 18 to 21 and in school	406, 000
5. Benefits for disabled under broadened definitions	60, 000
6. Benefits for blind under liberalized requirements	7, 000
	738, 000
B. As a result of the 1966 amendments:	
7. Benefits for certain people aged 72 and older with no work (or very little work) under social security	730, 000
Total, 1965 and 1966 amendments	1, 468, 000
C. Number of people who will immediately be able to draw cash benefits as a result of the 1967 amendments:	
8. Increased benefits for certain people aged 72 and older with no work (or very little work) under social security	70, 000
9. Reduced benefits for disabled widows and widowers age 50 and older	65, 000
10. Benefits for workers disabled before age 31, and their dependents	100, 000
11. Benefits for dependents of women workers on basis of liberalized eligibility requirements	180, 000
Total, 1967 amendments	415, 000
D. Grand totals, 1965, 1966, and 1967 amendments	1, 883, 000

NOTE.—The memorandum and report were released at San Antonio, Tex.

ITEM 3: "SOCIAL SECURITY AND WELFARE PROGRAMS"

STATEMENT BY PRESIDENT JOHNSON UPON SIGNING THE SOCIAL SECURITY AMENDMENTS OF 1967 AND ANNOUNCING THE APPOINTMENT OF A COMMISSION ON INCOME MAINTENANCE PROGRAMS. JANUARY 2, 1968

This coming year will mark one-third of a century since social security became the law of the land.

Because of social security, tens of millions of Americans have been able to stand straighter and taller—unafraid of their future.

Social security has become so important to our lives, it is hard to remember that when it was first proposed it was bitterly attacked—much as Medicare was attacked and condemned before it came into being 2½ years ago.

Today, for the second time in 30 months, I am signing into law a measure that will further strengthen and broaden the Social Security System. Measured in dollars of insurance benefits, the bill enacted into law today is the greatest stride forward since social security was launched in 1935.

In March, 24 million Americans will receive increased benefits of at least 13 percent. In the years to come, as the 78 million American earners now covered by social security become eligible, they will gain even greater benefits.

—For a retired couple, maximum benefits will rise from $207 to $234 and ultimately to $323 per month.

—Minimum benefits for an individual will be increased from $44 to $55 a month.

—Outside earnings can total $140 a month with no reduction in benefits.

—65,000 disabled widows and 175,000 children will receive benefits for the first time.

—Medicare benefits are expanded to include additional days of hospitalization.

Combined, the social security amendments of 1965 and 1967 bring an average dollar increase of 23 percent. Medicare protection amounts on the average to an additional 12 percent. This makes total increases of 35 percent in the past 30 months.

When the benefit checks go out next March, 1 million more people will be lifted above the poverty line. This means that 9 million people will have risen above the poverty line since the beginning of 1964.

Social security benefits are not limited to the poor. They go to widows, orphans, and the disabled who without them would be reduced to poverty. They relieve an awful burden from the young who would otherwise have to divert income from the education of their children to take care of their parents.

Franklin Roosevelt's vision of social insurance has stood the test of the changing times. I wish I could say the same for our Nation's welfare system.

The welfare system today pleases no one. It is criticized by liberals and conservatives, by the poor and the wealthy, by social workers and politicians, by whites and by Negroes in every area of the Nation.

My recommendations to the Congress this year sought to make basic changes in the system.

Some of these recommendations were adopted. They include a work incentive program, incentives for earning, day care for children, child and maternal health services, and family planning services. I believe these changes will have a good effect.

Other of my recommendations were not adopted by the Congress. In their place, the Congress substituted certain severe restrictions.

I am directing Secretary Gardner to work with State governments so that compassionate safeguards are established to protect deserving mothers and needy children.

The welfare system in America is outmoded and in need of a major change.

COMMISSION ON INCOME MAINTENANCE PROGRAMS

I am announcing today the appointment of a Commission on Income Maintenance Programs to look into all aspects of existing welfare and related programs and to make just and equitable recommendations for constructive improvements, whether needed and indicated. We must examine any and every plan, however unconventional, which could promise a constructive advance in meeting the income needs of all the American people.

That Commission of distinguished Americans will be chaired by Ben W. Heineman, chairman of the board, Chicago and Northwestern Railroads. Its membership will include Messrs. Thomas J. Watson, Jr., chairman of the board, IBM Corp., Donald C. Burnham, president, Westinghouse Electric Corp., James W. Aston, president, Republic National Bank, Dallas, Texas, Asa T. Spaulding, recently retired president, North Carolina Mutual Life Co., Durham, N.C., Henry S. Rowen, president, Rand Corp., Santa Monica, Calif., George E. Reedy, Jr., president, Struthers Research and Development Corp., Washington, D.C., Anna Rosenberg Hoffman, public and industrial relations consultant, New York City, Julian Samora, professor of sociology, University of Notre Dame, Robert M. Solow, professor of economics, MIT, Edmund G. "Pat" Brown, partner, law firm Bell, Hunt, Hart and Brown, and David Sullivan, general president, Building Service Employees, International Union, New York.

Over the last third of a century in America we have proved that people who earn their living can make their lives better and more secure if they divert part of their incomes to protect themselves from the twists of fortune that face all men. Our challenge for the coming years is to see if we can extend that same human insurance and human dignity to persons who are not able to buy their own protection. Our challenge is to save children.

NOTE: As enacted, the Social Security Amendments of 1967 (H.R. 12080) is Public Law 90–248. The statement was released at San Antonio, Texas.

ITEM 4: EXCERPT FROM ECONOMIC REPORT OF THE PRESIDENT FEBRUARY 1968 PAGE 25

INCOME MAINTENANCE

"I have recently appointed a Presidential Commission on Income Maintenance. This distinguished group of citizens, under the chairmanship of Mr. Ben Heineman, has a broad charter to examine every aspect of our present public welfare and income maintenance programs and to propose necessary reforms. The Commission will examine a number of major reforms proposed in recent years—including several varieties of minimum income guarantees. It will evaluate the costs and benefits of these proposals in terms of their effects both on the recipients and on the economy."

ITEM 5: THE POVERTY GAP IN 1965*

NOTE: This memorandum supplements No. 18, "Counting the Aged Poor, 1965," to provide data tabulated late in 1967. Data on poverty in 1966 has also become available; an issue of Useful Facts providing the pertinent materials is in preparation.

In 1965, the total income of 11.2 million households (units containing one or more persons) fell below the computed poverty level for their type and composition of household. Almost 37 percent (4.1 million) of these households were headed by persons aged 65 plus. Of these older households, 2.6 million or almost two-thirds consisted of an older person living alone or with nonrelatives. Another 1.5 million households, a third of all older households, represented families and actually contained another 2.6 million older persons, a number equal to the older unrelated individuals.

If we compute the deficit or gap in each household, that is, the amount needed to raise the actual income to the poverty index level for that specific type of household, we find that it would have required $11 billion to close the poverty gap in 1965 for all poor households. Closing the gap for older households would have required $2.6 billion, or less than a quarter of the total $11 billion.

The fact, however, that while older households make up about 37 percent of all poor households, they account for only 23 percent of the dollar gap, is misleading. The significant reflection of the poverty situation of the 30 percent of the aged who are poor is the fact that although the 5.3 million aged poor made up 16 percent of all poor persons, they would have required 23 percent of the total $11 billion to raise their incomes to the poverty level.

TABLE A.—THE POVERTY GAP IN 1965 (AMOUNT NEEDED TO RAISE ACTUAL INCOME TO POVERTY INDEX LEVEL)

Type of household and age of head	Poor households		Dollar deficit	
	Number (millions)	Percent distribution	Amount (billions)	Percent distribution
All ages	11.2	100.0	$11.0	100.0
Unrelated individuals	4.8	42.5	3.4	30.5
Families	6.4	57.5	7.7	69.5
Under 65	7.1	63.3	8.5	76.9
Unrelated individuals	2.2	19.1	1.9	17.2
Families	5.0	44.2	6.6	59.7
65 plus	4.1	36.7	2.6	23.2
Unrelated individuals	2.6	23.4	1.5	13.5
Families	1.5	13.3	1.1	9.7

Source: Social Security Administration.

IMPACT OF 1967 SOCIAL SECURITY INCREASES ON AGED POOR

The original proposal for increases in social security payments was included in the President's January 23, 1967, message on older Americans. It provided for an overall increase of 20 percent made up of raising the $44 minimum to $70, raising the special benefit to certain 72-plus beneficiaries from $35 to $50, a 15-percent increase in the remaining benefits, and other, minor, changes. It is estimated that these changes, if enacted, would have lifted 1.6 million persons aged 65-plus out of poverty.

The 1967 amendments enacted by the Congress provided for benefit increases beginning with February 1968 totaling about 16 percent, made up of raising the

*A report by Mr. Herman Brotman, Administration on Aging.

minimum to $55 and the special 72-plus benefit to $40 and an increase of about 13 percent to the others. These increases moved an estimated 800,000 older persons out of poverty. (About 200,000 under-65 beneficiaries also were moved out of poverty or a grand total of 1 million.)

If the Congress had enacted the same 13-percent increase for the above-the-minimum beneficiaries but had raised the minimum to $70 and the special benefit for 72-plus persons to $50, the number of 65-plus persons moved out of poverty would have been 1.3 million. The change in the minimums would have lifted an additional half million older persons out of poverty.

ITEM 6: PRESS RELEASE, SENATE FINANCE COMMITTEE, AUG. 11, 1967*

Chairman Russell B. Long (D., La.) Committee on Finance, today announced that the conferees on S. 16 had reached agreement regarding the differences between the House and Senate versions of this legislation. As agreed to by the conferees, S. 16 would provide more than a quarter billion dollars in additional veterans benefits each year. Senator Long pointed out that the most important features of the bill (a) extend wartime rates of benefits for Vietnam veterans and their dependents; (b) increased educational allowances and broadened opportunities under the "Cold War G.I. Bill;" and (c) provide a cost-of-living increase with respect to non-service-connected pensions similar to the increase Congress voted in the 89th Congress for those receiving compensation growing out of death or disability.

VIETNAM VETERANS

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EDUCATIONAL BENEFITS

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PENSION

Both the House and Senate agreed to provide:

Cost-of-living increase.—A 5.4 cost-of-living increase for all pensioners who are now receiving payments under the so-called new pension law, together with a greater pension increase—approximately 8½ percent—for widows and widows with children in the lowest income categories. (See attached schedules.)

War widows.—A $5 monthly rate increase (from $65 to $70) for Spanish-American and prior war widows;

Housebound allowance.—An increase of $5 a month (from $35 to $40) in the housebound pension allowance for new pension veterans;

Widows aid and attendance allowance.—Initiation of a new program providing a special aid and attendance allowance of $50 a month for widows pensions under the old pension or the new pension program, the Spanish-American War and prior war programs in need of regular aid and attendance.

Total disability.—Presumption of permanent and total disability for pension purposes on attainment of age 65; this removes the necessity for veteran aged 65 and over to prove that he is totally and permanently disabled.

Aid and attendance presumption.—Presumption of regular aid and attendance for pensioners given to war-time veterans receiving nursing care in public or private nursing homes in lieu of requiring a veteran so situated to prove he requires aid and attendance.

Marriage requirement.—Reduction of the 5-year alternative marriage requirement for widows to 1 year (or any period if a child is born to the parties of the marriage).

Income exclusions.—Enlargement of present exclusions from income for pension purposes by disregarding amounts paid by wife for last illness of veteran prior to death and amounts paid by a widow or a wife for last illness and burial of a veteran's child; and

Medical devices.—The furnishing of certain devices, medical equipment and supplies (except medicine) to pensioners in need of regular aid and attendance.

In addition to these benefits, the conferees agreed to the following provisions for pensioners:

Housebound old law veterans.—A housebound rate of $100 per month is given to old law veterans, similar to housebound allowances presently provided under the new pension program.

*This is, in effect, a summary of the provisions of the Veterans' Pension and Readjustment Assistance Act of 1967, Public Law 90-77 (Aug. 31, 1967).

Spanish-American and Indian War veterans.—The Administrator of Veterans' Affairs is directed to pay aid and attendance veterans of the Spanish-American and Indian Wars the higher rates as between the new pension program (based on need) and the service pensions they currently receive (regardless of need) when the facts in each particular case warrant it.

MISCELLANEOUS

Anatomical loss.—The conferees agreed to add to the basic rate of compensation payable to severely disabled veterans by allowing a statutory award of $47 monthly for each anatomical loss they suffer except that the combined benefits may not exceed a total of $400 monthly. Under present law only a single $47 award is payable, regardless of how many anatomical losses are sustained.

* * * * * * *

Social security—Veterans benefits.—The conferees deleted the provision contained in the Senate bill which would have prevented an increase in social security benefits from applying to reduce or terminate a veteran's benefit. However, the conferees firmly agreed that once the amount of the proposed 1967 social security benefit increase has been determined, legislation would be swiftly enacted to assure that no veteran benefit would be reduced or terminated because of the social security hike.[1]

The following schedules reflect the new amounts of pension payable under the conference agreement as compared with present amounts;

VETERAN WITHOUT DEPENDENT

Annual income: More than—	but Equal to or less than—	Conference agreement	Present rate
	$600	$104	$100
$600	1,200	79	75
1,200	1,800	45	43

VETERAN WITH DEPENDENTS

Annual income		Conference agreement			Present rate		
More than—	but Equal to or less than—	1 dependent	2 dependents	3 or more dependents	1 dependent	2 dependents	3 or more dependents
	$1,000	$109	$114	$119	$105	$110	$115
$1,000	2,000	84	84	84	80	80	80
2,000	3,000	50	50	50	48	48	48

WIDOW WITHOUT CHILD

Annual income: More than—	but Equal to or less than—	Conference agreement	Present rate
	$600	$70	$64
$600	1,200	51	48
1,200	1,800	29	27

[1] For discussion of H.R. 12555, the bill introduced pursuant to the agreement of the conferees, see p. 17.

WIDOW WITH CHILD

Annual income			Conference agreement[1]	Present rate[2]
More than—	but	Equal to or less than—		
		$1,000	$86	$80
$1,000		2,000	67	64
2,000		3,000	45	43

[1] Plus $16 for each child in excess of 1.
[2] Plus $15 for each child in excess of 1.

CHILDREN (NO WIDOW)

	Conference agreement	Present rate
1 child	$40	$38
Each additional child	16	15

Appendix 4

MATERIAL RELATED TO EMPLOYMENT AND SERVICE OPPORTUNITIES*

ITEM 1: DESCRIPTION OF "AGE DISCRIMINATION IN EMPLOYMENT ACT OF 1967" (P.L. 90-202, Dec. 15, 1967)

INTRODUCTION

The purpose of the Age Discrimination in Employment Act of 1967 (effective June 12, 1968) is to promote the employment of the older worker based on ability rather than age; to prohibit arbitrary age discrimination in employment; and to help employers and employees find ways of meeting problems arising from the impact of age on employment. This pamphlet is intended to outline the major provisions of the act and what action can be taken by any person who has a question regarding its application.

COVERAGE

Individuals protected by the law are those in covered industries who are at least 40 but less than 65 years of age. Age discrimination must be avoided by:

Employers[1] of 25 or more persons in an industry affecting interstate commerce[2]

Employment agencies serving such employers

Labor organizations with 25 or more members in an industry affecting interstate commerce[3]

PROHIBITIONS

It is unlawful for an employer:

To fail or refuse to hire, or to discharge, otherwise discriminate against any individual as to compensation, terms, conditions, or privileges of employment, because of age;

To limit, segregate, or classify his employees so as to deprive any individual employment opportunities, or adversely affect his status as an employee, because of age;

To reduce the wage rate of any employee in order to comply with the act.

It is unlawful for an employment agency:

To fail or refuse to refer for employment, or otherwise discriminate against, any individual because of age, or to classify or refer anyone for employment on the basis of age.

It is unlawful for a labor organization:

To discriminate against anyone because of age by excluding or expelling any individual from membership, or by limiting, segregating, or classifying its membership on the basis of age, or by other means;

To fail or refuse to refer anyone for employment so as to result in a deprivation or limitation of employment opportunities or otherwise adversely affect the individual's status as an employee because of age;

To cause or attempt to cause an employer to discriminate against any individual because of age.

It is unlawful for such *employers, employment agencies, or labor organizations:*

To discriminate against a person for opposing a practice made unlawful by the act, or for making a charge, assisting, or participating in any investiga-

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*See ch. II for discussion of matters related to this appendix.

[1] The term employer does not include the United States, a corporation wholly owned by the Government of the United States, or a State or a political subdivision thereof.

[2] Fifty or more prior to June 30, 1968.

[3] Fifty or more prior to July 1, 1968.

tion, proceeding, or litgation under it;

To use printed or published notices or advertisements indicating any preference, limitation, specification, or discrimination, based on age.

EXCEPTIONS

The prohibitions against discrimination because of age do not apply:

Where age is a bona fide occupational qualification reasonably necessary to the normal operations of the particular business;

Where the differentiation is based on reasonable factors other than age;

Where the differentiation is caused by observing the terms of a bona fide seniority system or any bona fide employee benefit plan. This applies to new and existing employee benefit plans, and to the establishment and maintenance of such plans. However, no employee benefit plan shall excuse the failure to hire any individual;

Where the discharge or discipline of an individual is for good cause.

RECORDKEEPING AND POSTING REQUIREMENTS

Such records must be kept as the Secretary of Labor requires. Also, an official notice provided or approved by the Secretary must be posted and maintained in conspicuous places on the premises by covered employers, employment agencies, and labor organizations.

ENFORCEMENT

The act is enforced by the Secretary of Labor, who is authorized to make investigations, to issue rules and regulations to administer the law, and to enforce its provisions by legal proceedings where voluntary compliance cannot be obtained. The law provides that acts which it prohibits shall be deemed to be prohibited under the Fair Labor Standards Act and that amounts owing to a person as a result of a violation shall be deemed unpaid minimum wages or unpaid overtime compensation for purposes of the provisions of the Fair Labor Standards Act which authorize enforcement through civil actions in the courts.

The Secretary of Labor or an aggrieved individual may bring suit under the act. Suits to enforce the act must be brought within 2 years after the cause of action accrued, or in the case of a willful violation, within 3 years.

Before the Secretary of Labor brings civil action, the act requires him to attempt to secure voluntary compliance by informal methods of conciliation, conference, and persuasion. Before an individual brings court action, he must give the Secretary not less than 60 days' notice of his intention to do so. The notice must be filed within 180 days of the occurrence of the alleged unlawful practice, except that where a State has taken action in accordance with its own laws prohibiting discrimination based on age, an individual must file his notice within 300 days of the alleged violaion. The law provides that the Secretary, after receiving such a notice, will notify the prospective defendants and try to eliminate any alleged unlawful practice by informal methods of conciliation, conference, and persuasion.

The following methods of recovery of amounts owed as a result of violations of this act are provided:

(1) The Secretary of Labor is authorized to supervise the payment of amounts owed;

(2) In certain circumstances, the Secretary of Labor may bring suit upon the written request of the individual;

(3) An individual may sue for payment, plus attorney's fees and court costs. In the case of willful violations, an additional amount, up to the total of the amount owed, may be claimed as liquidated damages. (An employee may not bring suit if he has been paid the amount owed under the supervision of the Secretary, or if the Secretary has filed suit to enjoin the employer from retaining the amount due the employee.)

(4) The Secretary of Labor may also obtain a court injunction to restrain any person from violating the law, including the unlawful withholding of proper compensation.

In enforcement actions brought under the law the courts are authorized to grant such relief as is appropriate to carry out the act's purposes, including among other things judgments compelling employment, reinstatement, or promotion.

Forcible interference with authorized representatives of the Secretary of Labor engaged in duties under the act may be prosecuted criminally and the

violator subjected to a fine of not more than $500, or imprisonment for not more than 1 year, or both.

INFORMATION AND HELP CONCERNING EMPLOYMENT OF OLDER WORKERS

The Act provides that the Secretary of Labor, in addition to his responsibilities for administering and enforcing its regulatory provisions, shall undertake research and carry on a continuing program of education and information concerning the needs and abilities of older workers and their potentials for continued employment and contribution to the economy. The program will include, among other things, publication of the results of studies and other pertinent information, fostering through the public employment system and through cooperative effort the development of facilities of public and private agencies for expanding the opportunities and potentials of older persons, and sponsoring and assisting State and community informational and educational programs.

ITEM 2: A REPORT BY THE U.S. DEPARMENT OF LABOR* ON OLDER WORKER PROGRAMS IN 1967

Older worker programs in the Department of Labor received renewed emphasis in the Department of Labor in 1967. In January 1967, Louis H. Ravin was appointed Special Assistant for Older Workers to serve as principal staff adviser on policy and to provide the leadership, direction, and coordination required to implement the Department's older worker program involving virtually all the Bureaus and Offices. Shortly thereafter a Departmental Committee on Older Workers was reconstituted, made up of representatives of each of the Bureaus.

Early in the year, the Special Assistant prepared for the National Manpower Advisory Committee a review and analysis of the program. This working document was entitled "Problems in the Implementation of the Older Worker Program: The Situation of Older Workers, History of Labor Department's Efforts, and Current Problems and Issues."

The analysis showed the size and seriousness of unemployment among older workers to be greater than generally recognized. Over a number of years, there have been clear expressions of policy and specific steps taken in the Labor Department, but there remains the overall problem of how best to gain momentum and sustain programs over "the long pull" rather than on an "on-again-and-off-again" basis. One major problem is how to bring into public awareness the situation of many older workers—long-term unemployment, discouragement in search for work, decrease in real income, premature and involuntary retirement, family hardship and poverty. These problems of older workers, widespread in impact but low invisibility, have contended unsuccessfully for attention and priority with other more dramatic and concentrated problems, such as youth and the urban ghettos.

Partly because of recent events, and in good part because of the emphasis of recent legislation, programs for the training and employment of older workers have had insufficient resources allocated. Also, there is substantial doubt whether staff providing services in the field have given the attention to services for older workers which has been expected by departmental leadership.

In order to ascertain the facts concerning the provision of services and to strengthen these as needed, several evaluations were initiated. One of the evaluative approaches was undertaken by the Division of Program and Evaluation in the Manpower Administration. The principal objectives of the evaluation are to assess the strengths and shortcomings of older worker programs, specifically employment services and manpower training; and to formulate recommendations designed to overcome operating problems, to counteract program weaknesses, and to suggest program improvements.

Cities visited were selected so as to give representative samples based on the following criteria: (1) Types of service provided—cities with and without older worker service units; (2) geographic distribution; and (3) size of population.

Persons interviewed include Employment Service officials, older workers, employers, and community leaders. Some of the problems being explored are:

1. Is it better to have special "intensive" older worker services units in the larger ES office or to spread the older worker specialists throughout a number of employment offices?

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*This report, transmitted to Committee Chairman Williams by Secretary of Labor W. Willard Wirtz on Jan. 15, 1968, was prepared and submitted by the Department of Labor, at the request of the Committee on Aging.

2. What can be done to get employers to change their attitudes so that they will be willing to hire workers over 45 years of age?

3. Why is there such difficulty in motivating older workers to take job training?

4. What is necessary to develop more training programs suitable for older workers?

5. How can more publicity be developed concerning the importance and value to employers of hiring older workers?

The field phase of the evaluation was begun in August 1967, and will be completed January 1968. The full report is expected toward the end of March 1968.

Another evaluation, specifically of the newly established intensive older worker service units, was undertaken by the Branch of Special Worker Services in the Employment Service. Reports of both of these efforts will be available in the early part of 1968. A third approach to evaluation and improvement was an effort to summarize the findings of a number of experimental and demonstration programs relating to services to older workers.

In addition to the review of past and current operations, the need for new programs and legislation was explored. The President recommended, in a message on older Americans, the enactment of legislation to combat age discrimination in employment. This legislation is discussed in some detail later.

Secretary of Labor W. Willard Wirtz in testifying before the Subcommittee on Aging of the Senate Committee on Labor and Public Welfare regarding a proposed community senior services program expressed full support of the purposes and objectives of such legislation and undertook to launch such a program, with the cooperation of the Department of Health, Education, and Welfare and the Office of Economic Opportunity, under present authorizations and from appropriations recommended to Congress for approval, at a level not less than that which would have been authorized for the first year under the proposed legislation. Plans were prepared for the initiation of this program by the turn of the year. Although the increases anticipated in appropriations for the Office of Economic Opportunity were not, in fact, made available, the Secretary of Labor is proceeding with the community senior services program.

In the previous year, the U.S. Employment Service was essentially the only agency in the Department involved in the older workers program. Its activity continues. However, in 1967 the Bureau of Work Programs developed a substantial role—specifically in terms of work opportunities provided by its Operation Mainstream; the Bureau of Labor Statistics renewed its involvement in a variety of studies related to pertinent issues in the older workers situation; the Manpower Administration increased its research, demonstration, and evaluation efforts in addition to establishing a new focus of program and policy planning and stimulation. The legislation enacted in 1967 will mean the addition of the Wages, Hours and Public Contracts as another agency with a key role in the older worker programs. These developments are treated in detail in the remainder of this report.

Age Discrimination in Employment Act of 1967

Age Discrimination in Employment Act of 1967, Public Law 90–202, was signed by the President on December 15. The act becomes effective 180 days after its enactment, except that the Secretary of Labor is authorized to delay the effective date for an additional 90 days if necessary. This administration-sponsored legislation establishes as a matter of national policy the elimination of arbitrary age discrimination in employment. The measure applies to workers between the ages of 40 and 64. Enactment of this legislation extended the protection of Federal laws against discrimination in employment to another major group of people—the middle aged. There are now more than 50 million men and women between the ages of 45 to 64, or one out of four of the total population. Workers 40 years of age and older account for about one-half of the labor force.

BACKGROUND

During recent years, bills were introduced in both the Senate and the House to bar discrimination in employment on account of age. Also during the last few years, significant legislation has been enacted to bar discrimination in employment based on race, religion, color, and sex.

Section 715 of Public Law 88–352 (Civil Rights Act of 1964) directed the Secretary of Labor to make a study of the problem of age discrimination in em-

ployment. The product of that study was the report—"The Older American Worker—Age Discrimination in Employment" issued June 1965. In his report, the Secretary recommended action to eliminate arbitrary age discrimination in employment. He said "the possibility of new non-statutory means of dealing with such arbitrary discrimination has been explored, that area is barren . . . A clear-cut and implemented Federal policy . . . would provide a foundation for a much needed vigorous nationwide campaign to promote hiring without discrimination on the basis of age."

Section 606 of Public Law 89–601 (Fair Labor Standards Act Amendments of 1966) directed the Secretary to submit "his specific legislative recommendations for implementing the conclusions and recommendations contained in his report on age discrimination in employment." The President in his Older Americans message of January 3, 1967, recommended the Age Discrimination in Employment Act of 1967. A canvass of State officials regarding the advisability of Federal action against employment discrimination on account of age, indicated that most operating officials in the States saw advantages in a national policy against such discrimination and were in favor of the passage of Federal legislation. Twenty-four States and Puerto Rico have age discrimination legislation. Section 14 of the act provides for concurrent Federal and State actions, except that in States having laws prohibiting discrimination in employment because of age, no suit may be brought under this act before the expiration of 60 days after proceedings have commenced under the State law, unless those proceedings have already terminated.

SUMMARY OF P.L. 90–202

(See pp. 194–196.)

Bureau of Work Programs

The Bureau of Work Programs officially launched its administration of Operation Mainstream on April 2, 1967, when Secretary of Labor Willard Wirtz signed the first agreement with Green Thumb, Inc., a nonprofit organization affiliated with the Farmers' Union. Green Thumb was created primarily for the older rural worker. The average age of enrollees in the first year was 67. The projects were funded under the Nelson provisions of the Economic Opportunity Act, and when this program was delegated to the Labor Department the concept of Green Thumb was broadened into Operation Mainstream whose goal is steady work at decent pay for chronically unemployed adults of all ages. These projects put adult men and women to work in community betterment projects when and where there are no prospects for finding other work; for example, older adults in Appalachia, Indian tribes in Wisconsin, and migrants in Texas are provided useful employment.

By June 30, 1967, the Labor Department had signed 146 Operation Mainstream project agreements providing 7,991 job opportunities for out-of-work adults at a Federal cost of $23,727,581. In fiscal year 1968, as of December 8, 28 Operation Mainstream project agreements have been funded at a cost to the Federal Government of $4,893,410, providing 1,352 additional job opportunities.

Mainstream has been successful in reaching the older unemployed male worker. Males outnumber female enrollees more than 10 to 1. Fifty-eight and three-tenths percent of the mainstreamers are aged 45 and over.

The accomplishments of the Mainstream workers have been greatly beneficial to the communities in which they live. The Green Thumbers, now about 800 strong, are employed in Arkansas, Indiana, Minnesota, New Jersey, Oregon, Virginia, and Wisconsin. These oldtimers, whose average age is 67, have planted 600,000 trees, built 35 new parks, reconditioned 60 more older parks, established several hundred new rest areas, and cleared hundreds of miles of highway rights-of-way.

A project in Rio Grande City, Tex., is giving 70 migrant families an opportunity to settle down, keep their children in school, save money, and develop community ties and spirit. In Monterey, Tenn., 90 enrollees—older men and heads of families—are at work, some for the first time in years. They have tapped a mountain spring and laid a half mile of pipe to the center of one hamlet, where coal mining ceased years ago. Now the residents no longer have to haul their water from a town 3 miles away.

Mainstream has enabled the Menominee Indians in Wisconsin to open small industries that produce park benches, tables, and handicrafts. The Indians are

being moved out of the 19th century and there is a strong belief among the Indians that when the county is developed over the next 10 or 15 years, young people who left will filter back home to live.

The Norwich, Conn., Mainstreamers by August 29, 1967, had built (*a*) an entirely new county park, (*b*) a playground in a village that had none, and (*c*) a Little League baseball park in a low-income area. They had also painted and repaired many public buildings in the county. The female enrollees work in hospitals and day-care centers.

In the Brockton, Mass., Mainstream project, last year the directors trained 48 persons for jobs in legal aid, employment, housing, mental health, and community development. Enrollees received 3 months of formal training, followed by a schedule of 20 hours work experience a week coupled with 20 hours of continued formal training.

Ninety Mainstream enrollees built baseball parks and recreation centers in 13 Texas towns by July 1967. Now they are paving streets, repairing water and sewer mains, and doing maintenance work on public buildings.

Eighty-one Mainstreamers from four Louisiana parishes are working in the Kisatchie Forest near Alexandria. They are building fences, learning the skills of linemen, radio repairmen, silviculture, building repair, and timber making.

The supervisor of Kisatchie National Forest said, "This is no make-work program. These men are doing jobs that badly need doing, but that we've never had the funds to do." He estimated that Kisatchie needs over 2,000 miles of fences built, worth $100 a mile to the Forest Service. That's how much it would cost to build normally.

The Pulaski County Operation Mainstream in Little Rock, Ark., though less than 4 months old and funded for only 20 job slots, had by mid-September 1967, moved 17 enrollees into permanent full-time jobs. Four of these were former welfare recipients, four were women, nine were 44 or above, five were past 50, and one was 60. A majority of the jobs were of the custodial or maintenance variety, but one woman, 53, is now driving a taxi; another, 30, is a receptionist for a college president; and the other two, 34 and 29, are medical aides.

Many Mainstreamers testify to the worth of the program. E. C., 29, Negro, left with seven children when her husband deserted, had been living on food stamps and $125 a month welfare money in Little Rock. Mainstream enrolled her and assigned her to the V.A. hospital in Little Rock as a trainee in the blood laboratory. She did so well the hospital hired her in 1967. Now she has a full-time job at $275 a month.

"This has been a big thing for me," she said. "It's been better for my kids, better in school, better clothes, and we got a better home * * * It's been wonderful. I feel like I accomplished something. I enjoy working with the people (at the hospital). They need your attention."

Green Thumbers responding to a recent confidential questionnaire made these remarks: "It made me see things I never saw before"; "* * * kept us from starvation"; "* * * made me feel useful, healthy, and happy"; and "* * * even starting to look at the girls again."

U.S. Employment Service and Affiliated State Employment Service Agencies

Older Worker Services Program

The Employment Service defines an older worker as one who is having difficulty in getting or keeping a job principally because of his age, or of characteristics ordinarily associated with age. For statistical reporting purposes, age of 45 years and over has been used for this worker group. The USES program of services to older workers, implemented through its affiliated State agencies, consists primarily of counseling, job development, referral to training or to other social services, and job placement—all on an intensified and individualized basis.

A moderate expansion of services to older workers was initiated by the Employment Service in fiscal year 1966 through the allocation of 100 positions to the States to be used exclusively for such services. In fiscal year 1967, an additional 291 such positions were allocated. Most of these positions were used to staff "older worker service units" in 27 of the Nation's major cities. Although budget restrictions did not permit additional allocations in fiscal year 1968, program progress continued, largely through the emphasis generated by establishment of the "units."

Overall services to older workers are reflected in the following statistics for calendar years 1966 and 1967. Since total figures for 1967 are not yet available, the period January through October is used, and a comparable period for 1966.

	1966 (January through October)			1967 (January through October)				
	Total	Age 45 plus	Percent of total	Total	Age 45 plus	Percent of total	Percent of total change	Percent of 45-plus change
New applications	9,917,439	1,366,042	15.1	9,385,908	1,428,281	15.2	+4.1	+4.6
Initial counsel	1,049,232	101,830	9.6	1,069,724	108,364	10.1	+2.0	+6.4
Non-ag. placements	5,559,794	1,116,420	20.0	4,964,367	1,034,776	20.8	−10.7	−7.3

OLDER WORKER SERVICE UNITS

Of the 27 cities to which allocations have been made to establish older worker service units, 23 cities now have such units in operation. Seven units were established in 1966, and 16 in 1967; four cities have encountered temporary operating and staffing problems, but are expected to be in operation soon. Cities with older worker service units are:

Boston	Cincinnati	New Orleans
Providence	Chicago	Houston
Rochester	Minneapolis-St. Paul	San Antonio
Buffalo	Milwaukee	Dallas
New York	Kansas City	Los Angeles
Washington, D.C.	San Diego	Oakland
Baltimore	San Francisco	Long Beach
Detroit	St. Louis	

The following cities have received position allocations, but are still in the process of establishing functional units:

Pittsburgh Philadelphia Seattle Cleveland

These older worker service units represent one of the most concerted and direct efforts to expand employment services to older workers since the late fifties. The units are basically a concentrated augmentation of staff, to be used, on a full-time basis, for intensified services to older workers. The older workers they serve are those with more complex problems than applicants in the "mainstream," necessitating a qualitative, time-consuming service process. Operationally, the units vary from city to city; original plans for the units were kept flexible enough to permit easy adaptation to local organizational patterns and service needs. In some cities, unit staff are all in one location; in others, they are assigned to various operational sections; in all cities they are expected to operate as a functional entity, with a unit supervisor, frequent staff meetings, and a cohesiveness which will most effectively promote the objectives of the older worker services program.

With most of the service units in operation only a few months, and with differing starting dates, it is too early for a statistical summarization of their activities. However, the original five units (Detroit, Minneapolis-St. Paul, Kansas City, Rochester, and Houston) have been operating since 1966; a summarization of some of their activities for the period January through October 1967, gives some indication of the services they are providing:

OLDER WORKER SERVICE UNIT ACTIVITIES, JANUARY THROUGH OCTOBER 1967

	Detroit	Minneapolis-St. Paul	Kansas City	Rochester	Houston	Total
New applications	1,664	450	706	683	2,710	6,213
Initial counseling	1,082	395	699	605	1,564	4,349
Placements	798	621	344	415	743	2,921

In regard to the new applications, it should be borne in mind that the units also served applicants who had previously been registered with the local offices. In many cases this number exceeded the number of new applicants.

A noteworthy aspect of these activities is the fact that the ratio of initial counseling interviews to new applicants is high—70%. The same ratio in overall employment service statistics for 45+ applicants is approximately 7 percent. This gives an indication of the extent of intensification of service the units are providing.

HUMAN RESOURCES DEVELOPMENT PROGRAM

The HRD program of the Employment Service has added significant impetus to the older worker service program. The programs have identical goals and concepts, and services to older workers thus becomes an integral part of HRD. With relatively few exceptions, "older workers," as defined, fit the criteria for HRD, that is, they are 45 years of age or older, and have been or may reasonably be expected to be unemployed for 15 weeks or longer. As a result, all local employment service offices are intensifying their service to older workers as a part of their participation in the HRD program. In those cities which have older worker service units, the units have been incorporated into the HRD effort.

MANPOWER DEVELOPMENT AND TRAINING

Older workers are increasingly being helped to greater employability through training offered under MDTA. The most recent figures for 1967, through June of that year, show that 12 percent of all trainees enrolled in MDTA institutional programs were 45 years of age or over. In MDTA on-the-job training programs the percentage for age 45-plus enrollees was 10.9 percent. It is expected that growing emphasis on training for older workers will continue to increase their share in MDTA training opportunities.

RESEARCH

The USES has contracted for a period of 1 year with the National Council on the Aging in New York to establish a National Institute of Industrial Gerontology.

1. Development of curriculum modules on a building-block basis for the training of Employment Service counselors and other responsible personnel, at whatever level desired and/or required in serving the older worker applicant group.
2. Development of an on-going research relationship between selected State employment service agencies, researchers and universities in the States.
3. Conduct a seminar on industrial gerontology for selected State employment service agency personnel, and selected labor and industry experts, who will be committed to developing and furthering the best technique for dealing with and aiding the older worker.
4. Development of plans for an on-going National Institute of Industrial Gerontology program relationship between the Bureau of Employment Security and State agencies.

Experimental and Demonstration Programs

Seven experimental and demonstration programs directly related to older workers were operating in 1967 out of a total of 16 such contracts initiated since the passage of MDTA in 1962. Although total projects were very limited in number for this broad complex field, it was thought desirable at the beginning of 1967 to sum up and evaluate the findings thus far. Therefore, a contract was entered into for the purpose of pulling together the total experience with older worker program for use as guidelines to organizations and agencies concerned with manpower problems and specifically the problems of older workers. This study is now in final draft and discusses the various components of demonstration projects constructed up to September 1966; estimates their strengths and weaknesses; and presents recommendations. The overall conclusion is that while "no startling innovative techniques were discovered * * * the application of known (but rarely practiced) techniques was imaginative and sympathetic and brought additional insight to older worker problems."

The six demonstration projects operating in 1967 are as follows:

(1) The program of the Cleveland Welfare Federation was designed to reach recently unemployed male workers before they could fall into a continuing pattern of unemployment, and develop a cohesive force among the numerous community agencies to provide supportive services to older workers. A sheltered workshop filled the gap between unemployment and reemployment for about one-fifth of the project clients. The majority were later successful in obtaining outside jobs. A few with severe emotional or physical problems remained at Goodwill Industries. Although those in greatest need of counseling usually resisted any action but immediate employment, individual counseling was still found to be an essential component of the program.

As a "spin-off" from this project, two recommendations have already taken effect.

(a) Development of specific interagency referral procedures and forms is being initiated by the Manpower Planning and Development Commission of the Cleveland Welfare Federation with the six largest manpower programs in the community.

(b) The Ohio State Employment Service has allocated State funds for 12 additional older worker counselors.

(2) A contract awarded to the John F. Kennedy Family Service Center of Boston called for continuation of earlier services to persons over 45 but added several innovative features:

(a) Further testing of the effect on employability of "Talents"—an organized effort of the white-collar unemployed directed toward self-help in job development and placement.

(b) Counseling and placement services for those over 62 needing part-time jobs to supplement meager pensions or social security allowances.

(c) Testing of the need of an on-going family service center to provide needed services (counseling, job development, health and welfare, and psychological, and so forth), increase employability and more accurately relate employer needs to older workers' potentials.

(3) A project by the Bay Area Social Planning Council of San Francisco was designed to study and to serve all active applicants aged 60 and over, in the active files of the public employment offices. The California State Employment Service was a participating agency during the first year of "Project 60," then withdrew, and the Bay area council took over full direction of the program.

Some job seekers had problems which they could not recognize and participated in the project although neither training nor employment had direct relevance to their difficulties. The socially acceptable search for work subconsciously became a ticket of admission to seek help. A very thorough medical examination was given to a random selection of 100. They proved to be surprisingly healthy; according to one of the doctors "capable of doing any reasonable kind of work."

The project pointed up the need for preretirement counseling and the importance of a combination of social casework and employment counseling in sustaining the individual during the crisis period of unemployment. Group counseling was effective. Besides the unmeasured adjustment benefits gained by the clients of this experimental program, over a third of the 1,200 persons served became employed during the project period from latter 1964 to August 1967.

(4) Community Progress, Inc. (CPI), the Community Action Agency, New Haven, Conn., in cooperation with the Organization for Economic Cooperation and Development (OECD) measured the relative effectiveness of new training methods for older workers being developed in Western Europe experiments as compared to those traditionally employed in the United States. The experiment showed no difference between the effectiveness of the two training methods in electrical work but the discovery group (European method) was superior on all aspects of achievement in machine operating. Although the two groups were small, there was convincing evidence of the high potential for uncovering more efficient ways of training older persons.

Within a month of the conclusion of phase 1, 75 percent of both groups were in better jobs than they had ever held. Three months later 70 percent were still in their jobs. This favorable outcome is attributed jointly to the specific skill development and to the variety of dispersed work-experience activities which supplemented the skills training.

(5) Bureau of Employment Security through California and Kentucky State Employment Offices. The BES contract was designed to demonstrate the suitability of senior citizen's centers as employment offices (Louisville and Sacra-

mento) and also to determine whether neighborhood employment offices for older workers (in the areas where they lived) could be operated effectively by a staff of volunteers.

These projects are still underway but it is already clear that both cities have been able to recruit devoted and competent volunteers and train them to perform the more routine Employment Service functions. Counseling, testing, referral to training, et cetera, are handled by the parent local offices.

Major problems of volunteers have been transportation, prospective commitments to other activities, and reluctance to work more than 2 or 3 days a week. The latter has militated against continuity in services provided.

(6) Golden Age Employment Service—Atlanta, Ga. Archie Crenshaw, of Georgia State College, completed a followup study of the Golden Age Employment Service's "HIRE" program, designed to test the hypothesis that a senior citizen's association is uniquely equipped through its established rapport to reach, counsel, motivate, and provide supportive services to unemployed older workers during the preemployment period and after placement.

Superimposing a professional staff in an employment service previously operated exclusively by volunteers was almost a built-in hazard and resulted in some conflict between what were, in essence, two staffs—both competent and both dedicated. A volunteer employer committee which had been highly effective in locating jobs slackened its efforts once a professional staff was employed. In spite of all, the project built a broad base of public acceptance. BES though the Georgia State employment contracted to continue the "HIRE" program previously operated by the Golden Age Employment Service in Atlanta, Ga. (as described under the Crenshaw followup study below), established special facilities and hired the staff of HIRE to demonstrate that the special services previously provided older workers by GAES could be absorbed into the ongoing program of the State employment service by broadening and emphasizing the services traditionally offered. At the end of the year, the special facilities were terminated and the HIRE staff released.

Factors Affecting Labor Force Participation of Older Workers—Bureau of Labor Statistics

Older workers (45+) are about two-fifths of the labor force. Participation rates fall consistently, beginning in middle age and with increasing rapidity with increasing age. In addition to a substantial fall in participation rates for men 65 and over in the last 20 years, there has been a significant decline in participation rates for men age 55 to 64. Yet, the average 55-year-old man has 12 additional years of work ahead of him, or more than one-fourth of the entire worklife expectancy for a man.

The median income for men steadily declines after age 45. The ratio of unemployment rises. Once unemployed older workers remain unemployed substantially longer than younger workers and some may never find a job again.

Actually, the overall rates of unemployment are understated, partly because relatively many are farmers or self-employed and partly because their unemployment may be concealed by presumed withdrawal from the labor force due to discouragement, although such withdrawal often is attributed to retirement or poor health. Social security beneficiaries of age 62 to 64 are mainly in the low-income group compelled to accept decreased benefits to continue for the rest of their lifetime as an alternative to continued or sporadic unemployment. We do not know what is the influence on withdrawal from the labor force of such factors as provisions for early retirement, mass layoffs and plant shutdowns, extended unemployed, ill health, or the desire for leisure.

The answers to such questions would need to come from extensive, preferably longitudinal studies. One such study is being done under contract with the Manpower Administration by the Ohio State University Research Foundation and the Bureau of the Census. This involves a series of interviews in depth on labor force behavior and motivation. Three age groups are included in the sample, including men 45 to 59 years of age. Initial interviews and first follow-up interviews have been completed for the older men and a report covering the findings is expected early in 1968.

Until findings are available from in-depth studies of the interaction among economic, sociological, psychological variables affecting work experience and labor force participation, the Bureau of Labor Statistics has published a number of valuable studies this year on labor force participation, productivity, pensions,

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other employee benefits, and other factors relating to continued labor force participation. Most, but not all of these, have been published in the Monthly Labor Review this year. Following is a list of references to these recent studies with brief statements of the findings.

1. Labor force participation

a. Robert L. Stein, "Reasons for Nonparticipation in the Labor Force," Monthly Labor Review, July 1967.

A survey made in September 1966 showed that—

—Of those men 55 years and over who said they wanted a regular job, but were not looking for one, the major reasons given were ill health (44 percent) and the belief that it would be impossible to find work (43 percent).

b. Susan S. Holland, "Adult Men Not in the Labor Force," Monthly Labor Review, March 1967.

A review of the available data showed that—

—In the decade 1956–66, nonparticipation in the labor force rose among men aged 55–64—from 11.5 to 15.5 percent of the population. (For men 18–65 years old, the nonparticipation rate rose from 6 to 8.7 percent.)

—The increase occurred primarily among men 60–64 years of age and was attributable mainly to retirement, both voluntary and mandatory.

—Early retirement was the major factor in declining participation for older men—increasing number and liberalization of private pension plans, extension of social security coverage and 1961 Social Security Act amendments.

—Also, however, retirement was involuntary or simply an alternative to unemployment or sporadic employment at low wages.

—Proportion of nonparticipants in the 55–64 age group is higher for nonwhites (19 percent) than for whites (15 percent), explained in part by the greater tendency of men with low educational attainment, low earnings, and poor work histories to withdraw.

c. Carl Rosenfeld and Elizabeth Waldman. "Work Limitations and Chronic Health Problems," Monthly Labor Review, January 1967.

—This study examined data from the National Health Interview Survey of the Department of HEW to study the effect of health problems on ability to work. As would be expected, work limitation owing to health problems occurred most frequently for those men 45–64 years of age. Over 40 percent of the men 45–65 years old not in the labor force reported they were unable to work, and another one-fourth said they were restricted as to the amount or kind of work they could do.

—Among men 65 years and over not in the labor force, the incidence of partial work limitation was about the same as for the younger group, but the proportion unable to work at all was 31 percent.

—For unemployed women 45–64 years old, work restrictions were reported by 12 percent, about half that for the men. The proportions were about equal for employed men and women in this group, and higher for men than for women over 65.

—Some of the retired men, 45–64 years old, might be available for work if they could obtain required job training, particular prosthetic devices, or special environmental conditions.

2. Productivity

Job Redesign for Older Workers: Ten Case Studies (BLS Bulletin 1523), March 1967.

—The report describes how 10 industrial establishments in the United States used methods of job redesign to maintain the employment and productivity, as well as the morale, of aging employees. The individual case studies were carried out through interviews with officials at 10 companies selected for visits from 284 firms that replied to a mail canvass. The plants studied employed from under 100 to several thousand workers, and produced a wide variety of products.

The report made these major findings:

—Job redesign for older workers generally resulted in improved productivity, contributing in several cases to substantial rises in output per man-hour.

—Job redesign for older workers usually involved very little money outlay for new equipment and scarcely any loss in output due to work interruption.

—The content of jobs was changed in conjunction with equipment improvement and, in some cases, duties were reallocated so older workers might adapt jobs to their capacities.

—Job redesign enables an older worker to continue using his skills, thus maintaining his morale and avoiding reduction of earning capacity.

—Generally, informal actions by foremen or plant managers were carried out to modify jobs to the capacities of older workers. Formal programs were less frequent.

—Other major benefits of job redesign are that the health of older workers is protected and employers keep experienced employees during a period of skill shortages.

3. Employee benefit plans—pensions, profit sharing and health

a. Emerson H. Beier, "Termination of Pension Plans: 11 Years' Experience," Monthly Labor Review, June 1967.

—This study, undertaken with the cooperation of the Internal Revenue Service, was concerned with the causes and effects of terminations and the characteristics of retirement plans closed between 1956 and 1965.

—Over half of the 8,100 plans that terminated were pension plans, but since the profit-sharing plans were somewhat larger, on the average, they accounted for slightly more than half the plan participants. The annual rate of termination was low in both types of plans. While the number of pension plan terminations reflected the influence of changing business conditions, profit-sharing plan terminations did not. Both types of terminated plans were young (averaging 5 or 6 years) and small (averaging 13 or 18 participants). Although mergers and sales were cited most often as the primary reason for terminations, they accounted for a larger fraction of the discontinued profit-sharing plans. Business dissolutions were responsible for about a fifth of each plan type. Financial difficulties also accounted for a fifth of the profit-sharing terminations but a fourth of the pension. This difference reflects the greater flexibility in the financing of profit-sharing plans. (An article on deferred profit-sharing terminations is scheduled for the Monthly Labor Review in 1969.)

b. Donald M. Landay, "Private Pension Plan Coverage of Older Workers," Monthly Labor Review, August 1967.

—This article summarizes the results of a January 1966 survey of privately employed wage and salary workers between 50 and 64 years of age who were asked about their coverage and vested rights under private pension plans.

—About half the men and a fourth of the women studied were covered by a pension plan. While most of these 4½ million older workers will be eligible for a pension at age 65 or earlier, few of the 6½ million older workers not covered will attain coverage and become qualified for a private pension by the time they reach 65. Even among older workers who had been with their employer 10 or more years, substantial numbers—about one-third of the men and one-half the women—were not covered by a pension plan in their present jobs. A small fraction, however, had vested rights to pensions earned in previous jobs.

c. A report on the prevalence of vesting provisions and vesting requirements for plans filed under the Disclosure Act was prepared for a compendium of pension plan studies to be published by the Joint Economic Committee and in the Monthy Labor Review.

—The prevalence of vesting provisions increased during the last 5 years from 67 to 70 percent of plans and from 59 to 63 percent of the workers. The largest increase in coverage occurred among negotiated single employer plans (from 72 to 78 percent of the workers).

—Age requirements were eased—notably in plans negotiated by the United Automobile Workers—so that over half the workers in plans with vesting need not now meet any age requirement. Largely as a result of this change, about 4 out of 9 workers in plans with vesting can vest at age 40 after 10 years of service.

d. With the cooperation of the Internal Revenue Service, the Bureau analyzed IRS reports on a 10-percent sample of recent approved retirement plans.

—Most plans were small. Less than one-fifth of each type had 25 or more participants. As a result, almost all of the pension plans were insured plans. All of the profit-sharing plans and 3 out of 4 pension plans had vesting provisions. However, the age and service requirements were much more restrictive than those of older plans. For example, 3 out of 4 pension plans required the attainment of age 50, 55 or 60. These advanced ages suggest that the plans were merely complying with the IRS requirement that plans which make early retirement conditional on the employer's approval, pro-

vide fully vested benefits at the age and service required for early retirement.

e. The updating of the 1964 digest of 100 selected pension plans under collective bargaining is now in progress.

f. The Bureau is preparing a digest of private plan benefits provided to workers and their dependents who are over 65 years of age in 100 selected health and insurance plans under collective bargaining agreements. Adaptation of these plans to medicare will be shown.

4. *Budget for a retired couple*

The Bureau is currently preparing a "Retired Couple's Budget" based on autumn 1966 prices, with publication expected in the spring of 1968. This budget continues the series originally prepared early in the 1950's and revised as of autumn 1959. All of these budgets present the dollar cost of maintaining a moderate but adequate standard of living for a retired couple.

The "Retired Couple's Budget" will show costs for the same areas as the recently issued "City Workers' Family Budget."

ITEM 3: REMARKS BY PRESIDENT LYNDON JOHNSON AND SECRETARY OF LABOR WILLARD WIRTZ AT SIGNING OF CONTRACTS FOR OLDER AMERICAN COMMUNITY SERVICE PROGRAM FEBRUARY 15, 1968

Exhibit A. Remarks by Secretary Wirtz

Nothing better illustrates the commitment of the President and of the Labor Department to the welfare of the older worker than these three contracts we are announcing today.

Our senior citizens don't want handouts. They want work. They want to continue to make a contribution to their fellow man. They want to continue to be a vital and living part of American society.

And we need their skills. The "Green Thumbers" have planted trees, beautified the green countryside and built roadside parks in seven States the past year. Without them this valuable and lasting work wouldn't have been done. We're happy today to be able to announce that the new contract doubles the number of States they will be beautifying in the next year, and that nearly three times as many workers will be employed.

With the other two contracts, we are entering a new and, I'm sure lasting phase of our efforts to apply the skills of older workers to the pressing needs of society. The 800 enrolleees covered by the agreements with the National Council on the Aging and the National Council of Senior Citizens will, in a sense, help care for their own. They will help ease the day-to-day burden of living from the shoulders of the elderly, the sick and the disabled.

We respect these men and women not only for what they've already done but for what they will do in the future. We respect them not only for building an America whose greatness we cherish, but also because they will help us make it even stronger and more beautiful.

I now have the honor to introduce the man who is the one who has made this and ever so much more possible for the benefit of older Americans——

Ladies and Gentlemen, the President of the United States.

Exhibit B. Remarks by the President

Secretary Wirtz, my distinguished friends:

One of our great poets had this to say about getting older: "The years between 50 and 70 are the hardest. You are always being asked to do things, and yet you aren't ancient enough to turn them down."

Well, today we are giving a great many older citizens a chance to do a great many things. And I'm willing to bet that we won't get turned down.

Today we are launching a program to provide work in community service projects for retired or unemployed citizens who are 55 and over.

The three contracts that were referred to by Secretary Wirtz that we will sign will create more than 3,000 job opportunities in the coming year. These jobs will be in schools, hospitals, in beautification projects and other efforts that will improve life for all of us.

There are a good many of us in this room today who can remember seeing people grow old 20 or 30 years ago: seeing what old age did to them.

Too often, it meant being alone. Too often, it meant being dependent on someone else—their children or their sons-in-law. It meant that as the years mounted up, their savings dwindled down. And worst of all, it meant being sick and afraid because they just didn't seem to be able to afford to be sick.

Things have changed some since then, largely because of a leadership that people like you have provided.

In March, more than 17 million older citizens will receive a Social Security increase of some 13 percent. When the benefit checks go out, another one million Americans will be lifted above the poverty line—a goal that we are working toward.

Medicare—that for many, many years was not seriously considered and after it was considered and passed, many said would not work at all—is now flourishing. More than 20 million senior citizens have its protection. Last year, 7½ million of these senior citizens received help in paying their medical bills. That is a fact—not a fantasy.

But beyond all of this, we all have another goal. That goal is to guarantee—to every older American—not only security, but the pride of being able to be active and being able to be productive.

Last year we took a major step toward that goal.

We passed a law forbidding age discrimination in employment.

We renewed and strengthened the Older Americans Act. It promised a new sense of involvement and usefulness to hundreds of thousands of our citizens.

And that is only a small part of the story. More than 4,000 Foster Grandparents in 38 States; nearly 300 older VISTA volunteers; 500 older Peace Corps volunteers; more than 3,000 members of SCORE—the Service Corps of Retired Executives—have already learned what it is to have a feeling of pride in serving others, regardless of one's age.

Now we meet here again this morning in another good cause. Soon, after the signing of these three contracts, thousands of older citizens will know what it is to have a long life. They will know what it is to have a full life; to know what the wise Frenchman meant when he said: "Growing old is nothing more than a habit which a busy man has no time to form."

In this day of trouble and trial for our people, I want to salute those representatives, who are here in the Cabinet Room this morning, of the older Americans in our country, for your objectives, for your goals, for your persistence and for the manner in which you have represented those for whom you speak.

You have spoken where it counts; you have been represented in the rooms where there is a pay-off.

In December we signed a Social Security Bill. It affected the lives of millions of people directly; it affected the lives of all of us—all 200 million—indirectly.

President Truman proposed Medicare. But you testified for it—and you presented your opinion—your concern—and your dissent—and your voice—and your logic—and your argument before the committees.

Those committees listened and they learned. As a consequence, 7½ million of your fellow citizens have benefited.

There will be hearings in the days to come—hearings on poverty, hearings on education, hearings on health, hearings on security for older Americans.

While we have made great progress, we have just gone a few steps up a long road. I had three figures in my mind that were brought to me by the Budget Director this year when we signed the budget.

The first one was on manpower training that is very important to you. In 1960, our budget was $3 billion—$3 billion for manpower training.

By fiscal year 1964—just before I took office—that had increased to $4 billion plus.

From 1964 to 1968, largely through help that you and other concerned citizens have rendered in the Congress, in the precincts and in the election, the Congress—by an overwhelming vote—increased that $3 billion in 1960 and that $4 billion in 1964 to $12 billion in this year's budget.

In poverty, which affects us all, but affects no one more than the older American—one million were removed from the poverty level by the last Social Security Bill alone—that poverty group was receiving a little over $9 billion in the year 1960.

We had moved that $9 billion up to $12 billion by the fiscal year 1964. In 1964, we renewed our pledges that were made and our promises of 1960 when President Kennedy went from one end of this Nation to the other. We pleaded with the

members of the appropriate committees to try to move forward with the New Frontier and the Great Society.

From 1964, when we had $12 billion to '68, this year, we have $28 million—more than double the amount of federal funds spent for those below the level of $3,000.

Now, finally, if there is anything that is vital to every citizen of this land, it is health. It doesn't make any difference how many Ph.D's he has if he is bed-ridden and can't get out of his room and requires the care of other people.

Education is one of the reasons, I think, that America leads the world. I was reading a book last night; Europe was very concerned about our industrial management. They felt that we were taking the place that some of their citizens should be taking. But they said we have this great ingenuity and this great industrial management system primarily because of the education of our people.

So health, education and Social Security: In 1960 we were spending $19 billion in that field. Fiscal '64—a little over three years later—we were spending $23 billion in that field.

We moved it up $4 billion. Since 1964, to 1968, we moved it not one billion, not four billion—but we have more than doubled it from $23 billion to $47 billion in the budget this year.

The Social Security Bill, the Poverty Bill, the Training Bill—all of these items overlap. But the important thing is that we are moving along.

Now that is not nearly what we ought to do. That is not nearly as much as we want to do. But it is a sign when you can triple manpower and when you can more than double aid to poverty in one Administration. When you can go in health, education and Social Security from $23 billion to $47 billion, it is something that you are not justified in saying is being completely neglected.

So to those of you who man the ramparts—to those of you who have marched in the committee rooms—to those of you who have written the letters and talked to your Congressmen and your Senators of both Parties, and the leaders of both Parties, I salute, congratulate, and thank you for what you have done for your fellow man.

Thank you.

Appendix 5

MATERIAL RELATED TO HEALTH OF THE ELDERLY*

ITEM 1: SUMMARIES OF FEDERAL STUDIES AND CONFERENCES RELATED TO HEALTH AND HEALTH COSTS—1967

A. Report to the President on Medical Care Prices by the Department of H. E. W., February, 1967 ("Gorham Report")

Under date of February 28, 1967, Secretary John W. Gardner transmitted this report to the President, presenting it as the result of a request which he said he had received from the President during August, 1966 "to study the reasons behind the rapid rise in the price of medical care." It was prepared under the direct responsibility of William Gorham, Assistant Secretary for Program Coordination, and came to be popularly known as the "Gorham Report".[1]

The report confirmed the impression held by the general public that prices of medical care have been rising rapidly, and identified the causes of the longrun upward trend and the recent acceleration in medical prices. It recommended Government actions to moderate the price rise and encourage greater efficiency in the delivery of medical care.

In receiving the Gorham Report on February 28, 1967, the President directed Secretary Gardner to convene a conference to "discuss how we can lower the costs of medical services without impairing the quality." The Secretary did call such a conference, and later called three other conferences to explore specific aspects of the problem and to make recommendations on them.

B. The National Conference On Medical Costs, Washington, D.C., June 27–28, 1967

Brought together in this conference were more than 300 of the Nation's health leaders, representing both providers and consumers of health services. The membership of the conference included men and women trained in medicine, dentistry, pharmacy, economics, administration, and in other relevant disciplines.

Among possibilities for meeting the problem of rising costs of health care which were discussed at the conference were increasing efficiency of hospitals and medical personnel, improving Federal criteria for determining Federal payments for health care, improving organization for delivery of health services, improving utilization review procedures, more effective area-wide health planning, more and better health services research and development activities, and improving education of health personnel.

C. National Conference On Private Health Insurance, Washington, D.C., September 28–29, 1967

Convened at this conference was a broad representation of decision makers from the private health insurance industry, including Blue Cross-Blue Shield, the American Medical Association, the American Hospital Association, group practice prepayment plans, labor, management, State health departments, and State insurance commissioners.

D. National Conference on Group Practice, Chicago, Ill., October 19–21, 1967

The conference brought together nearly 150 participants, including medical school deans; private practitioners of medicine, dentistry and other health pro-

*See ch. III for discussion of matters related to this appendix.

[1] Reproduced, beginning on p. 319 of hearing transcript "Costs and Delivery of Health Services to Older Americans," (pt. 1), hearings of Subcommittee on Health of the Elderly, Senate Special Committee on Aging, 90th Cong., 1st sess. (1967).

fessions; executives of large insurance companies, Blue Cross, Blue Shield and prepayment plans; union officials and representatives of management; Federal, State and local government employees; and lawyers and economists.

Those participating were divided into seven discussion groups, each of which considered one of the following topics and made recommendations on the topic assigned to it:

1. Among the various methods of organizing group practice, which should be encouraged? By what means?
2. What makes a good group? Why do some groups succeed and others fail?
3. What are the obstacles, legal and nonlegal, to the organization and expansion of group practice? What are the public and private roles in overcoming these obstacles?
4. Are there more imaginative uses of financing that can serve as incentives in the promotion of group practice?
5. What are the special problems associated with prepaid group practice and what are possible solutions?
6. How can consumer support be mobilized and sustained? What can be achieved through the labor-management partnership?
7. In what specific ways can group practice improve the efficient and effective use of the Nation's health manpower?

Among other recommendations, the discussion groups recommended that existing Federal health programs (such as Hill-Harris, Medicaid, the Appalachian Health Program, and Office of Economic Opportunity health programs) make maximum use of and encourage group practice; that Federal and State governments do as much as possible to eliminate such obstacles to group practice as restrictive State laws, Federal tax discriminations against professional corporations, discriminations by hospitals against group practice in staff appointments and bed allocations; and that Federal grants and/or loans be made available for "seed" or "startup" funds, capital construction, and personnel training.

E. National Advisory Commission on Health Manpower

The report of the National Advisory Commission on Health Manpower was issued during November 1967. This Commission was established by the President during the summer of 1966 to develop appropriate recommendations for action by Government or by private institutions, organizations, or individuals for improving the availability and utilization of health manpower.

Near the beginning of its report, the Commission stated: "There is a crisis in American health care * * *. The crisis, however, is not simply one of numbers * * *. Unless we improve the system through which health care is provided, care will continue to become less satisfactory, even though there are massive increases in cost and in numbers of health personnel * * *."

To increase the production of physicians and dentists, it was recommended that Federal grants and loans be made available to medical and dental students and that Federal funds in support of capital or operating costs of education be provided to a medical or dental school in such a way that they create economic incentives for the school to expand enrollment while improving its quality.

Regarding the nursing shortage, the Commission pointed out that "between 500,000 and 600,000 qualified nurses are not active in the nursing profession, although almost 300,000 of them have kept their licenses and registrations valid." For this reason, the Commission saw enticing trained nurses back to duty as offering a better possibility of curing the nurse shortage than increasing the output of new nurses. To do so, it recommended making nursing a more attractive profession by such measures as appropriate utilization of nursing skills, increased levels of professional responsibilities, improved salaries, more flexible hours for married women, and better retirement provisions.

The report discussed gaps in the distribution and quality of health care. To close the quality gap, the Commission urged improved licensure of health professionals, continuing education and relicensure, requiring foreign medical graduates to meet standards required of U.S. medical graduates, improved methods and requirements for monitoring new technologies, and improved procedures for peer review of the quality of medical advice and treatment.

The Commission recommended improved Selective Service and Defense Department policies and procedures to improve overall distribution and utilization of scarce medical personnel.

To improve hospital efficiency, the Commission recommended that the Federal Government and health insurance organizations introduce new formulas of payment which provide rewards for efficiency and high-quality care.

To control utilization, the Commission recommended underwriting by the Federal Government of a variety of experiments aimed at reducing utilization, that all health insurance organizations be encouraged to revise their payment methods to share savings with health care purveyors that demonstrate better control over utilization, and that there be a wide application of peer review of hospital utilization.

These and other recommendations in the report indicate the steps which a distinguished group of medical men and laymen believe should be taken to increase the quantity and quality of medical and health personnel to meet the needs of the Nation's population, including its elderly.

ITEM 2: REPORT ON MEDICARE PROGRAM

THE COMMISSIONER OF SOCIAL SECURITY,
Baltimore, Md., December 29, 1967.

DEAR SENATOR WILLIAMS: I am sorry that I am late in responding to your letter, dated December 11, 1967, requesting information on the medicare program for the annual report of the Special Committee on Aging on executive and legislative developments in aging during 1967.

I am sure you can appreciate the activity we have been engaged in for the last several months as the social security bill was being considered by the Congress. I hope that our delay has not held up the preparation of your report. We certainly appreciated the interest, emphasis and importance given to the medicare program in your 1966 report.

We are not able to give you all the information you requested on the operation of the medicare program for the 1967 calendar year. There is an unavoidable time lag in a claims processing operation before reliable data are available. Consequently most of our data are complete only for the first full year of the program—July 1, 1966 to June 30, 1967.

On your first request, we have a considerable amount of data on use of covered services for the first year of program operation, and these are reported in the R. & S. health insurance statistics report, "Current Data from the Medicare Program" which I have enclosed. In the report you will find data on the estimates of the number of persons hospitalized under part A and the number of persons using covered part B medical services up to June 30.

Our enrollment figures are not yet available for the year end either. Our most recent data are as of July 1, 1967, and show that about 19.3 million aged persons were covered under the hospital insurance program and 17.9 million under the supplementary medical insurance program. There was a net increase in number of eligible persons of only about 0.3 million during the first 6 months of this year. Our major enrollment effort was made during 1966 and the new open enrollment period for the supplementary insurance program started in October 1967 and will extend through March 31, 1968. The increase, therefore, was probably only a normal accretion to the benefit roles.

Concerning your second request, the fiscal intermediaries and carriers generally became quite current in their operations during the last year. I think that their progress to date can best be seen from the following figures. From January to October 1967, the weeks work on hand in the intermediaries for hospital insurance claims was reduced from 1.7 to 1 week. During the same period, the percentage of claims over 30 days old was reduced from 23.8 percent to 14.4 percent.

In the supplementary medical insurance program, the carriers reduced their weeks work on hand from 4.9 in January 1967 to 2.1 in October 1967. At the same time, they reduced the proportion of claims over 30 days from 24.7 percent to 14.3 percent. Rather than attributing these improvements to specific changes in policy or procedure, I think we would have to say that they are the result of the constant attention and management action both on the part of the carriers and our own staff. It was through the efforts of all that the personnel and systems problems of this program were overcome so that the claims could be processed as efficiently as possible.

Your last request was for information indicating the scope of medicare and its impact on the lives of the Nation's elderly. I am enclosing several reprints

from the July 1967 issue of the Social Security Bulletin which covers many of the facets of this question.

In addition to the information above, and in the enclosures, the Secretary of the Department of Health, Education, and Welfare will transmit to the Congress in the near future the first annual report on the operation and administration of the medicare program. I will send you a copy of that report as soon as it is available on the chance that there may be additional information you could use in your committee's report. I will also have a member of my staff call your office if other data or information becomes available which I think you might want to use.

Sincerely yours,

ROBERT M. BALL,
Commissioner of Social Security.

EXHIBIT 1: MEDICARE'S FIRST YEAR [1]

One year ago this month—on July 1, 1966—a major gap in the economic security of older Americans was closed. On that date, 18.9 million people in the United States aged 65 or over were enrolled for hospital insurance benefits under the new program of health insurance for the aged and 17.6 million voluntarily enrolled for supplementary medical insurance benefits. I would like to mark the first anniversary of operation of the program by briefly considering what it has already achieved in enhancing human values.

A year admittedly is a brief period on which to base an appraisal of the impact of a program of such magnitude. Yet, even in this short span, experience suggests some clear gains.

First and foremost, the program has provided the financial means to help older persons pay a major portion of their large bills for hospital and medical care. Those who incurred heavy medical expenses escaped some of the severe financial strains that so often plagued the aged in the past, depleted their savings, and required them to seek help from relatives or to demonstrate need to a public agency. Knowing that the protection is there when needed has added to the quality of life by alleviating the fear so many felt when contemplating the financial consequences of serious illness. Many who might have received care on a charity basis in the absence of the program have received it as insured patients with the dignity that goes with the ability to pay.

A second major accomplishment is the availability to the elderly of a wider variety of health services, again on an insured basis. Previously insurance covering hospital outpatient services, extended-care services, home health services, and physicians' home and office visits could rarely be purchased by the aged. Insuring alternatives to inpatient hospital care clearly has a beneficial effect on the use of insititutional facilities because it permits consideration of different levels of care with less concern for the financial cost to the patient. And since it enables the physician to select from a wider variety of services in prescribing care, it will tend to make medical care more responsive to the actual needs of the patient.

The program has already produced improvements in the quality of care in hospitals and related facilities through the upgrading of their physical plant, personnel, and services in order to meet the conditions for participation—a third significant accomplishment. In addition, because semiprivate accommodations are paid for by the program, and physicians' services for many of the elderly are more fully covered than in the past, many more now receive hospital care as private patients.

Fourth, the health insurance program has already provided needed hospital and medical care to many aged persons who might otherwise have postponed seeking medical care. More older people are getting care in hospitals—care some would otherwise not have received—and the quality of their lives, to the extent that their health problems have been taken care of, is better because of this program. For many, early treatment of illness and disease may mean postponement of disability and extended illness and a more useful and productive life.

The health insurance program for the aged has already succeeded in breaking down past racial barriers by requiring that participating hospitals and related

[1] Reprinted from the *Social Security Bulletin*, July 1967, U.S. Department of Health, Education, and Welfare, Social Security Administration.

health facilities be made available to all patients, as a basis of equality, regardless of race. In many communities, because of this program, minority group members for the first time have access to the best care available.

To conclude these brief observations on the first anniversary of health insurance under social security, we should not overlook the new patterns of cooperation and coordination that have been developed between various Federal departments and agencies, between Federal, State, and local government agencies, and between the public and private sectors. The various participants in this vast program with its complex relationships have performed their parts in a spirit of cooperation and understanding.

ROBERT M. BALL,
Commissioner of Social Security.

ITEM 3: REPORT OF 1967 ACTIVITIES, ADULT HEALTH PROTECTION AND AGING BRANCH, DIVISION OF MEDICAL CARE ADMINISTRATION, PUBLIC HEALTH SERVICE [1]

The change of the name of the Gerontology Branch to the Adult Health Protection and Aging Branch reflects increasing awareness of the fact that the health of the aged is to a great extent dependent on health protection measures taken during the middle years. The function of the branch is to overcome the barriers to optimal application of existing knowledge and technology which can reduce significantly the prevalence of disability—including both short-term disability of illness and long-term functional inability—and premature death.

Analysis of the barriers to optimal application of modern medical technology reveals three problem areas: lack of available health assessment services for the adult population; insufficient action by health professionals to protect adult health; and inadequate action by individual adults to protect their health. During the past year, the Adult Health Protection and Aging Branch has continued its three-pronged approach: development of health protection programs for adults, including the aging and aged; development of training and orientation programs for health practitioners who serve the health needs of aging and aged adults in our population; and development of activities and services designed to educate and motivate the population to follow through with health protection measures.

ADULT HEALTH PROTECTION

A new method of providing adult health assessment combines automated laboratory and functional testing with self-administered health history. Manpower is conserved by providing the physician with an array of data on the patient before the first visit, thus reducing the physician time required by eliminating the need for a second visit to complete a physical examination. Based on the amount of time currently spent by physicians on health assessment, as many as twice the number of persons can be served when this new system is utilized. Furthermore, the cost to the economy per amount of service given is reduced by organizing to achieve optimally efficient use of equipment. And, finally, an automated multiphasic screening center, organized to serve thousands of persons, is in a favorable position to efficiently provide high-quality services.

The methodology for providing automated laboratory and related individual health screening has been successfully demonstrated in a prepaid health plan at the Kaiser-Permanente Health Foundation through research and development programs supported largely by the Public Health Service. Branch activities have been directed toward testing and refining the methodology for application in various organizational settings for the community at large. Four demonstration programs currently are underway. The City of Milwaukee Health Department began offering services in July; Tulane University (New Orleans) in August; the Brookdale Hospital Center (Brooklyn) is expected to become operative in February 1968; and the program developed under the auspices of the Rhode Island State Health Department is expected to be prepared to offer health screening by the end of the year.

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[1] Prepared for the U.S. Senate Special Committee on Aging, Dec. 19, 1967, by P.H.S.

Tests and measurements provided in the screening programs include: screening tests for cardiac function (electrocardiogram); chest X-ray; ocular tension (tonometry); hearing (audiometry); pulmonary function (spirometry); cervical cytology (pap smear); retinal photography; visual acuity; and a number of laboratory tests including 12 blood chemistries, hematology, and urinalysis. In addition, questions concerning the past medical history, present symptoms, health habits, family history, and social history are self-administered.

In June, a working conference called by the Branch brought together representatives from each of the four prototype projects, outside experts and consultants, and concerned personnel from the Public Health Service. Their group purpose was to define a framework for evaluation, considering what specific information is needed to judge performance of an "adult health protection center," by what criteria "success" may be defined, and what answers might be expected from these programs within the next few years. The recommendations emanating from this conference provided the Branch with a valuable basis for developing specific procedures for implementation of the first stages of the evaluation plan.

In anticipation of a future need for information on which to base refinement of the methodology, the Branch contracted with the University of Southern California to develop a research design for a project identifying health characteristics of various strata of the population.

In August, a conference was called by the University of Rhode Island, supported through a contract with the Branch, which brought together approximately 100 representatives of New England agencies concerned with adult health. This conference, geared at imparting current knowledge about aging and adult health protection programs, was intended to stimulate the development of adult health protection programs in other localities in the New England area.

During the past year, three programs for aged, which offered health screening examinations utilizing traditional methods without automated laboratory procedures and computerization, were successfully completed. They were carried out in North Carolina, New Mexico, and Connecticut. Two of the three have been continued by the local health departments concerned. These programs successfully demonstrated: (1) that health maintenance services could be efficiently provided in a variety of geographic settings and to various socioeconomic groups; and (2) that they were a needed addition to health services in a community. A similar new contract has been negotiated with a local health department in New Jersey for the establishment of a well oldster conference.

PROFESSIONAL EDUCATION

It is becoming increasingly evident that the delivery of effective and appropriate health and health related services is being compromised by shortages in the supply of health personnel, as well as the paucity of teaching programs and resources necessary to train health professionals oriented to comprehensive health care. While these inadequacies affect the health status of the population in general, these are of critical significance to the adult health segment of the population, for it is this population group which is affected most by illness and disability.

Reports such as those of the Millis Commission and of the Ad Hoc Committee on Family Practice reveal that extant graduate training in medicine does not generally provide physicians with an orientation in comprehensive patient care. Contracts have been developed to stimulate interest in developing undergraduate medical curriculums which provide orientation in comprehensive patient management. The Adult Health Protection and Aging Branch has negotiated contracts with three medical schools—the School of Medicine of the University of Missouri, the School of Medicine of Tufts University, and the Mount Sinai School of Medicine of the University of New York City—each of which will develop a "blueprint" for a teaching program in comprehensive patient care.

A program has been developed at Meharry Medical College through which clinical experience is provided for dental and medical students in a community adult health maintenance program. At the University of Pennsylvania School of Social Work, a program now in its second year is providing supervised field experience for students in work with the aged. The Pennsylvania project has been most successful in generating interest among both faculty and students in this area, and serves as a demonstration to other schools.

For practicing physicians and other health professionals, graduate and continuing education courses are required to orient them to the unique health needs of the aged, and to alert them to new knowledge that is attained in this field. It is evident, however, that there is a significant paucity of adequately funded and well-organized activities for this purpose.

For several years, the Branch has been involved in providing initial support for the development of centers for continuing education in applied gerontology as components of university-based centers of continuing education. Such centers already have been developed at the University of Oklahoma and the University of Georgia. Two additional centers are in the developmental stages at Boston University and the University of Nebraska.

A contract wtih the Gerontological Society has produced an impressive curriculum in gerontology. Curriculum syllabi have been developed in four major fields. The Gerontological Society has been developing into a national resource for curriculum planning and development.

Under contract to the Branch, the Jewish Hospital of St. Louis conducted a study to evaluate the effectiveness of the program being carried out by the Gerontological Society The final report underscored the fact that the supportive resource materials for professional training activities developed and distributed by the Gerontological Society serves as a valuable adjunct to sorely needed continuing educational activities of health professionals who work with the aged.

The Adult Health Protection and Aging Branch has been involved in stimulating and providing professional consultation to the Menorah Medical Center in Kansas City to develop a year-round teaching program in comprehensive patient care. To date this medical center has offered 14 courses in various aspects of comprehensive patient management to health practitioners who have come not only from the Kansas City area but from as far west as Denver, and from Oklahoma, Illinois, and Connecticut.

An illustrated publication entitled "Office Evaluation of the Aging Patient: Disease Detection in Persons Over 45" was prepared by the Branch to encourage physicians to use a series of high-yield diagnostic tests and laboratory procedures as an integral part of regular health appraisal of adults. To gain knowledge about the reaction of the medical profession, the publication was mailed to a 2-percent stratified sample of all general practitioners along with a questionnaire. With no followup, almost 40 percent of the questionnaires were completed and returned. Sixty percent of the respondents indicated that the publication influenced their thinking; more than 75 percent recommended that the publication be sent to all general practitioners. Many unsolicited salutary remarks were received from respondents about the value of the publication and, in several instances, the recommendation was made that the brochure receive even broader distribution than general practitioners, and be sent to internists and other specialists as well as medical students.

ENCOURAGING INDIVIDUAL ACTION

One of the major activities of the Branch is developing and testing a method of providing personal health counseling which will motivate older adults to take positive action to protect their health. In most cases, such positive action takes the form of visiting their physician even in the absence of distressing symptoms. Whether or not this action has occurred after counseling is a primary criterion for evaluating success of the method.

During 1967, three health counseling projects supported by the Public Health Service in cooperation with the Social Security Administration became operative—in Milwaukee, Wis., Peoria, Ill., and New Orleans, La. All of these contracts are utilizing a similar population sample, individuals over 62 years of age or older who are new applicants for social security benefits. Each project is designed to secure information regarding common health maintenance practices held among a group of adults who are a high risk for chronic diseases. Such data will prove valuable in planning services for the older person, and evaluation of the findings is due in 1968. Preliminary data, however, indicates an increase in adequate health maintenance routines after counseling is provided. Three new contracts were developed in Fresno, Calif., Buffalo, N.Y., and Holyoke, Mass.

ENCOURAGING INDIVIDUAL ACTION TOWARD HEALTH PROTECTION

Reports on the sale and use of two Branch-produced films relating to health of the aging continue to be most encouraging. "The Critical Decades" deals with

the need for health protection during the forties and fifties to insure good health in later years. "Ready for Edna" focuses on the broad range of health services required for the elderly.

"The Critical Decades," offered for sale by the Center for Mass Communication of Columbia University Press, sells for $125. Of the 141 prints sold, 32 have been to local and/or State health departments, nine to heart associations, 12 to public libraries, and three to industry. Ten prints of "The Critical Decades" are in the AMA film library; prints of both films are distributed for free loan from the Public Health Service audiovisual facility in Atlanta. During the past year, "The Critical Decades" was loaned to 474 organizations, and "Ready for Edna" to 645 organizations. It is estimated that each film loaned is shown an average of 2½ times. The audiovisual facility reports that the demand for both films continues at the same high level.

Staff members have participated in various conferences on retirement planning with lay and professional groups.

SPECIAL STUDIES

A project funded by the Branch was developed on a contract with Washington University in St. Louis, calling for a national survey of physician's attitudes on the services rendered. The data has been collected and is under analysis; the final report is expected in the spring on 1968.

A contract was awarded to Community Studies, Inc., of Kansas City, Mo., for the purpose of developing the design and methodology for a study to determine the effect of changing socioeconomic forces on the utilization and provision of health services for the aged. The effect of medicare was a prime factor to be taken into consideration. Research grant support was ultimately awarded to the investigation, and this grant research has continued. A first round of data collection has been completed in five midwestern communities on a sample of persons over 60, physicians, and facilities offering health services to provide baseline data on use and provisions of health services and expectations for medicare. Information on experiences under medicare will be collected in a second round of data collection to be carried out in 1968. Papers on preliminary findings have been presented at such meetings as the American Public Health Association and the Midwest Sociological Society.

COORDINATION WITH OTHER AGENCIES

The Branch has provided professional staff as representatives for the Public Health Service to the Administration on Aging, Interdepartmental Committee on Aging, and the Task Force on Coordinated Services for the Aging. In the Department of Health, Education, and Welfare, consultation has been provided to staff members of the National Institute of Mental Health, the National Institute of Child Health and Human Development, the Bureau of Disease Prevention and Environmental Control, and the Medical Services Administration of the Social and Rehabilitation Service. In addition, consultation has been provided upon request to the Senate Special Committee on Aging.

ITEM 4: REPORT OF ACTIVITIES OF NIMH DURING YEAR 1967 IN THE FIELD OF AGING*

Today there are 20 million Americans above the age of 65. By the year 2000, an estimated 65 million persons will be in the over 65 population group. Given these present and future facts, it is appropriate that the mental health aspects of aging are among the major areas of scientific inquiry supported by the National Institute of Mental Health.

While medical science has increased longevity prospects, the complexities of modern life—urbanization, automation, new developments in knowledge and technology—pose problems of adaptation for aged persons far greater than those of earlier times and in other, simpler societies. The National Institute of Mental Health, as part of its research mission in the public health problems of aging, is providing support to a wide range of scientists, clinicians and behavioral science researchers who are directing their skills to solving the many problems involved

*Sent at the request of Chairman Williams by Stanley F. Yolles, M.D., Director of the National Institute of Mental Health, Jan. 17, 1968.

in maintaining the physical, intellectual, emotional and social functioning of older individuals. Through clinical studies, community demonstrations, and applied research endeavors, new techniques of treatment, care and rehabilitation are being developed that will permit the aged to fill meaningful and rewarding roles in American life.

The health problems of the aged are of greater magnitude than would be expected on the basis of the population figure alone. In addition to having many of the mental health problems common to other age groups, older people are vulnerable to specific difficulties associated with the aging process. Although some of the mental impairment of the aged is part of physical aging, psychological reactions to the physical process engender additional impairments that cannot be attributed to organic changes. Thus, the high incidence of depression, suicide, withdrawal, and regressive responses on the part of older people, are crucial study areas in the Institute program. Particular attention is also being given to handicaps, imposed by nonacceptance and loss of status in a youth-oriented society, which accelerated the psychopathological reactions of older persons.

The Division of Special Mental Health Programs in the NIMH is responsible for focusing and coordinating all the Institute's efforts and resources in this particular program area. In general, the Division has concentrated on stimulating and encouraging: (1) the incorporation of specific mental health considerations in programs for aging persons in which mental health components have previously been unrecognized or unacknowledged; (2) the provision of appropriate services for older people in mental health programs where this important segment of the population has been neglected; (3) services and research in areas in which innovative programs and knowledge are needed. Within the Institute, basic and applied research grants, training and manpower programs, hospital improvement projects, and intramural research have been involved in various aspects of aging program development.

RESEARCH STUDIES

An active program of research in the mental health aspects of aging is currently being supported through the Extramural Research Division of the Institute. During fiscal year 1967, approximately $2 million were distributed to 35 grantees. Nineteen of these grants are basic research studies concerned with areas such as the biological mechanisms of the aging process, clinical studies of psychiatric illness in the aged, and the social, psychological, and cultural influences related to satisfactory adjustment in later life. The investigators of the 16 applied research grants are concerned with identifying factors affecting mental health and testing out and demonstrating new and innovative methods of assisting older individuals to maintain optimum functioning. Research utilization of findings from these studies is intended to provide bases for more effective and rational planning to meet the needs of the aging.

For the past 10 years, Langley-Porter Neuropsychiatric Institute at the University of California Medical Center has been studying the incidence and manifestations of mental illness in the elderly population of San Francisco. This long-term, interdisciplinary research program was undertaken in order to contribute to policy, planning, and treatment for the mentally disturbed aged, and to add to the growing body of theory on aging as a developmental process. To date, three books and numerous articles have been published, providing authoritative psychiatric, physical, sociological, and anthropological data gathered from 600 elderly community residents and 534 elderly psychiatric ward first-admissions. Findings suggest that our society poses a series of adaptive tasks for the elderly which are more easily accomplished if the individual can sustain a relatively high level of involvement with others. Successful aging seems to be related to the ability to reevaluate one's life, and to the seeking of wisdom, rather than escape, in new-found leisure. While better educated oldsters seem to have an easier time with this phase, mastery can be achieved by oldsters in all socioeconomic groups. Elderly people who have withdrawn voluntarily from social relationships maintain higher morale than those forced to withdraw because of physical illness, widowhood, or other deprivations.

Funds have been awarded to Brookdale Hospital Center in Brooklyn, N.Y., to survey a random sample of aged individuals enrolled in a medical care program connected with the New York City Department of Welfare. This study has special significance since the investigators will attempt to identify and plan for the unmet mental health needs of a particularly vulnerable segment of the community's geriatric population, namely those in low-income groups.

Other projects dealing with the normal biological, psychological, and social components of the aging process in the noninstitutionalized geriatric population include: experimental studies of perception and memory; the relationship between different sociocultural patterns of living and the adjustment of women to menopause; the effect of late remarriage on the mental health of people over 60; and characteristics of the healthy aged.

The racial attitudes of older adults in and out of integrated settings are the focus of a 3-year study being conducted by the Senior Citizen Center of Nashville, Tenn. The attitudes and personality variables of older white and Negro participants in an integrated center are being compared with those of a control group of similar persons active in nonintegrated centers. Three hundred and twenty individuals, in four replication groups, are tested at 6-month intervals. Preliminary analyses of half the sample indicates that older Negroes: are less prejudiced than older whites; feel that they are different from both whites and other Negroes in that they value personal qualities rather than material objects or pleasure-oriented behavior; and believe they have less personal control over their environment, are more controlled by outside forces, than older whites.

HOUSING NEEDS

The National Institute of Mental Health has had a long continuing interest in the housing needs of elderly individuals and in how various types of housing can determine and influence the personal satisfaction and adjustment of people in later life. A project being conducted by the School of Public Health of the University of California at Los Angeles is studying the effects of special noninstitutionalized housing on elderly persons in good health. The first phase of this program was an extensive survey of low- and middle-income, rental and purchase, apartments, houses, and hotel units being built for the elderly, which resulted in the publication of a volume describing various types of housing in the State. Researchers are now studying the effects of different kinds of housing upon the mental, emotional, and physical well-being of the residents.

Investigators at the Philadelphia Geriatric Center are measuring the effects of the availability of social and medical services in housing projects for the aged, and identifying some of the characteristics of individuals who choose these types of group living arrangements rather than remaining in a larger, more heterogeneous community. Residents of eight different public, nonprofit, and commercial housing developments are being compared with one another and with community residents.

An important issue facing managers of public housing is the problem of maintaining their roles as landlords in the face of obvious needs for provisions of services. The Community Service Society of New York City is attempting to resolve this problem by giving special training to mature women, and placing them in public housing developments as information and referral sources for elderly residents. The program has been readily accepted by these older inhabitants, who have made the helpers' offices focal points for meeting, discussing their problems, and seeking information and help. The New York City Housing Authority has responded very favorably to the program and offered full cooperation in expanding it.

At the Institute for the Study of Retirement and Aging at the University of Southern California, researchers are identifying the needs which elderly persons wish housing to fill and estimating the extent to which they are met by various kinds of housing. This study is unique in that the data gathered will reflect what aged individuals, themselves, feel is important in housing and the extent to which their anticipated requirements affect their satisfaction with the housing into which they move.

EMPLOYMENT

Since our society excludes the aged from the world of work, it is essential that we learn more about reactions to retirement and ways of establishing new employment patterns for older citizens. Two grants are currently studying variables such as morale, role alteration, and uses of leisure time which affect adjustment to retirement.

A seriously neglected area is the role and function of elderly individuals in rural communities lacking the resources found in larger urban centers. A pioneering project in this area was organized by the University of Kansas School of Social Work. Elderly persons in Holton, Kans., were called upon to analyze and service the needs of the total community, not just the problems of their own

age group. They undertook community beautification projects, organized the county for OEO funds, stimulated the establishment of a taxicab service, generated publicity concerning community activity, and developed various home care services, thus benefiting both the community and themselves. The result was significantly higher morale for the elderly volunteer participants who felt that they had achieved a definite role in the community.

IMPAIRED OR INSTITUTIONALIZED AGED

The National Institute of Mental Health has also been supporting research dealing with the mental health aspects of aged persons with physical and mental impairment. Methods are being devised to locate and help impaired older persons within the community and special attention is being given to preventing unnecessary institutionalization. In Houston, Tex., a multidisciplinary team examined 112 individuals over the age of 65 who were referred to the county court for commitment proceedings. In about 75 percent of the cases, the team suggested an alternative to State hospitalization, and available community resources were mobilized to provide appropriate medical and psychiatric treatment. One of the findings of the project was that comprehensive evaluation and planning are necessary to enable older individuals to remain at a functioning level in the community.

For those aged who require institutional care, grantees are seeking ways to prevent further physical and psychological deterioration. The Hebrew Home for the Aged in Riverdale, N.Y., tackled this problem by establishing a sheltered workshop with scheduled hours and production standards. Participants in this workshop showed such significant improvement in morale and functioning that the institution took over the financing of the operation after the termination of the NIMH grant. This program has now been expanded to include residents whose physical handicaps and brain damage do not permit them to leave that part of the institution where they reside. Subworkshops have been established in the various living quarters, and special bedside facilities have been designed for nonambulatory patients.

The extent and nature of mental impairment among residents of homes for the aged is being investigated by the Council of Jewish Federations and Welfare Funds in New York City. Two hundred and fifty homes on the eastern seaboard were surveyed by questionnaire, and a representative sample was selected for more intensive study by a multidisciplinary team. Preliminary findings reveal that nearly two-thirds of the residents showed some symptoms of mental impairment, and almost one-third displayed signs of depression severe enough to justify the services of a psychiatrist. However, in only a small percentage of the cases did the personnel of the homes studied recognize the severity of the condition.

At the Home for the Jewish Aged in Philadelphia, a project is being supported to determine the effects of individualized treatment on mentally impaired older persons. Each patient is given a systematic physical, social, and psychological evaluation in order to identify the prime factors adversely affecting his level of functioning. The findings are used as a basis for formulating an integrated, organized treatment and service plan for each patient.

Some cases of apparent mental deterioration have turned out to be caused by undetected physical disabilities, such as loss of sight or hearing. Investigators at Rochester State Hospital in Minnesota made a study of the effect of physical impairment upon psychological function. Older patients were given a thorough examination by an audiologist to determine possible hearing loss. In feasible cases, correction and rehabilitative programs were undertaken, including surgery, provision of hearing aids, and cleansing of the auditory canal. It was found that patients, whose hearing was improved, demonstrated marked changes in ward behavior. The program has now been adopted by the State, and a hearing center has been established at Rochester State Hospital to serve all the hospitals in the Minnesota system.

Other grantees are contributing to increased knowledge about geriatric patients by providing information on the terminal phase of life and care of the dying, the effects of various milieu therapy programs upon inpatients and those discharged to various aftercare settings, the use of psychoactive drugs in the treatment of geriatric patients, sleep patterns in patients with chronic brain syndrome, and the biochemical bases of senile dementia.

The Institute has been actively engaged in improving the level of care for elderly patients in State mental hospitals through its HIP grant program. As of the end of fiscal year 1967, 17 projects directed specifically toward aiding geriatric State hospital populations were being supported.

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These projects hope to alleviate the tremendous problem posed by the larger number of aged residents in institutions for the mentally ill, through intensive efforts at medical and psychiatric diagnoses and comprehensive individual planning for the patient. Close attention is paid to milieu, and active remotivation programs are stressed. Attempts are being made to involve families and friends of the patient and to strengthen relations with community agencies. Several projects include preadmission screening and referral programs while others incorporate supportive followup services to community care facilities. Others address themselves to specific segments of the geriatric population, such as severely debilitated patients requiring considerable nursing care, chronic patients who have been long institutionalized, recent geriatric admissions, and patients showing the best chance of living independently outside the hospital.

At the Mendota State Hospital in Wisconsin, HIP funds were used to establish a Geriatric Treatment Center to provide intensive care for patients with the potential for independent living. During a 2-year period, more than half of the newly admitted patients were accepted for treatment on the project. Of this group of 200, almost 90 percent were capable of being discharged to alternative care facilities within 90 days after admission to the Geriatric Treatment Center. This continuing program is now housed in a new building designed to serve as a model for geriatric care.

A unique program at Kerrville State Hospital in Texas is demonstrating how a remote, isolated hospital for geriatric and long-term care patients, which lacks adequate staff and resources, can stimulate elderly, vegetating patients to care for themselves and maintain a more acceptable standard of behavior. A group of 90 women, mobile and in moderately good health, was moved to a renovated, partitioned ward. They were told that they were "ladies" and expected to behave as such. Lessons were given in self-grooming and the patients were required to bathe themselves and to buy or make their own clothes instead of having them issued. The milieu therapy stressed teaching self-reliance in pleasant, relaxed surroundings. The women responded positively and a men's ward is now in operation. It is expected that at least 250 patients will be included in this treatment program.

TRAINING

About $500,000 was awarded last year to 17 training programs in the areas of social work, geriatric psychiatry, and for training psychiatric nurses in the care of elderly psychiatrically ill patients. The psychiatry and nursing programs are located at Duke University in North Carolina, which maintains a Center for Studies of the Aged.

An increasing number of social work schools are responding to the need for manpower to provide services to the aged by preparing their students for careers in mental health and related programs. Graduate curriculum now includes seminars and courses dealing with geriatric problems and theory, as well as training and experience in group work and casework services to the aged in a variety of settings. The 14 schools with special training programs provide students with a broad range of field placements which include recreational and group work programs, community centers, hospitals, public housing developments, Golden Age clubs, homes for the aged, specialized social services for aged in social agencies, general hospital comprehensive care programs, nursing homes, and social service departments of medical schools. Field experiences are also available among groups such as retired workers in UAW Centers in Detroit, the "well" aged, aged with physical and mental disabilities, and indigent aged.

COMMUNITY MENTAL HEALTH CENTER PROGRAMS

Specialized services for the aged, which are part of comprehensive community mental health centers, are also being developed. Geriatric services are, for example, a program component in the Community Mental Health Center serving the South Boston and North Dorchester catchment area in which the Irish and Italian population has a significant proportion of adults in the 65 and over age group.

In California, where many aged reside, the San Luis Obispo Community Mental Health Center has an active program of medical, social, rehabilitation, family, and financial planning for older citizens. In collaboration with the Department of Public Welfare, the center provides consultation to all nursing homes and physicians in the county. The program's goal is to support and maintain general health at the maximum level, to prevent emotional problems, and to maintain

satisfying and meaningful functioning in the community. Prescreening and alternative community services are used to prevent unnecessary admissions to the State hospital 150 miles away. For those who are returned to the community after hospitalization, the center not only coordinates appropriate aftercare services but also becomes involved in the planning for the patient while he is still hospitalized. Home visits are made to older persons living in the remote areas of the county to familiarize them with the services available at the center and to encourage their utilization.

OTHER ACTIVITIES

The release of elderly patients from State hospitals to the community was the subject of a 2½-day conference funded by the National Institute of Mental Health and convened by the American Public Welfare Association. Conference participants included State public welfare and State mental health administrators as well as experts serving as resource persons. The meeting provided an opportunity for informal, frank, and significant discussion of the special problems of this important group of persons in the older population. Participants considered present services, apparent gaps, and directions which might be taken in planning and developing programs and services for these returnees. The mutual interests, goals, and concerns of the field of mental health and public welfare were clearly communicated throughout the conference discussions. A published report of conference proceedings will be available in the near future.

The Survey of Health Frauds Affecting the Elderly, recommended to the Institute by the Special Committee on Aging, is now underway with cooperative funding from seven Federal agencies. Immediate supervision of the study is being carried out by the Food and Drug Administration under general guidance provided by the steering committee composed of members from each of the sponsoring agencies. It is anticipated that the study will be completed during the coming year.

ITEM 5: MAJOR PROVISIONS OF 1967 LEGISLATION RELATED TO HEALTH

A. Public Law 90–174, Partnership for Health Amendments of 1967 (Dec. 5, 1967)

1. Extends and expands the existing program of formula and project grants for comprehensive health planning and public health services;
2. Consolidates and expands existing authorities in the Public Health Service Act for research and demonstrations relating to the provision of health services;
3. Establishes a new program for licensing clinical laboratories that solicit or receive specimens in interstate commerce;
4. Extends and expands the existing program of grants for schools of public health;
5. Authorizes Public Health Service health care facilities to (*a*) accept the uncompensated services of volunteers, (*b*) cooperate in the interchange and sharing of scarce or highly specialized health resources, (*c*) assist in community planning to meet health needs in the case of emergencies or disasters, and (*d*) provide health services to Federal employees at remote stations and to certain seamen-trainees;
6. Permits the use of not to exceed 1 percent of funds appropriated for certain grant programs to be used for program evaluation purposes;
7. Extends the existing contract authority of the Public Health Service Act;
8. Amends the Hill-Burton Act to authorize the loan of not to exceed two-thirds of the additional costs of an experimental hospital construction project where costs have risen substantially following initial approval of the project;
9. Amends the Nurse Training Act to define "federally sponsored students" as including those nurse students awarded loan funds from the nurse student revolving fund or an educational opportunity grant payment;
10. Increases from 12 to 13 the number of members of the National Advisory Council on Education for the Health Professions to be chosen from the fields of higher education;
11. Adds the Trust Territory of the Pacific Islands to the jurisdictions eligible for grant assistance under section 314 of the Public Health Service Act; and

12. Authorizes the Secretary of Health, Education, and Welfare to make a comprehensive survey of serious hunger and malnutrition and health problems related thereto in the United States.

B. Public Law 90–31, Mental Health Amendments of 1967 (June 24, 1967)

1. Authorizes for 3 additional years, through June 30, 1970, the appropriation of funds to continue the existing program of matching grants for the construction of community mental health centers, which authorization would have expired on June 30, 1967.

2. Authorizes for 2 additional years, through June 30, 1970, appropriations for initiating and continuation of staffing grants on a matching basis for community mental health centers.

3. Amends the definition of the term "construction" to permit the acquisition of existing buildings for community mental health centers.

4. Requires State plans to provide for enforcement of State standards for the maintenance and operation of community mental health centers.

5. Makes Federal hospitals eligible for Public Health Service funds for research, training, and demonstration projects on the same terms and conditions as non-Federal institutions.

C. Public Law 90–99, Vocational Rehabilitation Amendments of 1967 (Oct. 3, 1967)

The committee received the following letter summarizing this new public law and discussing its implications for the elderly:

Department of Health, Education, and Welfare,
Social and Rehabilitation Service,
October 30, 1967.

Hon. George A. Smathers,
U.S. Senate,
Washington, D.C.

Dear Senator Smathers: This is in response to your letter of October 13, 1967, concerning the impact of the Vocational Rehabilitation Amendments of 1967 on older Americans.

The recent amendments to the Vocational Rehabilitation Act extend through fiscal years 1969 and 1970, the appropriation authorization for grants to States for the basic program of vocational rehabilitation services for handicapped individuals under section 2 of the act. They authorize 1 additional year of appropriations for support of statewide planning in vocational rehabilitation by the States, through June 30, 1968. They also authorize the Secretary of Health, Education, and Welfare to enter into an agreement with a public or nonprofit private agency or organization for the establishment and operation of a National Center for Deaf-Blind Youths and Adults; authorize a program of project grants to States for providing vocational rehabilitation services to handicapped migratory agricultural workers and members of their families; require that vocational rehabilitation services be provided by State vocational rehabilitation agencies without regard to the place of residence of the handicapped individual; and provide a fixed allotment percentage for the District of Columbia. A substantial number of older workers, those 45 or over, will, of course, benefit from all of these proposals.

For example, the establishment of a National Center for Deaf-Blind Youths and Adults will be of great assistance to older workers. It is estimated that 65 percent of those persons benefiting from the center will be in the 45 or older age group. In a similar manner, the provision concerning migratory workers is designed to provide services to an estimated 40,000 migrant workers of which it can be assumed that a large number would be in the older worker cotegory. Grants will be made to the States to pay the cost of services to assist migrant handicapped individuals to return to gainful employment.

Even though the Vocational Rehabilitation Amendments of 1967 do not contain any specific provisions which affect the aged as a group, we expect to give increased emphasis to rehabilitation activities for older Americans as a result of the recent reorganization of several of the agencies of the Department of Health, Education, and Welfare, including the Administration on Aging, into the Social and Rehabilitation Service. One of the benefits expected to come out of

this reorganization is the facilitation of joint cooperative planning and action by the Rehabilitation Services Administration and the Administration on Aging. I can assure you that efforts will be directed to a large extent to people age 65 and over.

Sincerely,

MARY E. SWITZER, *Administrator.*

ITEM 6: AMERICAN MEDICAL ASSOCIATION RESOLUTION ON MEDICARE 3-DAY REQUIREMENT

AMERICAN MEDICAL ASSOCIATION RESOLUTION*

Whereas, Public Law 89–97 requires that a patient be hospitalized in an approved general hospital at least 3 days immediately preceding admittance to an extended care facility; and

Whereas, There are many patients whose conditions do not warrant hospitalization in a general hospital, but who do need the nursing care and attention provided by an extended care facility; and

Whereas, The 3-day hospital requirement sometimes causes unnecessary hospital bed occupancy, and increased cost to taxpayers; and

Whereas, The provisions for participation in the medicare program by an extended care facility call for a review of newly admitted patients by a utilization review committee of the facility; and

Whereas, The medical decisions as to what type of facility the patient can best be served by is the responsibility of the attending physician; therefore be it

Resolved, That the American Medical Association be encouraged to use all its resources, facilities and influence to have deleted the 3-day hospitalization requirement in a general hospital prior to admittance to an extended care facility.

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* Adopted at Philadelphia meeting of A.M.A. House of Delegates in Dec. 1965; reaffirmed by House of Delegates in Atlantic City, N.J., June 1967.

Appendix 6

MATERIAL RELATED TO HOUSING FOR THE ELDERLY*

ITEM 1: REPORT ON HOUSING FOR SENIOR CITIZENS IN 1967**

INTRODUCTION

The Department of Housing and Urban Development administers a wide and varied array of programs which provide financial assistance to public and private sponsors for the development of rental housing specially designed for senior citizens and the physically handicapped. These programs vary primarily on the basis of the type of financing, sponsorship, and the income group which will occupy the housing. The low-rent public housing program provides housing for the lowest income group; the direct loan program is utilized by nonprofit sponsors to build housing for those with lower-middle incomes; and for the elderly and handicapped in a wider income range, the FHA section 231 mortgage insurance program is available to both nonprofit and profit-motivated sponsors.

In addition, the Housing and Urban Development Act of 1965 permits housing for the elderly and handicapped developed under the FHA section 221(d)(3) market interest rate program to be eligible for rent supplements on behalf of low-income occupants. Eligible sponsors include private nonprofit corporations, cooperatives and limited dividend mortgagors. In addition, supplementary rent payments may be paid on behalf of certain low-income tenants, including the elderly, in some FHA section 221(d)(3) below-market and FHA section 231 projects and also in direct loan developments for the elderly.

While these are the programs in HUD which provide assistance particularly for rental housing for the elderly, the Department also administers a number of other programs which are of significant benefit to the Nation's senior citizens. For example, the FHA's section 232 mortgage insurance program provides mortgage insurance for profit-motivated and nonprofit sponsored nursing homes. While nursing homes provide care for all age groups, the elderly are the largest group by far to use such facilities. For older people who want to and are able to afford their own homes, the FHA offers mortgage insurance for the purchase of homes under its section 203 and section 221 sales housing programs. In 1966, the Demonstration Cities and Metropolitan Development Act included a new program authorizing the FHA to insure mortgage loans to private nonprofit corporations to finance the construction or rehabilitation of, and the purchase of equipment for, facilities for the group practice of medicine, dentistry or optometry. All age groups will benefit through the use of facilities developed under this program, but the elderly can be expected to benefit particularly.

HUD's Renewal Assistance Administration is responsible for administering the neighborhood facilities grant program under which grants for neighborhood facilities such as multipurpose senior centers are available. The RAA also administers the direct loan and grant programs which assist homeowners to rehabilitate their homes in urban renewal and concentrated code enforcement areas. Both programs can be very helpful to the many elderly people who reside, often in disproportionate numbers, in those areas subject to renewal and code enforcement.

The low income housing demonstration program, administered by the Office of Urban Technology and Research, provides grants to assist in the development of improved means of providing housing for the low-income population. A number of grants have been made which relate specifically to older people under this program.

*See ch. IV for discussion of matters related to this appendix.

**Prepared at the request of the Committee and submitted on Jan. 31, 1968, by Mr. Robert C. Weaver, Secretary, Department of Housing and Urban Development.

The model cities program, which has just begun to be fully operational with the announcement of the planning grant awards to cities in November 1967, also can be expected to make real contributions to the elderly and HUD's senior citizens housing programs will be available for the development of better housing for the older residents of those areas. President Johnson has directed that HUD give special attention to the needs of older people in poor housing and decaying neighborhoods included in the model cities areas.

PROGRESS AND ACTIVITY IN 1967

Through the end of 1967, HUD's low-rent public housing program, together with the section 202 direct loan program and FHA's section 231 program, had made net commitments for a cumulative total of over 231,500 specially designed units for the elderly. In 1967 alone, nearly 42,000 units were approved under these three programs, compared to about 29,500 in 1966. By the end of 1967, the cumulative total of specially designed units placed under construction in these three programs reached a total of nearly 165,500, compared to about 139,500 at the end of 1966. The year 1967 marked the first when the cumulative total completed under these three programs passed the 100,000 level. At year's end, the total completed amounted to 122,700 units, compared to 96,000 at the end of 1966, or an increase of 26,700 units. In 1966, by comparison, slightly over 24,000 units were completed.

RENT SUPPLEMENT ACTIVITY UNDER THE FHA SECTION 221(D)(3) MARKET RATE PROGRAM

As of the end of 1967, a total of 32 rent supplement projects were being planned for occupancy by the elderly and handicapped under FHA's section 221(d)(3) market interest rate mortgage insurance program. These 32 projects involved reservations or contracts for annual rent supplements totaling over $2.3 million and will contain about 2,500 units, the great majority of which (98 percent) will be eligible for rent supplements.

Fifteen of these 32 projects will be sponsored by nonprofit organizations and are planned to include a total of about 1,700 units with rent supplement reservations or contracts providing for up to slightly over $1.5 million annually. The 17 projects sponsored by limited dividend corporations will have over 800 units with reservations or contracts for up to about $800,000 annually in supplementary assistance.

Geographically, these 15 nonprofit projects will be developed in 11 States, while the 17 projects sponsored by limited dividend corporations will be distributed among only four States, with nine in Washington and four in Orgeon.

As of the end of 1967, formal applications for mortgage insurance had been received for 13 of the 32 projects. Of the 13 projects, eight with a total of over 850 units, received FHA commitments for insurance during 1967 and two with a total of about 100 units were placed under construction during the year. These commitments and construction starts are in addition to those noted previously, relating to the low-rent, section 202 and section 231 programs.

As of the end of the year, approximately $30.7 million of the $37.8 million available for allocation under the 221(d)(3) market rate program had been reserved. Of the $30. 7 million, over $2.3 million, as noted above, had been reserved for the elderly and handicapped in housing specially to be designed for their occupancy. In addition, it is anticipated that many low-income elderly people also will be among the occupants and beneficiaries of the approximately 300 projects already planned for all age groups with rent supplement allocations under the 221(d)(3) market rate program, as well as of the 39 projects with rent supplement allocations under the 221(d)(3) below-market rate program.

RENT SUPPLEMENTS UNDER THE SECTION 202 AND SECTION 231 PROGRAMS

Five percent of the rent supplement funds may be used to assist low-income elderly or handicapped occupants of section 202 and section 231 senior citizens housing projects under the experimental provisions of the rent supplement program. As of the end of 1967, over $1.7 million of the total $2.1 million available for rent supplement contract authority under these two programs had been allocated.

These allocations had been made for 124 projects in slightly over 100 cities in 35 States, estimated to provide assistance for occupants of 2,800 units of the approximate 15,000 units included in these projects.

As of the end of 1967, almost 100 section 202 and section 231 projects were receiving rent supplement payments or were under contracts providing for maximum annual payments of about $1.3 million. In these projects, it is estimated that occupants of over 2,000 units of the total 12,000 units in those projects could be receiving this important rent assistance. The other 25 projects with a total of 3,400 units had reservations for annual supplements totaling nearly $500,000 for occupants of about 750 units. Direct loan projects intended for occupancy by the lower-middle income elderly represent the great majority of the senior citizens developments participating in the rent supplement program under these experimental provisions.

IMPLICATIONS OF ACTION BY CONGRESS ON THE RENT SUPPLEMENT PROGRAM IN 1967

At the end of 1967, the total of all rent supplement reservations, contracts, and applications in process amounted to about $47.2 million. As of February 9, 1968, the total volume amounted to approximately $52 million, or $10 million above the total rent supplement contract authority appropriated by the Congress, including the increase of $10 million authorized for fiscal 1968. Because this increase is substantially lower than the authorization requested for fiscal 1968, the Federal Housing Administration has had to reassess the program and redefine its program goals and schedules.

To facilitate an effective and expeditious allocation of the severely limited additional funding, HUD regional offices and FHA insuring offices have been advised that all requests for reservations of rent supplement funds were to be evaluated based on the following project criteria:

1. Can the proposal be under construction or can rehabilitation begin within 90 days after a reservation of funds has been approved?
2. Does the proposal involve rehabilitation?
3. Is the proposal located in a "core city" neighborhood?
4. Will the proposal serve a significant percentage of larger families?
5. Is the proposal in a locality not already having or scheduled to have a rent supplement project?
6. Is the proposal located in an urban renewal area?
7. Will the proposal emphasize low cost and modest design?
8. Does the management planning for the proposal encompass an acceptable program for securing full utilization of existing social, technical and economic services available in the community for low-income families?

There is no implication in redefining the goals of the rent supplement program that proposals for housing for the elderly are unacceptable, and applications will continue to be processed on a case by case basis. However, with the volume of applications already far beyond the level that can be reserved under current authority, it is clear that many applications will be rejected simply because of the lack of funds. Until the authority to contract for rent supplements is increased, many sponsors, interested in increasing the supply of good housing for low income Americans, including the elderly, will be unable to participate in this crucial program. Most important of all, decent housing for thousands of low-income people will be delayed or denied.

THE INSURANCE INDUSTRY'S $1 BILLION INVESTMENT FUND

A vital aspect in the development of the rent supplement program was its emphasis on the role of the private sector. It was and is expected that substantial amounts of private capital would flow into the construction of low-income housing as a result of the enactment of the program. The first clear demonstration that this would occur was the announcement in September 1967 by a number of major insurance companies, of the creation of a $1 billion investment program for low-income housing purposes, and a pledge and primary emphasis first to purchase mortgages on section 221(d)(3) rent supplement projects when the mortgage is at the market interest rate of 6 percent. The billion dollar fund will not be pooled. Instead, each participating company will select the mortgages it wishes to purchase from among the mortgages referred by the FHA to a central committee established by the various companies. In addition to mortgages on multifamily housing, the fund also will be used to purchase mortgages on single family homes located in older or blighted neighbor-

hoods, providing significant assistance for families seeking to purchase homes in inner city areas. It should be recognized that arrangements for permanent financing from other sources may be made for a substantial portion of the mortgages referred to these insurance companies.

The first criterion for purchase under this program is that the mortgage be insured by FHA. Secondly; the projects are to provide low-income housing in or near urban slum areas; however, projects located outside the city core areas offering relocation housing for present slum dwellers also qualify. Finally, the program is designed to provide financing for projects intended to serve families currently living in substandard urban housing or those displaced by urban renewal projects.

By the end of the year, a total of $310.5 million in mortgages had been referred to the central committee, including both multifamily as well as home mortgages. Through November 1967, the companies had issued firm commitments to purchase $49.1 million of the mortgages from among those referred. These included 29 multifamily projects with about 3,700 units and mortgages of $45.4 million—the very large majority, mortgages on rent supplement projects. The commitments also included mortgages on nearly 350 homes in the amount of $3.7 million.

In addition to the firm commitments, the companies were reviewing and negotiating for the purchase of an additional $38 million of the mortgages referred to them, including 20 multifamily projects with over 2,000 units and mortgages of $19.3 million, and about 1,350 homes with mortgages of $18.7 million.

FIVE PERCENT EQUITY REQUIREMENT

In its report on the Independent Offices and Department of Housing and Urban Development Appropriations bill for fiscal 1968, the Senate Committee on Appropriations stated that "in every rent supplement project the sponsor shall be required to provide at least a 10 percent equity investment, except for nonprofit organizations; 5 percent of assistance is sought under the special assistance program of FNMA." While there is no language in the law requiring such investment, HUD will be guided by the language in the committee report in allocating the $10 million authorized in additional contract authority for this fiscal year. This equity requirement may prove difficult to nonprofit sponsors in particular. Fortunately, financing through the insurance company fund does not necessitate the equity investment required by the committee report when FNMA special assistance funds are used.

ACTIVITY IN LOW RENT PUBLIC HOUSING

With the great need for better housing among the elderly in the low-income group, it is fitting that low-rent public housing continues as the largest single program helping to meet that need. In 1967, there was a net increase of over 35,500 units for the elderly approved for annual contributions contracts compared to about 21,500 units in 1966. This brought the net total of units approved for the elderly by the end of 1967 up to approximately 155,500. Cumulative construction starts through 1967 amounted to about 96,000 units, of which over 18,500 were started in 1967, compared to about 19,800 in 1966. The cumulative total of units completed through 1967 amounted to over 68,000, with over 16,000 completed in 1967, about the same number completed in 1966. Older people also occupy non-specially designed low-rent units and as of September 30, 1967, there were 325,000 elderly persons in total occupying public housing. A table attached which shows the State distribution of projects with units for the elderly with annual contributions contracts executed through 1967,[1] and another showing the location, size and number of units for the elderly in projects placed under contract during 1967.

[1] For public housing activity for 1967 refer to chapter IV on p. 76.

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT LOW RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED DURING 1967—SOME OR ALL UNITS DESIGNED FOR THE ELDERLY

[Dollar amounts in thousands]

Location	Number of housing units		Total development cost
	Total	Elderly	
Alabama:			
Berry	22	8	$374
Fayette	70	40	931
Guin	50	20	752
Guntersville	50	50	752
Hobson City	40	6	646
Jacksonville	50	20	713
Leeds	40	10	600
Lineville	20	10	317
Millport	20	14	280
Montgomery	101	101	1,528
Opelika	100	20	1,560
Ozark	70	30	1,005
Pisgah	20	10	316
Scottsboro	26	14	417
Stevenson	50	23	772
Union Springs	60	20	927
Winfield	50	16	761
Total, Alabama	839	412	12,651
Arizona: Nogales	100	20	1,660
Arkansas:			
Alma	42	26	665
Brinkley	96	40	1,525
Caraway	30	20	457
Decatur	34	14	513
Fayetteville	200	120	3,159
Forrest City	200	100	2,972
Hickory Ridge	16	12	253
Lake City	20	10	303
McGehee	58	20	955
McRae	16	10	237
Magnolia	110	110	1,712
Malvern	125	75	1,951
Marianna	24	20	372
Trumann	80	40	1,330
Total, Arkansas	1,051	617	16,404
California:			
Contra Costa County (L)	500	260	10,164
Fresno (L)	200	50	3,688
Indio (L)	90	40	1,441
Port Hueneme	60	60	994
San Francisco	120	120	2,096
	500	250	10,597
Santa Barbara marketing area(L)	400	200	7,502
Total, California	1,870	980	36,482
Colorado:			
Salida	50	50	794
Wellington	16	12	257
Total, Colorado	66	62	1,051
Connecticut:			
Ansonia	4	4	66
East Hartford	100	100	1,753
Milford	50	50	870
New Haven (L)	100	20	2,899
Norwich	21	21	364
Total, Connecticut	275	195	5,952
Delaware: Wilmington	120	60	1,761

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT LOW RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED DURING 1967—SOME OR ALL UNITS DESIGNED FOR THE ELDERLY—Con.

[Dollar amounts in thousands]

Location	Number of housing units		Total development cost
	Total	Elderly	
Florida:			
Dunedin	50	20	$790
Gainesville	100	100	1,430
Hialeah	200	200	2,792
Miami	166	166	2,672
	600	600	9,062
	845	329	15,217
	56	56	668
	48	48	725
Pahokee	200	50	3,038
Pinellas County	100	100	1,123
Punta Gorda	80	50	1,198
Sarasota	101	101	1,638
Titusville	121	121	1,960
Total, Florida	2,667	1,941	42,313
Georgia:			
Americus	50	24	739
Atlanta (L)	500	85	8,075
	202	6	3,734
	220	8	3,975
Cairo	60	20	1,021
Douglas	70	70	853
Folkston	54	14	843
Fort Oglethorpe	40	16	645
Pembroke	38	10	594
Reynolds	20	14	310
Summerville	70	30	1,124
Vidalia	50	20	751
West Point	110	25	1,813
Total, Georgia	1,484	342	24,477
Hawaii: Honokaa-Hawaii	40	40	646
Idaho: Buhl	40	40	617
Illinois:			
Anna	80	50	1,309
Canton	120	120	1,952
Carbondale	150	100	2,789
Chicago (L)	1,000	500	16,273
Cobden	20	10	314
Fairfield	100	100	1,603
Galesburg	200	200	3,295
Jacksonville	102	102	1,512
Niles	127	127	1,812
Percy	12	8	183
Quincy	104	104	1,671
Rockford	183	183	2,795
	502	418	7,986
	187	187	3,089
Steelville	14	14	213
Taylorville	100	100	1,596
Thebes	10	4	156
Ullin	12	6	208
West Frankfort	80	80	1,354
Xenia	12	8	204
Total, Illinois	3,115	2,421	50,314
Indiana:			
Bloomfield	40	40	661
	52	40	859
Fort Wayne	102	102	1,641
Jeffersonville	100	100	1,658
Mishawaka	115	115	1,950
Tell City	80	80	1,322
Total, Indiana	489	477	8,091
Iowa:			
Farragut	20	16	345
Onawa	60	60	946
Sioux Center	40	40	573
Tabor	20	14	348
Total, Iowa	140	130	2,212

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT LOW RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED DURING 1967—SOME OR ALL UNITS DESIGNED FOR THE ELDERLY—Con.

[Dollar amounts in thousands]

Location	Number of housing units		Total development cost
	Total	Elderly	
Kansas:			
Anthony	46	40	$606
Atchison	164	114	2,743
	36	36	523
Bird City	20	14	317
Bonner Springs	50	30	827
Colby	40	40	666
Dodge City	180	120	3,057
Hanover	18	14	296
Holton	60	50	966
Horton	50	40	803
Linn	12	8	191
Oberlin	30	30	502
Seneca	50	42	823
South Hutchinson	150	100	2,400
Topeka	102	102	1,735
	109	109	1,763
Washington	50	42	793
Wichita (L)	200	200	2,592
Total, Kansas	1,367	1,131	21,603
Kentucky:			
Ashland	140	140	2,311
Barbourville	75	30	1,282
Bardstown	70	26	1,194
Covington	200	200	2,928
Harrodsburg	80	40	1,234
Knott County	60	16	1,078
Martin	32	20	576
Olive Hill	50	20	837
Owenton	32	16	558
Paintsville	40	15	700
Stanford	50	20	836
Sturgis	46	14	772
Vanceburg	40	10	719
Total, Kentucky	915	567	15,025
Louisiana:			
Allemands	12	4	186
Central Union area	36	10	543
Convent area	30	10	477
Edgard	34	10	433
Estherwood	20	10	300
Garyville	42	10	687
Hahnville	50	20	776
Hymel area	44	8	708
Lafayette	394	250	6,495
La Place	122	34	1,953
Luling	66	24	1,024
Lutcher-St.	76	24	1,215
Mermenteau	34	20	508
Ponchatoula	40	14	685
Reserve	84	14	1,365
Ruston	120	24	1,811
Vacherie	72	24	1,141
Vivian	30	20	474
White Castle Town	42	12	695
Total, Louisiana	1,348	542	21,576
Maine:			
Auburn	100	100	1,693
Brunswick	75	75	1,365
Lewiston	47	47	1,862
Total, Maine	222	222	4,920
Maryland:			
Baltimore (L)	420	150	8,528
	250	55	5,983
Montgomery County (L)	100	6	2,069
Total, Maryland	770	211	16,580

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT LOW RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED DURING 1967—SOME OR ALL UNITS DESIGNED FOR THE ELDERLY—Con

[Dollar amounts in thousands]

Location	Number of housing units		Total development cost
	Total	Elderly	
Massachusetts:			
Boston	36	36	$675
	2	2	41
	168	168	2,890
	436	360	8,275
	96	96	1,750
Brookline	100	100	1,879
(L)	100	90	1,778
Cambridge (L)	400	300	7,216
Chicopee	157	121	1,493
Fall River (L)	200	50	4,860
Fitchburg	40	40	712
Malden (L)	100	100	1,585
Medford (L)	50	50	790
Newton	56	56	1,065
Waltham (L)	100	50	1,925
Worcester	115	115	1,945
	26	26	406
	150	150	2,308
Total, Massachusetts	2,332	1,910	41,587
Michigan:			
Benton Township	100	100	1,535
Cadillac	75	75	1,254
Calumet Village	50	50	802
Dearborn	135	135	2,293
Detroit	206	206	3,423
Flint	13	13	150
	90	90	1,360
Hancock	86	50	1,473
Inkster	200	200	3,327
Jackson	68	68	1,175
Laurium Village	30	30	503
Lincoln Park	8	8	131
Livonia	79	79	1,330
Marquette	140	140	2,303
Pontiac	234	234	2,773
Royal Oak Township	48	10	769
Saginaw	105	105	1,697
	128	128	1,751
St. Clair	2	2	33
St. Louis	40	30	716
Stambaugh	28	28	465
Sturgis	70	70	1,186
Wayne	6	6	102
Total, Michigan	1,941	1,857	30,551
Minnesota:			
Blue Earth	60	60	1,000
Crookston	75	75	1,119
Duluth (L)	300	145	5,743
International Falls	80	80	1,294
Minneapolis	350	350	5,864
	901	876	15,285
(L)	750	500	15,011
Montevideo (L)	40	40	629
North Mankato	76	76	1,255
Perham	35	35	579
St. Paul (L)	1,185	210	22,788
	170	170	2,886
Sauk Centre	40	40	661
Thief River	80	80	1,314
Two Harbors	60	60	1,016
Walker	32	32	521
Winona	130	130	1,985
Total, Minnesota	4,364	2,959	78,950
Mississippi: Amory	60	30	841

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT LOW RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED DURING 1967—SOME OR ALL UNITS DESIGNED FOR THE ELDERLY—Con.

[Dollar amounts in thousands]

Location	Number of housing units		Total development cost
	Total	Elderly	
Missouri:			
Fulton	100	50	$1,677
Gideon	34	20	527
Houston	70	50	1,165
Kansas City (L)	200	150	2,973
Marceline	62	50	963
Osceola	76	38	1,150
Plattsburg	30	20	482
Poplar Bluff	114	114	1,828
	6	6	96
Portageville	50	16	797
Sikeston	75	75	1,246
Smithville	76	60	1,260
Total, Missouri	893	649	14,164
Nebraska:			
Aurora	38	38	645
Bassett	20	14	346
Bayard	20	20	523
Kearney	80	80	1,281
Lincoln (L)	600	330	1,039
Lyons Village	20	16	332
Minatare Village	20	16	336
Morrill Village	24	20	400
Omaha	750	750	11,996
Plattsmouth	60	60	1,019
Tekamah	26	26	407
Terrytown-Scotts Bluff	64	20	1,176
Washington Township	122	122	1,724
Wood River Village	20	20	306
Total, Nebraska	1,864	1,532	21,324
Nevada: North Las Vegas (L)	250	40	5,782
New Hampshire:			
Laconia	4	4	67
Lebanon	70	30	1,320
Manchester (L)	190	112	3,622
Total, New Hampshire	264	146	5,009
New Jersey:			
Bayonne	252	252	4,659
Brick Township	120	120	2,243
Camden	108	108	1,873
Carteret	50	50	896
Linden	200	200	3,535
Neptune Township	75	75	1,374
Newark	500	150	10,031
Plainfield	225	225	3,986
Red Bank	50	50	916
Vineland	150	150	2,586
Total, New Jersey	1,730	1,380	32,099
New Mexico:			
Albuquerque (L)	300	75	5,080
Eunice	20	14	320
Fort Sumner	26	12	415
Las Vegas City	100	40	1,598
Maxwell	12	6	189
Truth or Consequences	70	70	1,054
Total, New Mexico	528	217	8,656

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT LOW RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED DURING 1967—SOME OR ALL UNITS DESIGNED FOR THE ELDERLY—Con.

[Dollar amounts in thousands]

Location	Number of housing units		Total development cost
	Total	Elderly	
New York:			
Auburn	50	50	$787
Buffalo	12	12	209
(L)	200	100	4,254
Dunkirk	100	100	1,800
Elmira	46	46	790
Freeport	40	40	734
Geneva	26	26	477
Gloversville	50	34	893
Hudson	140	50	2,696
Ilion	152	100	2,839
Ithaca	220	152	4,330
Long Beach (L)	25	5	434
Massena	150	100	2,794
Newburgh (L)	250	150	4,944
	65	65	953
New York City	336	134	6,670
	236	196	4,285
	357	234	7,110
	112	84	2,220
	287	112	5,540
	360	132	6,930
	200	92	3,960
	588	201	11,640
	848	342	17,155
	342	137	6,480
	196	196	3,315
Niagara Falls	250	250	4,577
Ogdensburg	110	110	1,980
Oyster Bay	100	100	1,899
Saratoga Springs	160	130	2,998
Schenectady	400	200	8,874
White Plains (L)	75	10	1,639
Wilna	100	100	1,955
Woodridge	40	10	756
Total, New York	6,623	3,800	128,917
North Carolina:			
Andrews	50	12	829
Beaufort	100	15	1,734
Gastonia	301	26	4,924
Graham	100	20	1,644
Hickory	220	50	3,465
Lumberton	150	26	2,142
Madison	50	10	763
Mars Hill	50	16	911
Randleman	80	10	1,316
Roxboro	150	50	2,493
Sanford	150	50	2,350
Total, North Carolina	1,401	285	22,571
Ohio:			
Bellaire-Martins Ferry	80	80	1,355
Cincinnati (L)	200	50	5,179
Columbus	6	6	100
East Liverpool	130	130	2,135
Elyria (L)	54	24	898
Ironton	60	60	965
Lorain (L)	6	6	117
(L)	100	25	2,289
Martins Ferry	70	70	1,164
Oberlin (L)	20	20	311
Toledo (L)	500	320	10,774
Total, Ohio	1,226	791	25,287

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT LOW RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED DURING 1967—SOME OR ALL UNITS DESIGNED FOR THE ELDERLY—Con.

[Dollar amounts in thousands]

Location	Number of housing units		Total development cost
	Total	Elderly	
Oklahoma:			
Ada	60	60	$820
	80	80	1,248
Antlers	48	26	753
Apache Town	30	20	485
Boley	14	10	214
Bristow	75	50	1,191
Cache	16	8	263
Commerce	34	20	525
Grandfield	30	18	473
Guthrie	180	120	2,600
Hugo	100	70	1,507
Hydro Town	16	10	252
Indiahoma	8	4	129
McAlester	125	45	1,935
Madill	50	36	776
Miami	150	100	2,382
Newkirk	46	26	721
Oilton	24	18	383
Ringling	26	20	418
Roosevelt	8	6	129
Sayre	40	32	638
Seiling	14	10	210
Seminole	120	70	1,959
Sterling	8	4	131
Talihina	30	4	470
Tulsa (L)	240	140	3,226
Valiant Town	16	10	251
Watonga	46	32	721
Weleetka	24	20	358
Wetumka	30	20	481
Wynne Wood	28	20	423
Total, Oklahoma	1,716	1,109	26,072
Oregon:			
Eugene (L)	300	150	276
West Salem area	80	80	1,263
Total, Oregon	380	230	1,539
Pennsylvania:			
Ambridge	75	75	1,347
Blossburg	30	30	522
Bradford	200	125	3,517
Bucks County (L)	265	265	4,041
Butler City	80	80	1,397
Carbondale	70	70	1,252
Coatesville	200	50	3,836
Easton	50	30	919
(L)	100	20	1,828
Jessup	76	36	1,395
Lebanon	200	100	3,631
Mansfield	50	50	825
Meadville	70	70	1,240
Nanticoke	100	76	1,781
North Braddock	200	200	3,457
Renovo	30	30	529
Scottdale	70	70	1,210
Vandergrift	100	100	1,764
Zelienople	75	75	1,319
Total, Pennsylvania	2,041	1,552	35,810
Rhode Island:			
Cumberland	50	50	989
Lincoln	52	52	902
Newport	19	19	356
Total, Rhode Island	121	121	2,247

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT LOW RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED DURING 1967—SOME OR ALL UNITS DESIGNED FOR THE ELDERLY—Con.

[Dollar amounts in thousands]

Location	Number of housing units		Total development cost
	Total	Elderly	
South Carolina:			
Rock Hill	200	50	$3,180
Spartanburg	150	150	2,420
	150	50	2,284
Sumter	200	25	3,219
Union	120	74	1,858
Total, South Carolina	820	349	12,961
Tennessee:			
Bristol	115	115	1,692
Celina	34	8	548
Churchill	50	20	826
Cookeville	150	40	2,284
Humboldt	90	50	1,411
Huntsville	20	4	357
Lewisburg	80	34	1,374
Nashville	100	100	1,663
	100	100	1,598
	300	300	4,778
Rockwood	75	30	1,279
Tazewell	40	20	649
Winchester	64	24	956
Total, Tennessee	1,218	845	19,415
Texas:			
Alice	180	70	3,017
Alpine	50	28	578
Andrews	35	35	319
Balmorhea	22	10	345
Bellville	34	22	533
Brownsville	200	200	3,333
Caddo Mills	20	10	303
Cameron	50	36	837
Carrizo Springs	60	20	984
Como	16	10	233
Cumby	10	6	162
Dallas	201	201	3,502
	235	235	3,809
Diboll	80	10	1,181
Falfurrias	45	11	745
Farmersville	14	14	215
Flatonia	20	14	314
Galveston (L)	200	20	3,585
Grapeland	18	12	274
Grapevine	50	40	781
Gregory	18	4	306
Groveton	18	10	297
Houston (L)	500	130	7,536
Junction	40	24	632
Kingsville	60	60	985
La Feria	36	16	605
Lubbock (L)	236	23	4,031
Luling	40	40	644
Mineral Wells (L)	40	40	515
Omaha	12	6	201
Rankin	10	6	150
San Antonio (L)	250	150	3,549
Schulenburg	36	24	579
Seguin	180	90	3,000
Sinton	84	24	1,368
Sour Lake	24	16	358
Taylor	50	40	844
Thorndale	24	18	370
Winnsboro	44	34	675
Total, Texas	3,242	1,759	51,695
Virginia:			
Fairfax (L)	100	15	1,880
Richmond	400	200	7,809
Total, Virginia	500	215	9,689

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DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT LOW RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED DURING 1967—SOME OR ALL UNITS DESIGNED FOR THE ELDERLY—Con.

[Dollar amounts in thousands]

Location	Number of housing units		Total development cost
	Total	Elderly	
Washington:			
Aberdeen	130	130	$2,232
Bellingham	100	100	1,606
Boulevard Park area	70	70	1,178
Ellensburg	40	10	716
Kent	61	61	1,026
North City area	70	70	1,064
Northwest King County area (L)	250	75	4,989
Paramount Park area	70	70	1,086
Pasco	115	30	1,822
Port Angeles	70	70	1,145
Redmond	40	40	673
Riverton Heights area	60	30	1,029
Seattle	75	75	1,272
	76	76	1,267
	222	222	3,769
	107	107	1,797
	110	110	1,831
	81	81	1,333
Total, Washington	1,747	1,427	29,835
West Virginia:			
Clarksburg	100	100	1,597
Spencer	25	12	437
Weirton	130	80	2,076
Total, West Virginia	255	192	4,110
Wisconsin:			
Abbotsford	30	30	490
Algoma	40	40	632
Barron	30	30	499
Brillion	32	32	539
Bruce Village	25	25	424
Keshena-Neopit-Menominee Counties	50	8	817
Madison	168	168	2,071
	40	40	480
Manitowoc	101	101	1,703
Milwaukee	251	251	3,911
	230	230	3,597
	230	230	3,618
Monroe	86	86	1,388
New Richmond	40	40	657
Reedsville Village	30	30	473
Wausau	150	150	2,403
Total, Wisconsin	1,533	1,491	23,702
Puerto Rico:			
Bayamon (L)	100	6	1,487
Coamo	150	4	2,181
Total, Puerto Rico	250	10	3,668
Virgin Islands: Charlotte Amalie	300	81	5,336
Grand total	54,607	35,507	926,152

Note: (L) indicates leasing program.

Several low-rent public housing developments for the elderly completed and occupied in 1967 are of special interest. In Toledo, Ohio, Vistula Manor, with 164 units and the first project in the country specially designed for occupancy by both the elderly and handicapped, was dedicated by the Toledo Metropolitan Housing Authority.

In 1967, the Toledo Housing Authority, in cooperation with the Ohio Department of Mental Hygiene and HUD, also was the first to complete a housing development for low-income elderly in which nonpsychotic older people, released from the Toledo State Mental Hospital, live among other senior citizens. This project is known as Glendale Terrace and contains 100 dwelling units. It was developed to demonstrate that with certain facilities and services available, nonpsychotic elderly persons discharged from mental institutions, could live more

meaningful lives in an independent living environment rather than be forced to remain institutionalized because of the lack of suitable alternatves. A similar development is under construction by the Columbus (Ohio) Metropolitan Housing Authority.

Among the other low-rent projects occupied for the first time during 1967 were two congregate developments for the elderly; one, a 20-unit project in Burwell, Nebr., and the other, a 40-unit project in Alma, Ga. Both of these provide central dining for the occupants, rather than equipping each dwelling unit with private kitchens. In both projects, the local housing authorities have entered into long-term contracts with local hospitals which have assumed responsibilities both for providing meal services and any deficits incurred. This kind of arrangement with public agencies is necessary because the public housing program is not authorized by law to include such costs in its annual contributions contracts with local authorities.

Both projects were developed in response to the need among a small but substantial number of older people who, with the aid of a variety of supportive services, can continue to live independently, despite the onset of various frailties associated with advancing age.

ADMINISTRATIVE CHANGES IN HOUSING ASSISTANCE ADMINISTRATION

During 1967, in order to react more rapidly to the urgent housing needs of low-income Americans, the Housing Assistance Administration was reorganized to give regional administrators new responsibility and authority aimed at speeding and increasing actual dwelling unit production. This reorganization includes the centralization of production staff in the regional offices which provides a one-step processing unit, the elimination of many processing procedures and the development of streamlined, simplified forms. In the central office, a production division was organized to set production goals, allocate resources, monitor progress and to break bottlenecks.

During the year, a new Tenant Services Division was organized to serve, encourage and stimulate the citizenship capability of every occupant of federally assisted low-rent housing. Higher levels of social services will be provided, and tenants will be given increased training for participation in project management including expanded opportunites for employment.

Late in the year, guidelines were released for a modernization program with a joint Housing Assistance Administration-Local Housing Authority Review program organized to upgrade physical and social conditions, as well as management policies and practices. The Review will focus on the social implications of ongoing policies. In addition to modernization of buildings and grounds, and expansion of community facilities and programs, there will be a new emphasis on the involvement of tenants in developing the plans and programs.

Another important action taken in September 1967, was the initiation of a priority system by HAA to give assistance to those communities which could provide housing at the earliest possible time through the acquisition of housing under the leasing program, or under the new "turnkey" method of construction. This priority system was developed in response to the great excess of demand for low-rent housing over the funds available for annual contributions contracts.

While nearly 24,000 units specially designed for the elderly and covered by annual contributions contracts executed during the year were to be developed under the conventional method of new construction, over 6,400 leased units and nearly 4,600 "turnkey" units also were covered by annual contributions contracts executed in 1967. The leased and "turnkey" units made up almost one-third of the 1967 total for the elderly, and about 11 percent of the cumulative total. In contrast, at the end of 1966, leased and "turnkey" units amounted to only about 5 percent of the cumulative total of the 120,000 units covered by annual contributions contracts executed through that time.

THE DIRECT LOAN PROGRAM

Section 202 of the Housing Act of 1959, as amended, authorizes HUD to make long-term, low-interest loans to nonprofit organizations, consumer cooperatives, and certain public agencies to build rental housing for the elderly and physically handicapped. The maximum rate of interest is 3 percent and loans may be made for periods of up to 50 years. This program, administered by HUD's Housing Assistance Administration, is intended to provide good housing for lower-middle

income elderly. During the year, the national maximum income limits for occupancy were increased from $4,000 for single persons to $4,500, and for two-person families from $4,800 to $5,400. These were the first increases since income limits were introduced in 1962.

Activity and interest in this program continued at a high level during the year. Net applications were received for 53 projects and about 7,900 units for loans of nearly $104 million. In addition to these formal applications it is estimated that sponsors were developing applications for loans amounting to about $250 million. The 53 applications received in 1967 were slightly below the 58 net applications received in 1966, the year following the establishment of the maximum 3 percent interest rate, which was probably responsible for the increase in application activity that year compared to 1965 when there was a net total of 46 applications. Significantly, the net total of 33 applications received during the last 6 months of 1967 was 50 percent higher than in the same period of 1966, when 22 applications were received.

The direct loan program now has been utilized by nonprofit sponsors of housing for the elderly in 39 States and Puerto Rico. As of December 31, 1967, net loans of nearly $400 million had been approved for about 250 projects totaling nearly 33,000 units compared to loans of $324 million for 215 projects with approximately 27,300 units at the end of 1966. Construction starts during 1967 amounted to 44 projects with about 6,900 units, compared to 39 projects with 5,800 units in 1966, bringing the cumulative total of "202" projects placed under construction at the end of 1967 to 204 projects with over 26,500 units financed by loans totaling over $319 million.

During 1967, a total of 41 projects with over 6,000 units were completed, bringing the cumulative total of completions to 150 projects with over 17,500 units involving loans of nearly $206.6 million. A table is attached which summarizes projects approved in each State under this program from its inception through the end of 1967, and another table lists projects approved during the year.[1]

HIGHLIGHTS DURING 1967 IN THE DIRECT LOAN PROGRAM

During the year, the first housing development specially designed for occupancy by the elderly deaf was placed under construction in Los Angeles, Calif. The project, sponsored by the Pilgrim Lutheran Church for the Deaf will contain 112 dwelling units and to meet the special needs of the deaf, will include flashing lights as an emergency warning system rather than conventional sound alarms.

Two projects were approved during the year in Massachusetts and California which will involve the development of housing for the elderly on scattered sites. In Massachusetts projects will be built in Beverly, Danvers, Peabody, and Salem under the sponsorship of the Episcopal Housing Corp. and Episcopal Diocese of Massachusetts. The four sites will include a little over 300 units in total, all of which will be under centralized management and administration. In California a nonprofit corporation formed by five churches in Oakland and the Social Service Bureau of the Oakland Council of Churches will build three developments in Oakland and one in Berkeley, with a total of 200 units. These four projects also will operate through central management and all of their residents will have convenient access to a community center which will be financed separately.

In San Antonio, the first actual conversion of an existing structure into housing specially designed for the elderly under the direct loan program began in 1967, as the rehabilitation of the Granada Hotel started. The project, jointly sponsored by San Antonio's Building and Construction Trades Council, Housing Authority and Senior Community Services, Inc., will provide 250 dwelling units and related facilities for occupancy by moderate-income senior citizens. Rehabilitation loans under this program were made possible under an amendment contained in the Housing Act of 1964, signed into law by President Lyndon B. Johnson in September 1964.

FHA MORTGAGE INSURANCE FOR RENTAL HOUSING FOR THE ELDERLY

The Federal Housing Administration is authorized to insure lenders against losses on mortgages for construction or rehabilitation of rental housing for the elderly. This authority is contained in section 231 which was added to the National Housing Act in 1959. The program provides mortgage insurance for 90 percent of replacement cost in the case of profit-motivated sponsors and 100 per-

[1] Refer to p. 76, chapter IV (Housing), and app. 6, p. 228.

cent of replacement cost for nonprofit sponsors. Mortgage terms may be for as much as 40 years and the allowable interest rate is currently at the statutory maximum; 5½ percent, plus one-half of 1 percent mortgage insurance premium. Prior to the enactment of section 231, FHA mortgage insurance assistance for housing for the elderly was available under the section 207 program, pursuant to legislation enacted in 1956.

This program serves a higher income group among the elderly than that served by public housing or the direct loan program. While the 1967 activity in this program was somewhat improved over the prior year, it remained well below the levels of 1965 and prior years. During 1967, commitments were issued for 11 new projects totaling 1,600 units as compared with five projects and 565 units for 1966. Thus, as of December 31, 1967, mortgage insurance commitments had been issued on a total of 281 projects in 42 States and Puerto Rico, providing 43,200 living units for the elderly. A table is attached which summarizes projects for which commitments were issued for housing for the elderly under section 207 and section 231 from the inception of the program through 1967 and another table lists section 231 commitments during 1967.[1]

The tight-money market and associated high interest rates which continue to prevail account in large measure for the comparative inactivity in this program. Another factor was the continuing unfavorable experience which resulted in the acquisition of an additional 11 projects by foreclosure, making a total of 30 since the inception of the program. In 23 additional cases, mortgagees assigned the mortgages to HUD. Since these represent about one-fifth of all FHA-insured senior citizens projects, this experience no doubt has prompted the FHA insuring offices to adopt a cautious approach in making feasibility determinations.

THE FHA MORTGAGE INSURANCE NURSING HOME PROGRAM

Section 232 of the National Housing Act authorizes the FHA to provide mortgage insurance for proprietary nursing homes and those sponsored by private nonprofit corporations or associations. There is a statutory limit of $12.5 million per project under this program. Within this limit, the maximum insurable mortgage amount is 90 percent of the FHA-estimated value of the project at completion, but on rehabilitation projects, not over five times the cost of new improvements. The maximum mortgage maturity period is 20 years and the current maximum interest rate is 6 percent, plus one-half of 1 percent mortgage insurance premium. Each project covered by mortgage insurance under this program must consist of not less than 20 nursing beds.

Joint financing through a combination of FHA mortgage insurance and a Federal grant or loan made by the Department of Health, Education, and Welfare under the Hill-Burton Act is permissible for nonprofit nursing homes.

In 1967 the FHA approved applications for 66 nursing homes planned to contain about 6,200 beds and for mortgage insurance of nearly $49 million, bringing the cumulative net totals up to nearly 550 nursing homes approved with nearly 50,000 beds and insurance of about $340 million. At the end of the year, nursing homes with about 9,500 beds were under construction. In addition, slightly over 50 nursing homes were completed in 1967 with almost 5,500 beds and insured for nearly $41 million. The cumulative total of nursing homes completed by the end of 1967 increased to nearly 400 homes containing over 35,000 beds and insured for nearly $226 million. A table is attached which summarizes commitments issued through 1967 and another lists projects for which commitments were issued during 1967.[2]

At the end of 1967 five nursing home projects were in the "pipeline" involving joint FHA-Hill-Burton financing. Two (in Atlanta, Ga. and Phoenix, Ariz.) were under construction. One project to be located in Denver, Colo., had been approved, and applications were in process for homes in Columbus, Ohio, and Beaumont, Tex.

NEIGHBORHOOD FACILITIES

A program of grants to local public bodies or agencies to finance neighborhood facilities projects was established by section 703 of the Housing and Urban Development Act of 1965. The program provides grants, normally two-thirds of

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[1] Refer to p. 80, chapter IV (Housing), and app. 6, p. 228.
[2] Refer to next appendix for sec. 232, tables.

the development cost of such facilities, except in areas designated under the Area Redevelopment Act which may receive grants up to three-fourths of the development cost.

A center must be multiservice in character by offering a wide range of health, welfare, education, social, recreational, and other similar community services. Priority is given to those projects which are designed to primarily benefit low-income families or otherwise substantially further the objectives of a local community action program approved under title II of the Economic Opportunity Act of 1964.

Two senior citizens centers have been approved under this program. One is the Astor Dowdy Neighborhood Center in High Point, N.C., which is being constructed as a wing of a 106-unit low-rent housing project for the elderly. The center is intended to serve both the residents of the project and the elderly of the larger neighborhood. The second is the senior citizens center in Dayton, Ohio, which will be a 25,000-square-foot facility serving approximately 7,000 persons aged 60 and over living within a mile of downtown. A substantial number of neighborhood facilities plan to have senior citizens components and services. Approximately 46 out of 118, or 39 percent, of approved projects will offer senior citizen programs.

The types of services offered to senior citizens in a neighborhood facility are varied and include such things as health services, recreational and social activities, employment programs, welfare and social security services and legal aid.

HOME REHABILITATION LOANS AND GRANTS

Section 312 of the Housing Act of 1964, as amended, authorizes HUD to make direct Federal loans to finance the cost of rehabilitating property in federally aided urban renewal areas or concentrated code enforcement projects. In 1965 legislation also was enacted to permit HUD to make direct Federal grants under the new section 115 of title I of the Housing Act of 1949, as amended, to finance the rehabilitation of structures located in federally aided urban renewal areas or concentrated code enforcement projects. Both of these programs are administered by HUD's Renewal Assistance Administration. A significant difference between these two programs and most programs administered by HUD is that these loans and grants are made to individuals directly rather than through local public agencies or other private profit-motivated or nonprofit groups.

Prior to the enactment of these direct loan and grant programs, low income homeowners in blighted areas were severely limited in their ability to secure financing to rehabilitate their properties. As a result, their properties would continue to run down and eventually be subject to clearance. As a result of the rehabilitation loan and grant programs, families in federally aided urban renewal and concentrated code enforcement areas may receive direct Federal financial assistance. A substantial number of these families are elderly, and the availability of this direct assistance is of particular importance to such families since the other deterrents which the conventional money market places on them are aggravated and compounded by their age.

Any families owning and occupying the one-to-four family dwellings in federally aided urban renewal or concentrated code enforcement areas whose incomes are $3,000 or less are eligible for a grant of $1,500 or the cost of rehabilitation, whichever is less. Families with incomes of more than $3,000 also are eligible if their housing expense exceeds 25 percent of income. These families also are eligible for the direct 3 percent 20-year loans. These loans, not to exceed $10,000, or up to $14,500 in high-cost areas, are available basically for rehabilitation. However, in special cases where the sum of the monthly payments on existing debt related to the property and the proposed rehabilitation loans would exceed 20 percent of the family's income, the rehabilitation loan also could be used to refinance the family's existing debt. This combination often serves not only to make the rehabilitation possible, but at the same time to substantially reduce the monthly payments which the family has to make on its property. In many cases, the owner-occupant family is able to qualify for a combination loan and grant, and this assistance is particularly meaningful to the elderly.

As of the end of 1967, nearly 2,700 direct loans for over $14.1 million had been approved, compared to only about 650 loans for about $3.2 million approved at the end of 1966. With regard to the grant program, at the end of 1967, over 4,500 grants for about $6.3 million had been approved, compared to about 2,000 for

$2.8 million at the end of 1966. At the present time, data are not available with regard to the participation of the elderly in these programs, but a reporting system is being put into effect which will provide such data. It is estimated, however, that a substantial number of these loans and grants have been made to senior citizen homeowners.

The rehabilitation workload in urban renewal and concentrated code enforcement areas is very large, and as indicated by the rapid expansion of loans and grants approved under these new programs since their enactment, they are helping to meet the need and are expected to continue expanding their roles as a major force in the rehabilitation of blighted areas.

GROUP PRACTICE FACILITIES PROGRAM

The Demonstration Cities and Metropolitan Development Act of 1966 authorizes HUD, under title XI of the National Housing Act, to insure mortgage loans financing the construction or rehabilitation of, and the purchase of equipment for, facilities for the group practice of medicine, dentistry, or optometry. The program is administered by the FHA which receives technical guidance and assistance covering medical and health aspects of the program from the Public Health Service of the Department of Health, Education, and Welfare.

Group practice makes possible more efficient use of scarce manpower and costly health care facilities and equipment. It can be particularly beneficial to small communities and low income urban areas where adequate health facilities of a comprehensive nature may not otherwise be available. In addition, costly hospitalization can be significantly reduced where the group practice is combined with a comprehensive prepayment plan. This new FHA program was conceived in recognition of the potential of group practice in delivering efficient, comprehensive health services of high quality. It is intended to assure the availability of credit on reasonable terms to finance construction and equipment of medical, dental, and optometric group practice facilities.

Under the law, a group practice project may be sponsored by a group or organization which will either own and operate the proposed facility as a nonprofit unit, or will create a separate nonprofit entity to own the facility. Payment for health services provided by the group may be on either a prepayment or a fee-for-service basis.

The maximum mortgage is $5 million and a loan-to-value limitation of 90 percent of the FHA estimate of the value of the property, including equipment, covered by the mortgage. The term of the mortgage may be up to 25 years and the maximum interest rate is 6 percent, plus one-half of 1 percent mortgage insurance premium.

Although only one formal application for mortgage insurance had been received by the end of 1967 under this new program, there is considerable interest developing throughout the country and the FHA also has given its approval to the feasibility of a few medical groups as potential sponsors of group practice facilities. Senior citizens, whose needs for health care are so great, are certain to benefit significantly as activity under the group practice program moves ahead.

MODEL CITIES

The model cities program provides a major new program designed to demonstrate how the living environment and general welfare of people living in slums and blighted neighborhoods can be substantially improved in cities of all sizes and in all parts of the country. It calls for a comprehensive attack on social, economic, and physical problems in selected areas through the concentration and coordination of Federal, State and local public and private efforts. Financial and technical assistance is being made available to help cities plan, develop, and carry out comprehensive local programs containing new and imaginative proposals to develop "model" neighborhoods.

The model cities program has just begun to be operational with the November 1967 announcement of the planning grant awards to 63 cities. Communities now are in the process of making initial adjustments to comply with the conditions of these grants and it is anticipated that most communities will begin to implement their planning process after February 1, 1968.

While few of the applications submitted by the participating cities highlight the problems and needs of older persons, HUD's Model Cities Administration is developing the capacity to begin dealing with problems of the elderly as related to the program, as directed by President Johnson in his 1967 message on aid

for the aged. One staff member has been designated to concentrate, among other duties, on problems of the aged and to help cities develop programs designed to make an impact on them. A work program which is under consideration should yield (1) some hypotheses to be tested through the use of demonstration projects; (2) a method for offering technical assistance to staffs and communities; and (3) a sound plan for coordinating Model Cities Administration efforts on behalf of the aged with other divisions within HUD, other Federal agencies such as HEW's Administration on Aging, and the Office of Economic Opportunity and interested national and community organizations.

It is anticipated that activities of the Model Cities Administration on behalf of the elderly will be divided between programs exclusively for the elderly residents of model neighborhoods, and broad community programs. All model cities programs must provide for widespread citizen participation in them, including (1) constructive involvement of citizens in the model neighborhood and the city as a whole in planning and implementing the program and (2) the development of means whereby the area residents may significantly influence policy decisions.

ASSISTANCE TO LOW-INCOME RESIDENTS OF URBAN CENTERS

Throughout HUD, the focus of attention has turned to improving the quality of life, especially for the disadvantaged. HUD's Housing Assistance Administration, by placing increasing emphasis on the new "turnkey" method of construction and the leasing of units in the private housing market, is providing private enterprise with greater opportunities to meet the need for housing for low-income families. HUD's Renewal Assistance Administration also is giving much greater emphasis to the development of housing for the low- and moderate-income group in its various programs involving urban renewal. The crucial model cities program will permit cities and towns to develop new proposals aimed at improving living environments and the general welfare of people in slums and blighted neighborhoods.

The scope of FHA's activities over the years also has tended more and more towards serving the housing needs of the disadvantaged. In FHA, this has been accomplished by its basic role in encouraging private enterprise, through its mortgage insurance programs, to meet housing needs through private housing development. A key factor in accomplishing this emphasis is the stride FHA has taken in streamlining its processing procedures. Under its new accelerated multifamily processing (AMP), FHA will cut its average processing time from between 12–18 months to under 6 months. This program, initiated in 1967, will be fully operative during 1968.

In 1967, the FHA, recognizing that far more activity on behalf of the low-income population, including the elderly, was imperative, began a massive effort to help private enterprise improve housing and related human conditions in the inner city, especially in the slum and blighted portions of the inner city.

During the first part of 1967, it is estimated that about 50 percent of FHA's activity in insuring mortgages on existing homes under its section 203 program was in the central city and 20 percent in what could be described as blighted or "in-town" areas. In addition, over 67 percent of FHA's mortgage insurance for existing homes under its section 221(d)(2) program also was in the central city. FHA's progress with respect to the inner city also is reflected in its ability to work with profit and nonprofit sponsors in the development of section 221(d)(3) below-market interest rate housing. The rent supplement program, as discussed previously, with its emphasis on participation by the private sector, is the increasingly effective tool with which FHA is attacking problems of central city residents, including the older poor.

FHA HOUSING COUNSELING SERVICE

As a major part of its effort to better serve people in the low- and moderate-income range, including servicemen, minority groups, veterans, and others with housing problems, the FHA, during the latter part of 1967, instituted a new Housing Counseling Service in its insuring offices. This new service, generally headed by rent supplement specialists, is designed to insure that the FHA renders equal treatment to all prospective buyers and renters, including the elderly.

The Counseling Service includes advice with regard to the amounts people can afford to pay, including the purchase price and monthly payments on a mortgage, or rents in the case of rental housing. A very important part of the service

includes assistance in locating appropriate housing. As of the end of the year, 15 Insuring Offices were providing this service, and during January 1968, another 18 offices were in the process of organizing Counseling Services. The service will be expanded during 1968 to other FHA Offices as soon as possible.

In 1967, the FHA's highest priority was given to the task of enlisting private enterprise to provide housing for low- and moderate-income families and individuals, including the elderly. Further, the FHA is very much concerned that the needs of the elderly be considered as private enterprise is enlisted to help rebuild and restore inner city slums and blighted areas.

Summary

Interest and activity in HUD's senior citizens housing programs continued at very high levels during 1967, as is evident from the data included in this report and the tables which accompany it. The potential investment by the Federal Government in housing for the elderly through HUD's low-rent, direct loan and FHA programs for the elderly, is estimated at about $3 billion. A cumulative total of over 165,000 units for the elderly have been placed under construction, and well over 120,000 of these specially designed dwellings have been completed. There is a continuing high level of interest in the development of public housing for the elderly, and among private sponsors for housing for older people in the low and lower middle income groups served by the direct loan and rent supplement programs. With respect to the low-rent program, the national problem is to increase the public housing available for large families, as well as for the elderly.

This past year also was marked by the emergence of strong interest in the development of housing for special groups of the elderly and handicapped. This has been demonstrated by an increasing number of potential sponsors seeking assistance in financing housing for the blind and deaf, among other handicapped groups, and for the more frail elderly who require modest assistance in order to live independently. Increasingly, hospital and nursing home representatives have indicated the need for housing that could be occupied by their older patients who do not require the skilled attention and expensive residency in institutions, but who lack suitable alternatives in housing environments that could provide the limited care that would make independent living possible once again. Housing for the frail elderly is of particular concern and the Department is giving attention toward the development of new policies and other actions which would permit serving their needs more adequately.

Another area of increased interest has been demonstrated by potential sponsors of housing for senior citizens responsive to customs and habits of certain ethnic groups. Various groups also had discussed the need for better housing for older "skid row" residents; for fishermen who want only simple accommodations during their brief stays on shore after long periods at sea; and for retired agricultural workers who want to maintain small gardens, even though no longer actively employed.

Some progress has been made in these special areas of housing needs, in addition to the substantial increase in housing for the great majority of older people who are capable of living independently. HUD-assisted projects for the elderly now include the Toledo, Ohio, developments for the handicapped and discharged mental patients. A project for the elderly deaf is under construction in Los Angeles, as is one for the blind in Omaha, Nebr. These are some of the new directions that have evolved as our programs for the elderly respond to the wide variety of needs and desire for expanding choices in housing and living arrangements among the Nation's senior citizens.

ITEM 2: REPORT ON RURAL HOUSING

Department of Agriculture,
Washington, D.C., December 21, 1967.

Dear Mr. Chairman: This will reply to your letter of December 11 requesting information about several of the programs administered by the Department; namely, mortgage insurance for multifamily rental housing in rural areas, direct loans for rental housing for the elderly in rural areas, and financial assistance for elderly persons in rural areas.

INSURED RENTAL HOUSING

Insured rural rental housing loans are made to build, improve, repair, or buy rental or cooperatively owned housing for rural residents with low or moderate incomes and for senior citizens. Through this program, the Department has insured loans for 809 units as of June 30, 1967. This will provide housing for an estimated 1,400 persons, most of whom are elderly.

As of November 30, 1967, we had on hand about 340 applications for insured rental housing loans for both elderly and younger families. We estimate that these applications will result in housing for about 2,000 elderly persons.

Recent changes in this phase of our housing program were the inclusion of cooperative housing as a purpose for which loans could be made and the broadening of the authority to include low and moderate income nonsenior citizen rural families as eligible occupants. Both of the changes were authorized by the Demonstration Cities and Metropolitan Development Act of 1966.

DIRECT RENTAL HOUSING

Direct rural rental housing loans are made to provide loans to eligible nonprofit corporations to build, improve, repair, or buy rental or cooperative housing for rural residents with low incomes and senior citizens with low to moderate incomes. Units may be houses or apartments for independent living.

As of June 30, 1967, direct loans have been made to provide 840 living units. As of November 30, 1967, we had on hand about 100 applications from organizations to provide rental housing. These applications will provide housing for an estimated 1,000 elderly persons. The Demonstration Cities and Metropolitan Development Act of 1966 also authorized direct loans for cooperative housing and occupancy by low-income persons who are less than 62 years old.

LOANS TO INDIVIDUALS

Direct and insured loans are made to senior citizens to provide, build, buy, or improve homes and when necessary to buy a building site. As of June 30, 1967, the Department had made loans to 8,793 senior citizen families and had an additional 1,519 applications on hand.

A recent legislative change in the program permits the refinancing of housing debts under certain conditions when necessary to help the family retain ownership of its home. An administrative change in our rural housing program has been made within the past month that will enable more low-income families to improve the homes they own. This change involves loans of up to $3,500 to repair or enlarge a home without requiring the customary title search or the immediate completion of some of the less essential features of the home.

HOUSING RESEARCH

The Economic Research Service in the Department has several studies underway which deal with the problems of the aging in rural areas. They are in Kentucky, South Carolina, the Mississippi Delta, the Ozarks, and the Cornbelt. Currently, data are being processed showing the socioeconomic characteristics of the rural aging and the status of their housing in these areas. Other studies underway include estimates of type and cost of remodeling and construction needed to bring housing of older Americans up to various levels of quality. Information on credit and its use by the aged in operating their homes is being analyzed. Preliminary results of some of these studies should be ready next summer.

Also of interest is a book entitled "Older Rural Americans," edited by a research worker of the Department. It will be released by the University of Kentucky press on December 29. In it is a chapter of the housing of rural aging.

The Agricultural Research Service is continuing its work in developing house plans that reflect current research in housing for the elderly.

We appreciate your interest in the programs of this Department that relate to housing for the rural elderly. If you would like additional information, we shall be glad to furnish it.

Sincerely yours,

JOHN A. BAKER,
Assistant Secretary.

Appendix 7

MATERIAL RELATED TO NURSING HOMES AND LONG-TERM CARE*

ITEM 1: STATEMENT BY SENATOR MOSS ON "REASONABLE COST"

Mr. President, the bill we have before us, the Social Security Amendments of 1967, as reported by the Committee on Finance is a good and well-thought-out measure. It contains many important provisions which will contribute significantly to the health and well-being of our retired citizens as well as others whose difficult circumstances can be alleviated through programs under the Social Security Act. I am especially pleased that the committee has adopted amendments to help assure the proper care of public assistance nursing home patients offered by myself and the distinguished senior Senator from Massachusetts (Mr. Kennedy).

These amendments are the outgrowth of hearings and studies conducted by the Subcommittee on Long-Term Care, of which I am chairman, of the Special Committee on Aging. These studies showed that deplorable conditions exist in some nursing homes. In many cases patients who are presumably getting skilled nursing home care under our medical assistance programs are actually receiving no more than custodial care. Our public-assistance programs are maintaining many patients in homes that are unsafe and endanger their very lives. State licensing and inspection are not as effective as they should be in assuring safety and adequate care.

The senior Senator from Massachusetts, who is a member of my subcommittee and who has been very active in this work, joined with me, as did a number of other Senators, in introducing a bill designed to correct many of these deficiencies. He also introduced his own bill which will go far toward upgrading and professionalizing the whole field of nursing home administration. It is these measures, reintroduced as amendments to H.R. 12080, which the Committee on Finance has adopted and included in the bill before us.

However, the committee has omitted from the bill which it has reported one feature of my amendment which I consider to be highly important; sufficiently so that I now offer it as an amendment and ask that the Senate add it to this bill. That feature is the provision that nursing homes serving title XIX patients be paid the reasonable cost of services provided.

This is not a novel idea. Under title XVIII, the medicare program, both hospitals and nursing homes which serve as extended care facilities are reimbursed on the basis of reasonable costs. In title XIX States are required to reimburse hospitals on the basis of reasonable cost, but only hospitals. The Department of Health, Education, and Welfare has recognized the validity of this approach to reimbursement of nursing homes. The supplement to the Handbook of Public Assistance Administration issued in June 1966, relating to the medical care programs under title XIX includes the statement that fee structures for institutions such as nursing homes should "focus on payment on a reasonable cost basis determined according to commonly used accounting methods on a per diem or relationship of costs to charges basis."

It is my understanding that reasonable cost reimbursement to nursing homes was considered when title XIX was enacted in 1965 and rejected because of apprehension that it would add too much to the cost of the program. There is a widespread belief that nursing homes are almost universally underpaid and that to pay them properly would be inordinately expensive. Thus, we have in the law today a payment provision which discriminates between the two types of providers of service.

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*See ch. V for discussion of matters related to this appendix.

My amendment No. 294, which the Committee on Finance has largely adopted, contained among its provisions a requirement that States also reimburse nursing homes on the basis of reasonable costs. When my amendment was before the committee the Department of Health, Education, and Welfare again came forward with one of its spine-chilling cost estimates. Mr. President, I certainly do not criticize the committee for its concern over the cost factors in the various proposals it considered. It was the committee's desire to report to the Senate a prudent and fiscally responsible bill. I believe they have done that and I commend them for their long hours of effort and for the results of their work.

I differ with the committee, however, on the matter of omitting reasonable cost reimbursement to nursing homes on two grounds. First, I do not believe the Department's cost estimate and, second, I believe that payment on the basis of reasonable costs represents one of the best methods of controlling nursing home costs.

The amendment I am offering today would simply call upon States to develop methods and procedures for determining the reasonable cost of nursing home care, to set these methods and procedures forth in their State plans, and after June 30, 1970, to pay nursing homes the reasonable costs of caring for title XIX patients. Not only does this provide a fair and equitable way of paying nursing homes, but it will provide methods of cost control now sorely lacking in our public assistance programs.

Mr. President, my subcommittee has given major attention in its studies to the methods now used by the States to determine nursing home reimbursement because of the important relationship of these methods to quality of care. Let me describe our findings.

Ten States now pay for nursing home care on the basis of reasonable costs or reasonable charges. Most of the remaining States establish through negotiation or through legislative or administrative action a single rate of reimbursement for the care of public assistance nursing home patients. It seems to me that the single rate system is inherently incapable of producing good results despite the best intentions of its administrators. If an effort is made to relate the rate determination to cost of care, it is likely to be predicated upon a median level of care among the homes in the State, and for some the rate will be inadequate and for others it will be too high. Furthermore, incentives to poor care are built into this system since the home which cuts corners thereby increases its monetary rewards, while the home which gives full measure may just barely get by or may even lose money on publicly assisted patients.

Some States have attempted to refine their systems with some type of classification. Systems of classifying homes according to the level of care provided give a scale of rates which may roughly approximate the relative differences in costs involved in these levels of care, but at leach level of the classification system we again have a single rate applied and the same disincentives to giving full measure are found among homes in each classification. Then we have the added problem of assuring that patients are placed in homes having the appropriate level of care, and of what to do with the resident of an intermediate care home, for example, who develops intensive care needs.

Some States classify patients according to the care they require and establish different rates for patients needing maximum care, intermediate care, and minimum care. Again we have not gotten away from the basic problem associated with a fixed rate and we have created a still worse problem. We have established a monetary incentive to keeping patients in a maximum care state. The home with an active program of rehabilitation and training in self-care may actually be working against its own financial interest. If a nursing home gets a bed-bound patient back on his feet the reimbursement rate goes down.

In short, our present approaches to payment for care tend to discourage initiative and promote passivity in patient care, to penalize excellence, and to assure the continuance of marginal and even substandard homes by giving them a relative financial advantage.

Mr. President, I am convinced that we are paying more than we should for some nursing home care. By paying a fixed rate to all, or to all of a certain classification, we are paying some for levels of care or for services not actually delivered. On the other hand, I am equally sure we are paying some nursing homes inadequately. If we paid all the reasonable cost of services actually rendered, how would it balance out? How much impact would it actually have on the budgets of the States and the Federal Government? The Department reported to the Committee on Finance that requiring States to pay on the basis

of reasonable costs would increase the cost of the program by at least $200 million per year in Federal funds and a like amount in State funds. I regard that estimate with the greatest skepticism.

Public assistance payments are the economic backbone of the nursing home industry. Sixty percent of all patients in nursing homes are paid for by public assistance, and many homes have virtually all public assistance patients. We are currently paying a total of about $600 million per year for the care of these patients. Now the Department tells us that if we pay the actual cost of care we will be paying $400 million more. In other words, the Department is telling us that we are meeting only 60 percent of the cost involved in taking care of these patients. Mr. President, this seems incredible.

If it is true that we are falling this far short of meeting our obligations under laws we have enacted, if it is true that we are imposing on providers of service and imposing on private paying patients to absorb 40 percent of the burden of a public program, then I say it is a shame and we should put a stop to it forthwith. But I don't believe it is true. We have only to look about us at a thriving industry to see that it is not. No business would survive if it discounted the price of its product to 40 percent below cost for a majority of its customers. Yet nursing homes are surviving. The many homes which have 80 and 90 percent of their patients on welfare rates are not going out of business; indeed, they are expanding and building new facilities. I do not offer an alternative figure to the Department's estimate because the information necessary to derive such a figure has never been assembled by the Department or anyone else. But this estimate is outlandish.

Mr. President, the second and major point I would make about the effect of my amendment on costs is that, far from turning loose the floodgates of the Treasury, this approach to nursing home reimbursement provides important and heretofore almost nonexistent methods of cost control. The Department's estimate takes no account of the savings to be made from a reimbursement system based on reasonable costs. While the conscientious nursing home administrator may be underpaid for his services, there is ample evidence that we are overpaying others in terms of value actually received and in some cases paying for goods and services not delivered at all.

The findings of my subcommittee suggest that in some cases nursing home profits, for example, are extraordinary. At our hearing in Boston, a witness who had directed a study by the State legislature in Massachusetts told us "* * * we were satisfied that the nursing homes figured at least $1,000 a year profit per bed and that was on the basis of (welfare rates)."

This statement was disputed, of course, but its credibility is supported by reports from other States. A survey in another State reported an annual profit of over $1,000 per bed in a home where blind patients were sometimes served scrapings from the plates of others. From another State we heard from an authoritative source of a 28-bed home which realized a profit of $32,000 and another of similar size which realized $44,000. In still another State in another region of the country, a local investigator was shown plans for a new home and was told by the owner that he expected to recover the entire construction cost in 3 years.

Mr. President, all of these homes have welfare patients. Our public assistance programs are paying a considerable part of these outrageous and unwarranted profits. Of course, a nursing-home owner expects to realize a return on his investment. This is entirely proper, but we cannot continue to countenance these kinds of profits squeezed out of public funds at the expense of helpless patients.

Nursing-home financing provides in some cases another rathole into which we are pouring public money. My subcommittee learned of a case in which a nursing-home owner borrowed $1,300,000. That is, he executed a note for that amount but actually received $700,000. Thus it cost him $600,000 to obtain his capital, and public assistance funds paid a large share. The same situation was found in the case of smaller loans for operating capital. In the State of Maine a nursing-home owner borrowed $8,000, she thought, and later discovered she had signed a note for $15,000. In another case we were told by a former nursing-home owner that his interest costs alone had amounted to one dollar per patient-day; and he, as well as others told us it was not unusual for nursing homes to pay interest rates aggregating 40 percent per annum.

Mr. President, public funds are paying these exorbitant financing costs while the care we are supposed to be reimbursing must be curtailed in order for the owner to meet his payments.

Are we paying for goods and services not delivered? We almost surely are. The Welfare Federation of Cleveland testifying before the Committee on Ways and Means on the results of its study of nursing homes reported:

"One nursing-home administrator has claimed that his particular home, as well as others, normally obtains household supplies under the guise of drugs for patients, paid for as drugs by old-age assistance."

Mr. President, I should like to point out at this time that the statement of the Cleveland Welfare Federation before the Committee on Ways and Means is reprinted in volume two of the hearings of the Finance Committee, which is on each of our desks, at page 973. I think Senators will find this statement, as well as the further testimony of the federation before our Committee on Finance beginning at page 964, worthwhile reading in connection with the amendment I am offering.

Do the improper payments reported here represent an isolated stiuation? We believe not. A survey was made of all the nursing homes in another large metropolitain area by a well-known and reputable hospital consultant. My subcommitte staff has had access to his report which shows that in many cases drugs and medicines for which homes had been reimbursed were being recorded as operating expense. Here are some of his other findings:

More than half of the homes were padding billings to welfare agencies.

Several carried fictitious persons on their payrolls.

Inflating of food cost several times over by the device of the owner buying food wholesale and reselling to his own home was common.

Some owners have set up dummy real estate corporations to own the facilities and charge high rents to the nursing-home corporations.

Mr. President, public assistance funds, both State and Federal, are pouring through these cracks in the system. Total public assistance expenditures for nursing-home care exceed $600 million annually. How much of these funds is lost through unwarranted payments or even fraudulent payments? How much could be saved by a system of reimbursement based on the reasonable costs of services actually rendered; a system under which claims for payment are supported by appropriate records and accounting information which can be verified and audited? I do not know the answers to these questions and neither does the Department of Health, Education, and Welfare, but I suspect the amounts are substantial.

The General Accounting Office reporting in August 1966 on its study of the provision of nursing-home care and prescribed drugs in California noted the possible existence of abuses in several areas and emphasized the inadequacy of the controls exercised both by the State and at the Federal level. At my request the General Accounting Office conducted a study in Ohio also. One of the areas of inquiry was to determine whether payments were being made for services or goods not actually needed by recipients or not actually provided to them. The GAO concluded in its report; "because of inadequacies in pertinent policies, procedures, and controls, practices * * * of the types described * * * could exist without detection by appropriate authorities * * *."

In the same report GAO also made the following observation which I think is pertinent:

"The amounts allowed by the State do not vary on the basis of the actual costs incurred by individual nursing homes in providing the required care.

"It appears to us that allowing a nursing home a fixed amount of compensation which does not consider the actual costs of the nursing home may generate economic pressure on the nursing home to reduce costs at the sacrifice of the quality or level of care provided or to avoid incurring increased costs necessary to improve the level or quality of care."

A report just issued by the General Accounting Office on its study of reimbursement methods in Massachusetts details in a most convincing way the shortcomings of reimbursement methods which are not related directly to the cost of services provided. The GAO was critical of the Department for not having exerted leadership in encouraging the States to develop sound reimbursement methods, although the Department's authority to do so is not explicit in the present law, and recommended that the Department—

(1) Expedite the formulation and issuance of appropriate criteria and requirements to guide the States in establishing payment rates for nursing-home care under public assistance programs;

(2) Require that State plans include a description of the methods and procedures to be used in establishing payment rates; and

(3) Institute effective policies and procedures for the review and evaluation of methods and procedures actually being used by the States in determining payment rates.

Mr. President, under the terms of my amendment these recommendations would be carried out by July 1, 1970, and I concur with the Comptroller General's view that they would help insure that Federal financial participation in costs of nursing-home care is as effective and economical as possible. But one more element is needed, and that is the establishment of the principle that reimbursement must be related to the reasonable costs of services actually provided.

Mr. President, I wish to make absolutely clear that in citing these abuses I am not attacking nursing homes in general. I will not recite the usual caveat that these conditions are true only of a small minority because it is my impression that they are far more prevalent than this kind of statement implies. But it is clear to me that the present leadership of the industry reflects a solid constituency of reputable businessmen who deplore this exploitation of people and of the public purse as much as anyone.

During the preparation and consideration of this legislation the American Nursing Home Association has played a constructive role. ANHA President Ed Walker, of Oklahoma, regional vice presidents Harold Smith of Louisana, and David Mosher, of Florida, and others in the leadership of the association made a number of worthwhile contributions to the development of the legislation and supported it before the Finance Committee. The ANHA also supports the requirement that States pay for care on the basis of reasonable costs. They support this method of reimbursement both because it is fair to the reputable nursing home which gives its patients full measure and because it will help put an end to subsidizing the inept and the unscrupulous out of public funds.

ITEM 2: STATISTICS ON NURSING HOME PROJECTS—1967

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT—FEDERAL HOUSING ADMINISTRATION

NET COMMITMENTS ISSUED ON NURSING HOME PROJECTS UNDER SEC. 232 THROUGH DEC. 31, 1967

State	Projects	Beds	Mortgage amount
Alabama	9	819	$5,054,259
Alaska			
Arizona	5	349	1,825,300
Arkansas	2	150	965,500
California	39	3,166	22,169,630
Colorado	6	658	3,563,300
Connecticut	17	1,641	10,459,768
Delaware	2	216	1,710,300
District of Columbia	1	199	1,450,000
Florida	29	2,554	15,306,951
Georgia	13	1,322	8,112,400
Hawaii	2	224	1,774,200
Idaho	7	519	2,279,443
Illinois	25	2,814	16,968,622
Indiana	8	710	4,301,700
Iowa	6	443	2,333,700
Kansas	6	420	2,525,529
Kentucky	11	824	4,049,549
Louisiana	6	548	3,035,900
Maine	3	192	1,054,000
Maryland	9	1,191	9,103,544
Massachusetts	11	885	6,361,063
Michigan	37	2,894	18,855,112
Minnesota	5	423	2,245,900
Mississippi	10	528	3,160,000
Missouri	13	1,596	13,467,900
Montana	4	320	2,025,500
Nebraska	12	747	4,276,531
Nevada	3	214	1,971,900
New Hampshire	3	200	1,561,700
New Jersey	42	4,439	40,586,146
New Mexico	2	100	661,500
New York	30	4,063	35,839,898
North Carolina	2	193	1,310,800
North Dakota			
Ohio	21	1,843	12,132,863
Oklahoma	8	548	2,779,300
Oregon	15	1,270	7,272,800
Pennsylvania	16	1,735	12,274,800
Rhode Island	1	135	1,118,900
South Carolina	11	686	4,348,800
South Dakota	2	115	644,400
Tennessee	14	1,127	6,894,500
Texas	31	3,414	19,830,300
Utah	7	559	3,315,600
Vermont	2	118	538,700
Virginia	7	673	4,653,800
Washington	13	1,184	6,971,403
West Virginia	2	145	774,200
Wisconsin	8	722	4,144,619
Wyoming			
Puerto Rico			
Virgin Islands			
U.S. total	538	49,835	338,062,530

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT—FEDERAL HOUSING ADMINISTRATION

COMMITMENTS ISSUED DURING THE YEAR OF 1967 ON SEC. 232 NURSING HOME PROJECTS

State	City	Name of project	Number of beds	Mortgage amount
California	Los Angeles	Romalis Lane Nursing Home	32	$141,900
	Sacramento	Camellia Manor	99	686,000
	San Francisco	San Francisco Convalescent Center	172	1,935,000
	Visalia	Visalia Convalescent Center	99	600,600
Connecticut	Bristol	Eden Park Convalescent Home	120	809,700
	Derby	Riverview Convalescent Home	84	729,300
	Meriden	Meriden Memorial Nursing Home	120	685,600
	West Haven	Terrace Dell Nursing Home	90	658,100
Florida	Fort Lauderdale	Dillard Convalescent Center, Inc.	100	483,000
	Tampa	Padgett Nursing Homes, Inc.	100	478,500
	Winter Park	Haven House Nursing Home	54	382,700
Georgia	Dalton	Greater Dalton Nursing Home, Inc.	100	655,200
	Valdosta	The Lakewood Convalescent Center	110	704,700
Idaho	Coeur d'Alene	Coeur d'Alene Nursing Home	89	475,000
	St. Maries	St. Maries Manor	50	248,000
Illinois	Bridgeview	Bridgeview Villa	147	957,700
	Chicago	Beacon View Nursing Home, Inc.	141	836,900
	do	Hyde Park Nursing	150	939,700
	Greenup	Cumberland Nursing Home	50	307,500
	Mount Vernon	Hickory Grove Manor, Inc.	50	468,900
Iowa	Marshalltown	Marshalltown Senior Citizens Home	80	483,300
	Waterloo	Parkview Nursing Home, Inc.	160	861,000
Kansas	Seneca	Crestview Manor	50	292,700
Kentucky	Lexington	Merrick Manor, Inc.	100	560,000
	Somerset	Sunrise Manor	98	539,500
Massachusetts	Falmouth	Falmouth Nursing Home	74	690,500
	Saugus	North Shore Convalescent Center	100	789,400
	Worcester	Peoples Church Nursing Home	80	651,100
Michigan	Detroit	Georgia Court Nursing Home	125	1,519,700
	do	Law Den Nursing Home	100	432,700
	Farmington	Grosse Pointe Nursing Home	65	1,297,200
	Grand Rapids	Grand Valley Nursing Centre	160	1,317,700
	Ionia	Ionia Manor, Inc.	120	704,000
	St. Joseph	Shoreham Manor, Inc.	107	755,400
Minnesota	Worthington	Lake Haven Nursing Home	87	432,400
Mississippi	Booneville	Aletha Lodge, Inc.	50	243,100
	Brookhaven	Brook Manor Nursing Home	50	300,000
	Columbus	Medi-Center of Columbus	50	330,300
	Gulfport	Driftwood Nursing Home	50	342,100
	Hazlehurst	Pinecrest Guest Home, Inc.	50	344,700
	Winona	Ridell Nursing Home	50	347,100
Missouri	Wentzville	Geri-Medics, Inc.	52	260,000
New Hampshire	Laconia	Lakes Region Convalescent Center	50	500,000
New Jersey	Cranford	Cranford House, Inc.	128	1,336,400
	Holmdel	Arnold-Walter Nursing Home, Inc.	124	1,212,200
	Lawrence Township	Blosom Hill Nursing Home	100	936,500
	Montclair	Van Dyks Nursing and Convalescent Home	62	695,000
	Plainfield	Plainfield Nursing Home	100	1,059,200
	Rivervale	Rivervale Nursing Home, Inc.	50	565,500
	Wayne	Geriatric Nursing Home	100	982,300
	do	Murray Manor Nursing Home	100	992,000
	West Milford	Milford Manor Nursing Home	100	937,200
New Mexico	Farmington	San Juan Manor	50	324,900
New York	Astoria	Astoria General Convalescent Home	114	1,210,500
	Flushing	Long Island Nursing Home	200	2,018,700
	Huntington	Carillon Nursing Home	120	1,200,000
	Lockport	Briody Nursing Home	50	412,200
	Mamaroneck	Sarah R. Newman Care Facility	180	1,742,400
Ohio	Cincinnati	Beech Knoll Nursing Home	100	773,100
	Marietta	Christian Anchorage Nursing Home	52	444,600
	Marysville	Milcrest Nursing Home	48	320,000
	Urbana	Independence House	100	731,700
	Westerville	Westerville Nursing Center	116	999,800
	Worthington	Norworth Convalescent Center	132	1,155,200
Oregon	Portland	Colonial Manor	88	549,000
Pennsylvania	Selinsgrove	The Doctors	32	245,000
Rhode Island	North Providence	Pezzelli Nursing Home	135	1,118,900
South Carolina	Abbeville	Abbeville Nursing Home	50	304,600
	Darlington	Oakhaven	40	338,000
	Gaffney	Brookview House, Inc.	40	299,900
Tennessee	Bristol	Bristol Nursing Home, Inc.	100	639,000
	Morristown	Downtown Nursing Home	50	305,500
Virginia	Wise	Wise County Stryrest Nursing Home	50	402,900
Washington	Spokane	Spokane Convalescent Center	53	393,400
Wisconsin	Bayside	Bayside Nursing Home	100	522,000
Total, 75 projects			6,729	52,345,500

Appendix 8

MATERIAL RELATED TO CONSUMER INTERESTS OF THE ELDERLY*

ITEM 1: REPORT FROM THE SPECIAL ASSISTANT TO THE PRESIDENT ON CONSUMER AFFAIRS

THE WHITE HOUSE,
Washington, January 5, 1968.

DEAR MR. CHAIRMAN: Thank you for asking us to contribute to your Annual Report on Legislative and Executive Developments in Aging During Calendar 1967.

The President's Committee on Consumer Interests acts as the voice of the consumer in the administration, coordinates consumer activity in Government agencies, cooperates with State agencies and voluntary organizations in advancing the interests of consumers, promotes action programs designed to improve consumer education, and recommends legislation of benefit to consumers. Our elderly consumers are a part of the overall consumer responsibilities we serve.

In his consumer message of February 16, 1967, the President recommended 12 consumer bills, which make our aged citizens one of the principal, but not the exclusive, beneficiaries.

In a number of cases, the direct effect upon the elderly is readily apparent from the name of the bill such as clinical laboratories improvements, truth in lending, interstate land sales, Welfare and Pension Plans Disclosure Act, among others.

Of the 12 bills recommended by the President, four have passed both the House and Senate and have been signed into law; these are:

National Commission on Product Safety (Public Law 90–146).

Partnership for Health Amendment of 1967 (Public Law 90–174); section 5 of the law covers clinical laboratories improvements.

Flammable Fabrics Act Amendments of 1967 (Public Law 90–189).

Wholesome Meat Act (Public Law 90–201).

Three of the 12 have passed the Senate only, these are:

Truth in lending.

Fire and Research and Safety Act of 1967: S. 1124, has passed the Senate (amended); House bill H.R. 11284, passed House Committee on Science and Astronautics, awaits House action.

Natural Pipeline Safety Act of 1967; S. 1166 (amended), passed Senate; House has referred its H.R. 13936 (which supersedes the original H.R. 9148) to Committee on Interstate and Foreign Commerce. Hearings held and is awaiting further committee action.

The status of the other consumer bills recommended by the President is as follows:

Interstate Land Full Disclosure Act: S. 275,[1] has undergone hearings and awaits action by Subcommittee on Securities, Senate Banking and Currency Committee; its companion bill, H.R. 6158, has been referred to Interstate and Foreign Commerce Committee and awaits hearings.

Welfare and Pension Plans Disclosure Act: S. 1024, referred to Committee on Labor and Public Welfare and awaits hearings; its companion bill, H.R. 5741, was referred to Committee on Education and Labor and awaits hearing.

Medical Device Safety Act of 1967; No bill was introduced in Senate; however, the House referred its H.R. 10726 to the Committee on Interstate and Foreign Commerce, but has held no hearings to date.

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*See ch. VI for discussion of matters related to this appendix.

[1] This bill is the result of studies by this committee and its Subcommittee on Frauds and Misrepresentations affecting the elderly (1964–65).

Mutual funds: S. 1659, Senate held hearings and awaits action by its Banking and Currency Committee; the House held hearings on the companion bill, H.R. 9510, and awaits action from its Subcommittee on Commerce and Finance, House Committee on Interstate and Foreign Commerce.

Electric Power Reliability Act of 1967: S. 1934, Senate held committee hearings and awaits further action by Committee on Commerce. House held hearings on H.R. 10721 and awaits further action by Committee on Interstate and Foreign Commerce.

In addition to our work on these bills, the President's Committee has also worked with the Administration on Aging in the preparation of a handy wallet-sized card to help the elderly protect themselves against fraud. The document has not as yet been released for publication.

The balance of the activities of the President's Committee on Consumer Interests has been in the area of speeches and testimony presented by the Special Assistant to the President for Consumer Affairs. For your records we are enclosing the following:

Remarks by Betty Furness before the Conference on Consumer Problems of Older People, Hudson Guild-Fulton Center for Senior Citizens, October 16, 1967.

Remarks by Betty Furness before the Conference on Aging, Indiana University, Bloomington, Ind., October 3, 1967.

Testimony by Betty Furness on Proposed Wholesome Meat Act before the Senate Committee on Agriculture and Forestry, November 15, 1967.

Testimony by Betty Furness on amendments to the Flammable Fabrics Act, S. 1003, May 4, 1967.

Statement by Mrs. Esther Peterson before the Subcommittee on Consumer Interests of the Elderly of the Special Committee on Aging, January 17, 1967.

We hope that this information will be useful to your Committee. You may also be assured that the President's Committee on Consumer Interests will continue to support efforts to make the lives of our senior citizens productive, healthy and happy.

Sincerely,

BETTY FURNESS,
Special Assistant to the President for Consumer Affairs.

ITEM 2: REPORT FROM THE FEDERAL TRADE COMMISSION*

The Federal Trade Commission has broad responsibility under the Federal Trade Commission Act to protect the public from unfair and deceptive trade practices in interstate commerce. When Chairman Paul Rand Dixon appeared before the committee January 18, 1967, he told of the Commission's deep concern about deceptive promotions having an impact on the health and economic well being of older citizens and stated that it attaches extremely high importance to them. The following are among those which concerned the Commission during 1967.

HEMORRHOID PREPARATIONS

The sale of hemorrhoid products is especially successful to those aged persons who have been persuaded by the advertising that the product is an adequate substitute for professional medical or surgical attention. The Commission concluded formal corrective action during the year respecting the advertising of five major products. At the end of the year the advertising of one large selling preparation remained under investigation.

ORAL ANALGESICS

The Commission has been developing scientific evidence for several years, including clinical testing, to permit an informed determination of the truth of advertising for these products which are sold in great volume to the aged. Since many of the claims for them also appear in labeling the Commission and the

*A report submitted at the request of committee chairman by F.T.C. Chairman Paul Rand Dixon on January 4, 1968.

Food and Drug Administration coordinated their efforts. The latter proposed comprehensive regulations covering safety and efficacy claims in labeling. The Commission instituted a Trade Regulation rule proceeding for the advertising of nonprescription systemic analgesics. This proceeding is under challenge in Federal court by one major analgesic manufacturer. If the Commission is eventually successful in this effort it will represent a major breakthrough in the field.

VITAMINS

The advertising for these products is addressed principally to older persons and holds out hope for rejuvenation. Reliance upon them as a substitute for proper medical care may actually impair health. The project was held up pending the appellate court decision on a Commission order involving the advertising of a major product. The decision in late 1967 sustaining the order in greater part enabled the Agency to reactivate its monitoring surveillance over these preparations with the result that at the end of the year a favorable initial decision had been issued against another major advertiser and investigations of claims for three other high volume preparations were underway.

HEALTH INSURANCE

The regulation of insurance lies principally with the States. However, the Commission's experience with mail order promoters reveals that there are those who would deceive the elderly to enrich their coffers. Some dangle bright promises even to the extent of persuading the aged to take the tragic step of abandoning longstanding policies which in reality afford greater protection. Since medicare went into effect, some mail promoters have sought to trade upon that program by falsely identifying their insurance as in some way endorsed or approved by the Federal Government. By year's end a great number had received Commission attention. Correction of the practices had been secured informally in 15 matters, 3 formal orders were issued, 20 investigations were closed primarily for jurisdictional reasons and 22 investigations were pending. The Commission also issued a public bulletin warning of "Pitfalls to Watch for in Mail Order Insurance Policies".

EARNINGS SCHEMES

One of the most vicious deceptions is that practiced on the elderly and retired who need and seek to augment their meager incomes. Many gimmicks are practiced upon them. One of the favorites involves the sale of chinchillas as breeding stock. The advertisements lead prospective purchasers to believe that raising them in the home is a "can't-miss, get-rich-quick" investment only for them to soon become generally rudely awakened to the fact that they cannot ever expect to recover their original substantial investment of $2,000 to $4,000 depending on the number of breeding stock purchased. Thirty such promotions are under current investigation and eight corrective orders were issued.

Another favorite to lift hard earned dollars saved from the pocketbooks of the elderly is the franchise scheme where potential earnings are exaggerated and the seller utterly fails to provide promised assistance in establishing and operating the business. Promoters of franchises for paints, shell homes, laundry and dry cleaning equipment, and vending machines are among those receiving active attention. Forty-seven of these cases are under investigation, three are in the process of formal litigation, one was settled by consent order and two were closed on the basis of informal corrective action.

FEDERAL-STATE COOPERATION

Since 1965 the Commission has particularly sought to encourage the States to act against deceptive practices which would be unlawful if used in interstate commerce. The program is enjoying marked success.

During the past year, with the Agency's encouragement, nine States either strengthened or enacted pertinent legislation. They were Arizona, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, New Mexico, Texas, and Vermont. Three States passed laws to require licensing of hearing-aid fitters and dealers, in accord with a Commission proposal. The five which now have this requirement are Florida, Indiana, Michigan, Oregon, and Tennessee. The elderly will benefit immeasurably from this forward step.

The Commission provided training assistance to 36 consumer personnel from 18 States; and State officials were furnished with law enforcement assistance on 188 occasions. During the year State consumer protection officials forwarded 390 complaints about deceptive practices across State lines. The Commission referred 100 matters to them as involving practices primarily intrastate in nature.

ITEM 3: REPORT FROM THE FOOD AND DRUG ADMINISTRATION

This replies to requests * * * concerning FDA's 1967 consumer education program for the aging. The answers to the questions as asked are as follows:

1. What was the extent of the FDA conference program and which State level groups were involved?

Consumer specialists in FDA's 17 district offices and National Drug Testing Center conducted 44 conferences or workshops in the year 1967 for a face-to-face audience total of 7,549. With our limited number of consumer specialists (17 on a full-time basis), we have had to restrict our consumer education activities to professionals and leaders working with the aging and to depend on these leaders to carry our life protection message to individuals with whom they come in contact.

In addition to the conferences, the consumer specialists also spoke to 90 local senior citizen centers or clubs for a total audience of 7,900. FDA exhibits were shown at several State or local health fairs, in libraries or public buildings in an effort to reach additional audiences.

Mrs. Maurine B. Neuberger, special consultant on consumer affairs to Commissioner Goddard, spoke at the Baltimore and Boston district aging conferences and at the Wisconsin State Medical Society annual convention. The theme of the medical meeting was, "The High Cost of Quackery in Lives and Money."

The attached list of FDA conferences gives the location, date, attendance, and local groups involved.

The enclosed December 1967–January 1968 issue of FDA Papers gives an additional narrative summary, "Meeting Senior Citizens," of the conferences.

2. What is the status of the proposed new regulations on vitamin and mineral supplements?

As you know, new regulations and standards pertaining to special dietary foods were published in the Federal Register of June 18, 1966, which were to become effective December 15, 1966. However, as a result of the objections and requests for a public hearing, an order was published in the Federal Register of December 14, 1966, which stayed the effective date of these regulations and standards; proposed several amendments to them; and outlined the issues for a public hearing. A date has not been set for this hearing as of yet. We enclose a fact sheet and a reprint from the Federal Register of December 14, 1966, concerning the regulations.

3. What information has been given senior citizens on the Fair Packaging and Labeling Act?

Final regulations for food products—which will make it easier to compare the contents of different products and in other ways to make a value judgment—have been discussed at conferences sessions. Final regulations are expected to be published soon on drugs, cosmetics, and devices. The public will be seeing the effects of this act during 1968.

4. What is the status of the report on susceptibility to health fallacies and misrepresentations?

The first phase of this study—which is a seven-agency study—on pretest-screening to identify types of susceptibility has just been completed. The steering committee will meet on January 15 to consider use of the first phase materials.

If we can be of further assistance, please let us know.

Sincerely yours,

PAUL A. PUMPIAN,
Director, Office of Legislative and Governmental Services.

EXHIBIT A. "MEETING SENIOR CITIZENS: DIALOGS FOR ACTION," AN ARTICLE IN FDA PAPERS, DECEMBER 1967–JANUARY 1968

(By Catherine Stahl)

Another milestone on the road to consumer protection is the consumer education conference, tailored to bring FDA's "Life Protection" message to our older citizens.

A year ago FDA asked the consumer specialists in its 17 district offices to direct special attention to health education of the elderly. They were to develop, as part of an overall national program, effective local and State programs. The FDA would sponsor such projects on its own, or with the help of other Federal and local agencies.

Included in this new program to bring senior citizens up to date on foods, drugs, cosmetics, medical devices, and certain hazardous substances was the sponsoring of regional conferences directed at professional groups and organizations concerned with the problems of the elderly.

The audience is 19 million Americans, 65 years and over—with 4,000 swelling their ranks daily. This represents one in every 10 people—10 percent of what FDA considers the Nation's richest resource—people. These Americans also represent a total buying power of $40 billion. And this, according to the hearings held by the Senate Subcommittee on Consumer Interests of the Elderly, "makes them an alluring target for pitchmen inside or outside the law."

The target is not only alluring but also ample. For these older people, exposed by susceptibility and shibboleths, have an Achilles heel larger than that of the rest of the population. What makes them more vulnerable is the high incidence of chronic illness, low income, and loneliness. Add to these factors, human credulity, distaste of growing old, visual impairments, and faulty judgment, and the chance increases that they may become the major victims of fraudulent practices.

To protect them—through awareness of the medical care they receive, of the drugs prescribed for them, of the foods they eat, and of the devices that are used for their health—was one of the FDA's incentives for launching its program. Awareness, it was felt, would not only protect them from abuse in the marketplace, but would also buy their independence and self-esteem, and spark their will to continue to grow.

This is what the FDA set out to do, and the conference technique was the tool enlisted to carry out its mission.

Conferences are not convened full-blown. They evolve from meticulous, long-range planning and careful coordination among the sponsoring agencies.

Consider the "Health Frauds and Quackery Leadership Conference," presented in Boise, Idaho, earlier this year. It grew from suggestions offered by the FDA's Denver and Seattle consumer specialists at the Administration on Aging-sponsored conference held in Salt Lake City in the fall of 1966. Impressed with their idea that a program on health frauds and quackery would be valuable if offered at the State level, the AOA representative contacted the Boise Council on Aging.

The result—a leadership conference to increase knowledge of health frauds and to encourage educational programs on wise selection of health products.

Attending were 75 leaders representing the professions, community organizations, voluntary health agencies, and government. Sponsoring were the Idaho State Nurses Association, the Boise Council on Aging, the Idaho Dietetic Association, the Idaho Cooperative Extension Service, and the FDA.

Steered by competent conference leaders, and garnished with kits of educational materials, a new FDA film, "The Health Fraud Racket," and a chamber-of-horrors exhibit, prepared by the Post Office Department and the FDA, the suggestion planted 6 months earlier had developed into a full-fledged leadership conference.

While each conference displays a different "mix" of sponsors, the general mosaic is an integrated effort by individuals, private groups, industry, and representatives of all levels of government.

The Los Angeles meeting was under the sponsorship of the FDA, the Los Angeles County Department of Senior Citizens Affairs, and the University of Southern California Rossmoor-Cortese Institute for the Study of Retirement and Aging.

This program attracted 164 professionals in positions concentrating on assistance to the aging. Among them were medical doctors, architects, registered nurses, social workers, recreation directors, teachers, consultants from the fields of sociology and psychology, administrators from voluntary organizations, and resource people from county, State, and Federal offices.

After a morning session of exploring nutritional and medical quackery, the professionals were instructed to select and attend two of the four workshops offered. An evaluation card, filled in by the participants and tabulated by IBM computers, gaged the conference evaluation.

At the Governor's annual aging conference in Austin, Tex., the sponsors included the AOA, the FDA, the Governor's committee on aging, and the Texas Agricultural Extension Service.

The Tampa conference for 170 community leaders, also under FDA-AOA sponsorship, with the help of the Florida Commission on Aging, zeroed in on today's marketplace in an effort to help older citizens sidestep fraudulent products and appeals. Again, in Boston, the FDA and AOA teamed up to play conference hosts to 75 participants representing the aging.

Before the year is over, each of the 17 FDA districts will have held at least one such conference.

From the outset, it was abundantly clear that the conference leaders shared President Johnson's confidence in the integrity of industry and the role private enterprise should assume in attacking social problems. "The consumer," said the President in his February 17 consumer message, "must be protected against unsafe products, against misleading information and against the deceitful practices of a few businessmen that can undermine confidence in the vast majority of diligent and reputable firms."

"It is our conviction," voiced the representative of the National Better Business Bureau, and the other speakers echoed his belief, "that the majority of American businessmen are honest * * *. Unfortunately, a small but strident minority has cast a large, gray shadow over the marketplace."

Following are excerpts from conference proceedings:

Noting that many older people are often stranded in the marketplace instead of being supported by it, it was observed that the health professions have not been as effective as the ad agencies and their clients in reaching the elderly. "Because the aged tend to place faith in advertising, the tendency is for them to seek self-medication rather than professional help. False or misleading advertising is twisting the art of healing into the art of stealing."

This art is refined and extensive. "It contains illegally promoted therapeutic and pseudotherapeutic devices, food supplements, and so-called health foods. In its most sophisticated form it involves deliberately falsified scientific studies and false promotional claims for potent drugs or drugs that are not efficacious where serious illness is involved."

In the area of food the participants were briefed on the proposed regulations that substitute for "minimum daily requirements" the more accurate phrase "recommended dietary allowances."

"If the older person suspects that he is not eating right, he is ready prey for the nutritional quack who says 'take my pills and don't worry.' Yet he may not be able to intelligently read the label on that food supplement to know what he is buying, and may spend money for 50 times his maximum daily need of vitamins—which he could have had with his food."

Since older people often lack the incentive to prepare well-balanced meals for themselves, "they should be encouraged to take a fresh look at some of the convenience foods that are on the market. The unit cost may be a little higher than the same quantity of food prepared in the traditional manner, but lack of waste and better nutrition resulting from a greater variety of food could easily make up the difference."

"Malnutrition among the aging is not solely the result of low income; it is also due to loneliness, to poor cooking facilities, to shopping problems, to poor teeth, and to careless eating habits."

"Drugs have changed even more than foods during the past 20 years. More of our elderly citizens are taking advantage of new medical care than ever before. Yet, many of them are still generally unaware of the need for their intelligent choice of medicines and medical services. They do not understand why they cannot diagnose and treat all 'minor' ailments safely. They do not realize the importance of following their doctor's directions exactly when they take the drugs he prescribes."

"Since the elderly frequently do not consult physicians for regular checkups because of economic reasons, they rely heavily on drugs which may be purchased over the counter.

"In this connection, it should be remembered that any drugs which produce temporary relief of a symptom, whatever that symptom may be, may be masking a more serious condition if that symptom persists when the medication is discontinued. It is important, therefore, that on any over-the-counter drug, the directions on the label be read carefully, the limitations as to temporary relief be taken literally, and the instructions against continued use be observed.

"It is important to compare the statement on the label and in the package with what has been said in the advertisement. There is a good reason for this. The FDA, when a new drug is introduced into the market, has jurisdiction over the labeling and will carefully study this labeling and restrict it to those conditions for which the drug has been shown to be safe and effective in the dosage and in the duration specified—and in these only."

The category of drugs available only on prescription are really the "big guns" in the drug world. "These drugs are for Mrs. Jones to take in a certain way for a certain period of time, and for her specifically—for her symptoms or disease."

And after Mrs. Jones is well, and there are still a few tablets or capsules left in the prescription bottle, the instruction she should follow is to flush them down the toilet. One of the most dangerous things she can do is to share her prescription drug with someone else.

Industry and Government try hard to be sure that the food and drugs on today's market are pure and safe. "Wise selection and use of these items are the responsibility of the consumer."

To assure this wisdom of selection and use, the conference leaders recommended "more, better, and specific information and education."

"I would like to suggest that those professionals who have significant contact with the elderly should help educate them directly. Physicians, ministers, lawyers, social workers, could make it their business to aid the elderly * * *. The doctor could play a much more important part in bringing to the attention of the patients some of the dangers of fake arthritic remedies, the pointlessness of unnecessary vitamins, and the like. One of our leading geriatric physicians has commented that the older person is better off getting his vitamins from the grocery store than from the drugstore. Older persons themselves could and should organize to protect themselves through administering educational programs and pressuring for legislation. Control of advertising, via self-policing by periodicals and by enforcement, is necessary * * *."

But it was obvious to both the conference leaders and the participants that a working partnership among the professions, Government, and private enterprise was essential to meet the overwhelming challenge that confronts us in dealing with the health problems of the Nation's elderly. Only through this harmonious partnership, with each group contributing new solutions to common problems, would the goal of assuring optimum health protection for every American be reached.

With this goal in mind, the consumer specialists headed for the grassroots. Their reports, full of promise and activity, show that they have been speaking to retired groups, conducting workshops and seminars, answering tough questions, manning exhibits, and publishing articles. They also show that business, local government, private organizations, the professions, and—most rewarding of all—senior citizens themselves are responding favorably and keenly—

In Chattanooga, 50 firms were invited to attend a capsule conference where they were presented with an informal review of FDA's concern for the older citizen.

In Boston, the consumer specialist talked to a senior citizens group; found them appreciative and alert—asking such questions as "What about prescriptions ordered by a doctor—are they cheaper by generic names?"

In Chicago, an individual contact with an official of the Amalgamated Clothing Workers of America yielded six "mini-workshops," featuring a "short and snappy" series on "How to Get the Most for Your Money." Such workshops, say the consumer specialists, provide an opportunity to try new teaching ideas, to observe the learning patterns of older people, and to become more experienced in how to work with them.

In Detroit, the consumer specialist arranged exhibits for the United Automobile Workers Older and Retired Workers Department, and conducted workshops with leaders of older citizens' clubs to encourage a wise use of medicines, devices, and health services.

So it goes—across the country.

FDA, with the help of sister agencies in Government and similarly oriented private or commercial groups, will continue to penetrate the world of our elderly citizens and bring to their doorsteps awareness of the new medicine, the new foods, and the new hazards of the marketplace.

ITEM 4: REPORT FROM THE ADMINISTRATION ON AGING

(A description of consumer activities by AOA appears as part of appendix 2)

Appendix 9

MATTERS RELATED TO THE WAR ON POVERTY AND THE ELDERLY

ITEM 1: REPORT ON OEO PROGRAMS RELATING TO OLDER PERSONS *

There are about 8 million people 55 years of age and older who are poor. Their problems are not as apparent as those of other age groups, because they are with their children or in rented quarters, old rooming houses, hotels or isolated farm homes.

OEO has developed programs for these older Americans recognizing that these older Americans have skills, wisdom and patience to give to the society that they helped to build.

I. In August 1965 the President announced the first 21 foster grandparents demonstration projects. This program recruits, trains, and employs low-income men and women over 60 years of age to work with neglected, deprived, mentally and physically handicapped children. It has two functions:

1. To help older men and women supplement their income as well as to feel they are contributing to the needs of others.
2. To provide love and individual attention to infants and children who would not otherwise receive such care.

This program has proved so successful that by the end of fiscal year 1967, there were 65 foster grandparent projects in 38 States and Puerto Rico, employing 3,927 foster grandparents serving 8,000 children in 156 institutions, public schools, Headstart homes and programs at a cost of $8.3 million.

II. In 1965 Senator Nelson introduced an amendment to the Economic Opportunity Act for community betterment and beautification programs. A demonstration project known as Green Thumb was set up in 4 States to test the training of and future employment possibilities of older men with low incomes and farming backgrounds as workers in community development and beautification projects. This program is no longer a demonstration program and functions in 7 States, and employs 1,179 older men to plant, weed, cut and clean along the highways and build roadside parks and rest facilities.

III. OEO in cooperation with the Public Health Service developed a $1 million pilot study for various methods of training home health aides. Recruitment was directed primarily at the over-45 age group. By June 30, 1967, 2,000 persons had been trained as home health aides.

IV. At the end of fiscal year 1967, there were 200 OEO-financed Senior Citizens Centers and multipurpose centers serving about 150,000 older people. Community action agencies in 45 States, Puerto Rico and Guam have initiated programs designed to meet the needs of low-income older persons. These programs serve the needs of some 520,000 older people. Some 12.5 percent of the program employees (7,000) are over 55 years of age.

V. General and special programs of OEO have also served older people. Three hundred and twelve older people have been recruited as VISTA volunteers, and many of those served by VISTA volunteers have been older people with low incomes.

VI. Project FIND (Friendless, Isolated, Needy, Disabled) is OEO's latest demonstration project for older people. It provides funds for 12 community action agencies in 11 States and the District of Columbia to employ 372 men and women over 55 with low incomes to locate the exact number of older people in the community who need housing, health, employment, nutrition, and recreational services; and to direct them to these services.

*A report submitted on Dec. 29, 1967, by OEO Director Sargent Shriver at the request of Committee Chairman Williams.

This project has become so popular that many communities are independently (without OEO funds) cooperating in the study. Fourteen of the projects have agreed to have their data assimilated into the national study.

VII. The most significant development of the year, in long-range terms, was probably the establishment in April of the Office of Older Persons programs and the appointment of a new assistant director, who both heads this new office and works closely with the director in securing agencywide attention for the problems of the older poor. In each regional office as well as in each national program office, the new assistant director has one staff member designated to work with her and to look after older persons programs, and she has completed a country-wide tour of all of these offices to stimulate increased activity in this field. She has also reactivated the National Advisory Community, which had not met for some time but which held a very profitable meeting in September. In addition, she has helped plan two Regional Conferences on Aging, which have been conducted as part of their OEO contract by the National Council on Aging. These two conferences have been held in Minneapolis and New Orleans, and others will be held in other sections of the country during the next few months. The impact which they have had on the consideration and sponsorship of older persons programs by OEO Community Action Agencies has been very great already and can be expected to increase.

ITEM 2: ECONOMIC OPPORTUNITY ACT AMENDMENTS BENEFITTING THE ELDERLY POOR WHICH WERE ADDED BY PUBLIC LAW 90-222

(NOTE: Language of the Economic Opportunity Act previous to P.L. 90-222 which was not amended thereby is reproduced in roman type. Language added by that P.L. is reproduced in italic. Language in the Act which was deleted is enclosed in black brackets.)

TITLE I—WORK TRAINING AND WORK-STUDY PROGRAMS

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[PART B—WORK TRAINING PROGRAMS]

PART B—WORK AND TRAINING FOR YOUTH AND ADULTS

* * * * * * *

ELDERLY

Sec. 126. The Director shall provide that programs under this part shall be designed to deal with the incidence of long-term unemployment among persons fifty-five years and older. In the conduct of such programs, the Director shall encourage the employment of such persons as regular, part-time, and short-term staff in component programs.

TITLE II—URBAN AND RURAL COMMUNITY ACTION PROGRAMS

[PART A—GENERAL COMMUNITY ACTION PROGRAMS

[STATEMENT OF PURPOSE

[SEC. 201. The purpose of this part is to provide stimulation and incentive for urban and rural communities to mobilize their resources to combat poverty through community action programs.]

STATEMENT OF PURPOSE

SEC. 201. (*a*) *This title . . . Its basic purpose is to stimulate a better focusing of all available local, State, private, and Federal resources upon the goal of enabling low-income families, and low-income individuals of all ages, in rural and urban areas, to attain the skills, knowledge, and motivations and secure the opportunities needed for them to become fully self-sufficient . . .*

* * * * * * *

Part B—Financial Assistance to Community Action Programs and Related Activities

GENERAL PROVISIONS FOR FINANCIAL ASSISTANCE

SEC. 221. (*a*) *The Director may provide financial assistance to community action agencies for the planning, conduct, administration and evaluation of community action programs and components. Those components may involve, without limitation, other activities and supporting facilities designed to assist participants including the elderly poor—*

* * * * * * *

SPECIAL PROGRAMS AND ASSISTANCE

SEC. 222. (*a*) *In order to stimulate actions to meet or deal with particularly critical needs or problems of the poor which are common to a number of communities, the Director may develop and carry on special programs under this section. . . . Programs under this sections shall include those described in the following paragraphs:*

* * * * * * *

(*8*) *A program to be known as 'Senior Opportunities and Services' designed to identify and meet the needs of older, poor persons above the age of 60 in one or more of the following areas: development and provision of new employment and volunteer services; effective referral to existing health, welfare, employment, housing, legal, consumer, transportation, education, and recreational and other services; stimulation and creation of additional services and programs to remedy gaps and deficiencies in presently existing services and programs; modification of existing procedures, eligibility requirements and program structures to facilitate the greater use of, and participation in, public services by the older poor; development of all-season recreation and service centers controlled by older persons themselves; and such other activities and services as the Director may determine are necessary or specially appropriate to meet the needs of the older poor and to assure them greater self-sufficiency. In administering this program the Director shall utilize to the maximum extent feasible the services of the Administration of Aging in accordance with agreements with the Secretary of Health, Education, and Welfare.*

* * * * * * *

RESIDENT EMPLOYMENT

SEC. 223. *In the conduct of all component programs under this part, residents of the area and members of the groups served shall be provided maximum employment opportunity, including opportunity for further occupational training and career advancement. The Director shall encourage the employment of persons fifty-five years and older as regular, part-time and short-term staff in component programs.*

TITLE III—SPECIAL PROGRAMS TO COMBAT POVERTY IN RURAL AREAS

Part A—Rural Loan Program

STATEMENT OF PURPOSE

SEC. 301. It is the purpose of this [title] *part* to meet some of the special [problems of rural poverty and thereby to raise and maintain the income and living standards] *needs* of low-income rural families [and migrant agricultural employees and their families.] *by establishing a program of loans to assist in raising and maintaining their income and living standards.*

[Part A—Authority to Make Loans]

SEC. 302. (a) The Director is authorized to make loans having a maximum maturity of 15 years and in amounts not resulting in an aggregate *principal* indebtedness of more than $3,500 at any one time to any low income rural family where, in the judgment of the Director, such loans have a reasonable possibility of effecting a permanent increase in the income of such families *and in the case*

of the elderly, will contribute to the improvement of their living or housing conditions by assisting or permitting them to—

(A) acquire or improve real estate or reduce encumbrances or erect improvements thereon.

* * * * * * *

(b) Loans under this section shall be made only if the family is not qualified to obtain such funds by loans under other Federal programs.

* * * * * * *

PROGRAMS FOR THE ELDERLY POOR

SEC. 610. It is the intention of Congress that whenever feasible the special problems of the elderly poor shall be considered in the development, conduct, and administration of programs under this Act. The Director shall *(1)* carry out such investigations and studies, including consultations with appropriate agencies and organizations, as may be necessary [(1)] to develop *and carry out a plan for the participation of the elderly poor in programs under this Act, including* programs providing employment opportunities, public service opportunities, [and] education *and other services and activities which assist* [for] the elderly poor [under the provisions of this Act, and (2) to] *to achieve self-sufficiency; (2) maintain a constant review of all programs under this Act to assure that the needs of the elderly poor are given adequate consideration; (3) initiate and maintain inter-agency liaison with all other appropriate Federal agencies to achieve a coordinated national approach to the needs of the elderly poor; and (4)* determine and recommend to the President and the Congress such programs requiring additional authority and the necessary legislation to provide such authority. *In exercising his responsibilities under this section, the Director shall cooperate with the Commissioner on Aging. The Director shall describe the ways in which this section has been implemented in the annual report required by section 608.*

[TITLE VIII—VOLUNTEERS IN SERVICE TO AMERICA

[STATEMENT OF PURPOSE

[SEC. 801. It is the purpose of this title to enable and encourage volunteers to participate in a personal way in the war on poverty, by living and working among deprived people of all ages in urban areas, rural communities, on Indian reservations, in migrant worker camps, and Job Corps camps and centers; to stimulate, develop and coordinate programs of volunteer training and service; and, through such programs, to encourage individuals from all walks of life to make a commitment to combating poverty in their home communities, both as volunteers and as members of the helping professions.]

TITLE VIII—DOMESTIC VOLUNTEER SERVICE PROGRAMS

VOLUNTEERS IN SERVICE TO AMERICA

STATEMENT OF PURPOSE

SEC. 801. This title provides for a program of full-time volunteer service, for programs of part-time or short-term community volunteer service, and for special volunteer programs, together with other powers and responsibilities designed to assist in the development and coordination of volunteer programs. Its purpose is to strengthen and supplement efforts to eliminate poverty by encouraging and enabling persons from all walks of life and all age groups, including elderly and retired Americans, to perform meaningful and constructive service as volunteers in part-time or short-term programs in their home or nearby communities, and as full-time volunteers serving in rural areas and urban communities, on Indian reservations, among migrant workers, in Job Corps centers, and in other agencies, institutions, and situations where the application

of human talent and dedication may help the poor to overcome the handicaps of poverty and to secure and exploit opportunities for self-advancement.

* * * * * * *

PARTICIPATION OF OLDER PERSONS

SEC. 832. In carrying out this title, the Director shall take necessary steps, including the development of special projects where appropriate, to encourage the fullest participation of older persons and older persons membership groups as volunteers and participant agencies in the various programs and activities authorized under this title and, because of the high proportion of older persons within the poverty group, shall encourage the development of a variety of volunteer services to older persons, including special projects, to assure that they are served in proportion to their need.

Appendix 10

MATERIAL RELATED TO RETIREMENT TRENDS*

ITEM 1: REPORT ON AGING PROGRAMS, NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT**

The National Institute of Child Health and Human Development (NICHD) is the Institute at NIH that is responsible for the encouragement, development, and support of research and training directed toward an understanding of developmental and aging processes. The support of aging research by NICHD is broad, including biological, psychological, medical, and social aspects of aging. The NICHD Adult Development and Aging Branch is responsible for extramural programs concerned with aging research, the NICHD Gerontology Reseach Center is responsible for intramural research on aging, and the NICHD Scientific Information Centers Branch is responsible for the Aging Information Center.

NICHD supports research and training for research through a variety of mechanisms. In fiscal year 1967 there were 69 research grants funded at $3,233,799. Approximately one quarter of the funds were expended for psychological and social research. The other three quarters supported biological research. There were 21 training grants funded at $1,784,106. Somewhat over half of these were in the psychological and social sciences. The remainder were in biological aspects of aging. There were 13 fellowships funded at $158,327 and seven research career development awards funded at $146,680.

In addition to the support of research at universities, medical schools, and research institutions throughout the country, NICHD conducts direct research on aging at the Gerontology Research Center located at the Baltimore City Hospitals. This research activity involves a staff of over 100 persons carrying out investigations of cellular, physiological, biochemical, and psychological function with age. A colony of rats is maintained with animals ranging from infancy to senescence. Men from a volunteer population ranging in age from the teens to over 100 years of age visit the Center periodically for studies of medical, biochemical, physiological, and psychological functions. In these studies normal changes that occur over the lifespan are being carefully characterized. A new building of about 90,000 square feet of laboratory to house the Gerontology Research Center has been constructed on the grounds of the Baltimore City Hospitals and will be occupied early in 1968. This building will also provide space for collaborative studies with the staff of the Baltimore City Hospitals, the Johns Hopkins School of Medicine, the University of Maryland School of Medicine, and the Maryland State Commission on Aging.

NICHD is placing emphasis on the development of university-based training programs on aging. The number of training programs doubled in fiscal year 1966 and increased by 30 percent in fiscal year 1967. These programs support graduate and postgraduate students who are learning to conduct research that bears on the problems of aging in a great many fields. Because of the importance of training for the future development of research, considerable importance is attached to planning of future training. A contract has been let to the Gerontological Society to survey research training needs in gerontology. The desired information has been gathered by conferences of scientists and educators interested in aging, questionnaires to individuals and institutions involved in training, and interviews at selected training sites. The information is being analyzed, and a report of the findings is being prepared.

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*See ch. VIII for discussion of matters related to this appendix.

**Prepared by Leroy E. Duncan, Jr., M.D., Chief, Adult Development and Aging Branch, NICHD.

There has been a great need for a directory that would provide information on persons and institutions interested in the field of aging. Such a document—a directory of international resources in gerontology—is being prepared under a contract with the Gerontological Society. The directory will consist of listing and descriptions of personnel involved in gerontological research, institutions with major commitments to research in aging and to training for such research, scientific and professional organizations concerned with research and training for research in areas relevant to the problems of aging, and resources of value in aging research such as colonies of old animals.

The ability to maintain effective coverage of the scientific literature in the field of aging is an important aid in the development of new knowledge. NICHD has supported the preparation and publication of bibliographic aids that facilitate the maintenance of such coverage by scientists. One of these is "Current Publications in Gerontology and Geriatrics," which consists of about 3,000 citations annually and is published in the Journal of Gerontology. This bibliographic information has been published in that journal for many years and provides a readily accessible source of information on research on aging. NICHD has also supported the publication of the abstract journal "Gerontology and Geriatrics," which is prepared by the Excerpta Medica Foundation. About 3,000 journals, in addition to books, reports, and other appropriate publications related to the basic and clinical sciences in gerontology and geriatrics, are reviewed and abstracted in this journal.

In order to make possible even more effective utilization of the world's literature on aging, NICHD is creating an Aging Information Center. The personnel of this Center will scan the periodical literature relevant to the problems of aging, identify communications that bear on aging, abstract them, and store the abstracts on tapes for computer processing. These abstracts will be published in periodic journals developed for this purpose. In addition qualified institutions and investigators may have the tapes searched for specific types of information that they desire. The system has been developed during the last 2 years and should become functional in 1968.

NICHD has held a series of conferences related to problems of retirement. In the four conferences held so far emphasis has been on the psychological impact of retirement on the individual and on the interrelations of chronic disease and retirement.

A conference on the effect of housing facilities on the life of the elderly was held by NICHD and has been published under the title of "Patterns of Living and Housing of Middle-Aged and Older People."

Large-scale longitudinal studies of humans provide an important means for studying physiological, psychological, medical, and social aspects of aging. A conference to bring together investigators from the major such studies in this country was supported by contract at Duke University. The conference provided the opportunity for a discussion of the similarities and differences of the goals, populations, and methodology involved in the different studies.

The interrelations of age and intellectual function are very important aspects of adult development and aging. Two conferences on learning and age have been held as a guide to program development—one at Duke University and the other in Bethesda.

ITEM 2: REPORT FROM U.S. OFFICE OF EDUCATION

DECEMBER 27, 1967.

DEAR SENATOR WILLIAMS: This letter is in reply to your request of December 20, 1967, for a summary of activities and accomplishments of the U.S. Office of Education during this calendar year with respect to older Americans.

Major programs reaching a considerable number of older Americans are the adult basic education program, the manpower development and training program, library services and construction program, and community service and continuing education programs.

The adult basic education program, established as title II–B of the Economic Opportunity Act of 1964, is continued as the Adult Education Act of 1966 (title III of the Elementary and Secondary Education Act, 1966 amendments). The program provides instruction in basic skills—reading, writing, speech, comprehension, computation—up to and including the eighth-grade level for persons 18 years of age and older who need and desire such skills. Adults enroll because they want to prepare for a job or job promotion, they want to be able to follow their children's progress in school, they want to be more functioning citizens.

The program is administered by State education agencies according to State plans submitted to the U.S. Office of Education and approved by the U.S. Commissioner of Education. Facilities and resources of local public school systems are utilized where available. Approximately 31 percent of the students currently enrolled in adult basic education classes are 45 years of age or older.

Training under the Manpower Development and Training Act has continued its efforts for older workers in line with the 1966 amendment to the act (title II, pt. A, sec. 202). Nationally, 11.6 percent of the trainees in institutional training programs and 10.1 percent of the trainees in on-the-job training programs were 45 and over.

Because many of the older worker trainees bring with them to training a variety of problems, the program has been seeking out, through pilot efforts, the kinds of teachers, methods, schedules, and materials that meet the needs of the older worker. One approach to this in MDT programs has been the multi-occupational training program which provides a variety of training opportunities as well as supplemental services. Many older workers lack basic education and would benefit from prevocational training as well as vocational training. The multitype program provides these as well as counseling prior, during, and after training.

Programs are being reviewed to determine which training offers the highest rate of job placement for older workers in order that training in these areas may be expanded and strengthened. A manual for instructing the older worker and an instructors guide is being prepared for use in teacher training and inservice programs under manpower development and training.

The Division of Library Services through a variety of activities provides assistance on the needs of the elderly. The adult services specialist in the Library Planning and Development Branch gives advice and counsel to regional representatives of the Bureau to adult service librarians in State and metropolitan public libraries. The specialist plans for library participation with other relevant Federal programs in this Bureau, in the Office of Education, and in the Federal Government. The American Library Association bulletin recently published an article by the adult services specialist on Federal legislation relating to library services for older Americans.

Under Library Services and Construction Act projects for the aging, a new program serving the aging began in April 1967 in St. Louis, Mo., using $53,310 in Federal funds under LSCA. The St. Louis Public Library is providing specialized services to the city's 85,000 residents who are 65 years of age or older. Using delivery vans and specially designed book carts, the program staff brings books and library services into hotels, apartments, and rooming houses—directly to the aging wherever they are living. In California, the Los Angeles City Public Library is continuing a service to shut-ins program financed with Library Services and Construction Act funds and primarily serves the aging.

Community service and continuing education programs, title I of the Higher Education Act of 1965, has established a number of programs designed to assist the older American.

Recognizing that early retirement and advances in medical science have provided the senior citizen with many years available for useful activities, this program is attempting to find solutions to the problems which confront the older adult and to increase the possibilities for effective utilization of this potential reservoir of knowledge, manpower, and experience. Programs with these objectives include—

Consumer education for the elderly through telecasts and counseling services;

Training programs for administrators of care facilities for the elderly;

Interdisciplinary courses in social gerontology, home nursing, health, recreation, and employment for professionals, volunteers, and community leaders to aid them in working with the aged;

Job counseling, retirement counseling, educational programs, and discussion groups for the elderly to enable them to be more productive and useful citizens of the community;

Training programs for volunteers who counsel the aging and who supervise leisuretime programs for the elderly in nursing homes and homes for the elderly;

Educational programs for senior citizens designed to help them adjust mentally and physically to a new "style of life," to enable them to qualify for leadership roles in community service projects.

Mature women face problems similar to the retiree due to their changing status in the economic, political, sociological, psychological, and intellectual milieu of our society. There is a need to enlarge their horizons, to help them assess their capabilities and define new goals, and to reorient themselves to the needs of the labor market and the community. Programs directed to meeting these needs include counseling for individual development and self-improvement; programs designed to help women assess their present status and their potential; programs to assist women in securing gainful employment, more education, and satisfying participation in civic affairs; and courses to prepare women for leadership roles as volunteers.

This will identify and briefly describe programs that include services and activities involving older adults. If we can be of further assistance, please do not hesitate to call on us.

Sincerely yours,

GRANT VENN,
Associate Commissioner for Adult, Vocational, and Library Programs.

Appendix 11

INFORMATION RELATED TO PROPOSAL FOR WHITE HOUSE CONFERENCE ON AGING*

ITEM 1: MAJOR PROVISIONS—SENATE JOINT RESOLUTION 117

a. Authorizes the President to call the conference in 1970 which will be administered by the Secretary of HEW.

b. Authorizes each State, upon application to HEW, not less than $5,000 nor more than $25,000 for planning and conducting a State conference; developing facts, recommendations, and reports; and for costs incident to attending the White House Conference.

c. Authorizes the Secretary of HEW to establish an advisory committee to advise and assist in planning and conducting the Conference, and provide for compensation of advisory committee.

ITEM 2: FACTS ON 1961 CONFERENCE AND PRECEDING STATE CONFERENCES

LEGISLATIVE HISTORY

On January 8, 1958, Congressman John Fogarty of Rhode Island introduced H.R. 9822 to provide for holding a White House Conference before December 31, 1958. The bill provided grants to the States for the purpose of enabling them to collect information and to organize and conduct conferences on aging prior to the national conference.

At a hearing before the Committee on Education and Labor, Congressman Fogarty, at the instance of a number of States, suggested that the date be changed from 1958 to some time in 1960. On July 28, the full Committee on Education and Labor reported favorably H.R. 9822 with amendments, (1) changing the date to September 30, 1960, and (2) giving the Secretary of HEW rather than the staff on aging the statutory responsibility for the administration of the act. The amended bill was passed in the House on July 29, 1958.

On August 13, 1958, Senator McNamara reported favorably for the Labor and Public Welfare Committee the bill passed by the House with proposals to amend the date to January 1961 and to reduce the amount of the State grants from a maximum of $50,000 to a maximum of $15,000 but not less than $5,000. The bill was passed by the Senate on August 19 and the House concurred in the Senate amendments.

On September 2, 1958, Public Law 85–908, the White House Conference on Aging Act was signed by President Eisenhower.

APPROPRIATIONS

Initial	[1] $100, 000
1959	[2] 844, 000
1960	452, 000
1961	760, 000

[1] To permit planning to begin.
[2] $810,000 was for State grants.

Total appropriations for the purposes of the act was $2,156,000.

*For additional discussion, see ch. X.

GRANTS TO THE STATES

Forty-eight of the States and territories applied for and were granted the maximum $15,000. Delaware applied for $12,000, Virgin Islands $10,000, and Montana $5,000. Indiana participated in the Conference but did not request Federal funds.

The first applications were received in June 1959 and the first grants were made available in August of that year, although the States were authorized to start using funds from the date of application. Ten criteria, entitled "Suggested Types of Provisions of State Plans" were provided to the States to be used in connection with their plans. Five of the provisions were required:

1. The designation by the Governor of a State officer.
2. The conduct of one or more conferences within the State.
3. A review of the needs and potentials of older persons and information on successful approaches and methods.
4. The development of facts and recommendations and a report of the findings to the Secretary prior to the Conference.
5. The submittal of necessary reports.

STATE, REGIONAL, AND LOCAL CONFERENCES

At least 35 of the States held regional conferences. Some States set up regional organizations while others conducted regional activities under the sponsorship of State commissions or subcommittees.

About 73,000 persons participated in at least 256 regional meetings and approximately 670 county or community meetings. In all, more than 103,000 citizens took an active part in conferences and meetings.

DEVELOPMENT OF RECOMMENDATIONS

The overall plan of the White House Conference on Aging called for the States to develop facts and recommendations over the entire range of subject matter area encompassed by the Conference structure. All 53 States and territories drew up recommendations and most of them covered each of the 20 subject areas. More than 6,000 recommendations grew out of a year or more of research and study.

The process by which State recommendations evolved followed a general pattern. Most were initiated at the local, county or regional level. They were then submitted—along with recommendations formulated by study groups of the State committee—to the delegates of the State conference for further discussion and often for final approval.

In some cases, postconference review and final approval was given by the State commission on aging or by a White House Conference committee.

In accordance with Conference planning, each State submitted its recommendations several months in advance of the Conference. They were classified and summarized according to 20 subject matter areas and distributed to the delegates as working papers of the Conference.

CONFERENCE PARTICIPATION

Registration at the Conference numbered 3,234 persons of whom 2,565 were voting delegates and 669 nondelegates. Of the 2,565 delegates, almost two-thirds (1,694) were named by the States and territories. Nearly one-quarter (628) were appointed by national voluntary organizations. The remaining 10 percent were members of the National Advisory Committee (132) and consultants to the planning committees (111). Nondelegates consisted of 405 invited guests and 264 nondelegates with program responsibilities.

STATE DELEGATES

Each State's delegate quota was established in relation to its congressional delegation, reflecting the State's total population with a slight advantage for the smaller States. Individual State delegations ranged from an arbitrarily established minimum of 10 to an arbitrary maximum of 100.

State delegates present at the Conference represented 97 percent of the State quotas. Thirty-three States sent a full quota of delegates, while the remaining 20 States sent from 70 to 99 percent of their quotas. The 20 States with a full

quota of delegates included the larger ones and accounted for more than half of the total State delegates.

ITEM 3: 1950 NATIONAL CONFERENCE ON AGING

The First National Conference on Aging took place in August 1950. The Conference was initiated by the Federal Security Administrator, at the direction of President Truman and as an outgrowth of the rising awareness of the growing problems of older people and of the magnitude of the effort that would be required to meet them.

It brought together 816 participants from all parts of the country. The discussion was organized around 11 broad subject matter fields.

The meeting took place over a period of 3 days and essentially constituted a forum type of exploratory conference. No action was proposed or taken by the body of conferees as a whole but each of the 11 sections developed a series of recommendations which became guides to action over the ensuing decade. The report of this Conference is entitled "Man and His Years."

ITEM 4: MAJOR LEGISLATION IN AGING AND RELATED FIELDS FOLLOWING 1961 WHITE HOUSE CONFERENCE

1964

Public Law 88–272—(February 26, 1964) providing tax benefits to elderly on—
1. Sale of residence.
2. Medicine and drug expenses.
3. Minimum standard deduction.
4. Retirement income credit.
5. Dividend exclusion.

Public Law 88–452—(August 20, 1964) Economic Opportunity Act of 1964.

Public Law 88–560—(September 2, 1964) provisions helping to meet elderly needs in Housing Act of 1964, included—
1. Low-rent public housing.
2. Occupancy by single elderly persons of 221 housing.
3. Relocation assistance.
4. Relocation rent assistance.
5. Rehabilitation loans.
6. Extension of rural elderly mortgage insurance program.

1965

Public Law 89–97—Social Security Amendments of 1965. Medicare, medicaid, and social security benefit increase.

Public Law 89–105—Community Mental Health Centers Act providing grants toward the costs of construction of comprehensive community mental health centers.

Public Law 89–253—Economic Opportunity Act amendment providing for program for the elderly poor.

Public Law 89–117—Housing and Urban Development Act of 1965 extending and improving existing elderly housing programs and authorizing:
1. Rent supplements.
2. Grants for home rehabilitation.
3. Neighborhood facilities.

Public Law 89–73—Older Americans Act of 1965.

Public Law 89–156—Appropriated $750,000 for a program increase for the older worker program of the Bureau of Employment Security.

1966

Public Law 89–368—Tax Adjustment Act of 1966 (Prouty amendment). Social security benefits for U.S. citizens over 70.

Public Law 89–601—Amendment to fair labor standards directing the Secretary of Labor to submit legislative recommendations for prohibiting age discrimination in employment.

Public Law 89–787—Appropriated $2,500,000 for an increase in the older worker program of the Bureau of Employment Security.

1967

Public Law 90–42—Older Americans Act Amendments of 1967.

Public Law 90–202—Age discrimination in employment.

Public Law 90–248—Social Security Amendments of 1967.

Appendix 12

REPORTS FROM OTHER FEDERAL AGENCIES

ITEM 1: REPORT BY THE NEW SOCIAL AND REHABILITATION SERVICE*

The new Social and Rehabilitation Service, established by Secretary of Health, Education, and Welfare John W. Gardner in August 1967, will place special emphasis on older Americans.

SRS unites under a single leadership both HEW's income support programs for needy Americans and the social service and rehabilitation programs that many families and individuals need.

The Administration on Aging is one of the five major components of SRS. The others are the Assistance Payments Administration, Children's Bureau, Medical Services Administration, and Rehabilitation Services Administration.

The Administration on Aging continues all of its previous responsibilities under the Older Americans Act and has assumed added responsibilities for services to the elderly poor under the old-age assistance program.

Mary E. Switzer, Administrator of the Social and Rehabilitation Service, has cited the following as among the objectives of the new agency with respect to achieving increased and better coordinated services for the aged:

FINANCIAL AND MEDICAL ASSISTANCE PROGRAMS FOR NEEDY OLDER AMERICANS

The Assistance Payments Administration of the Social and Rehabilitation Service administers public assistance grants to States for nearly 2¼ million older people who are aged, blind, or disabled. The Medical Services Administration administers grants to States for medical assistance programs serving these public assistance recipients and other medically needy people.

Public assistance provides three kinds of help for needy older people: cash to buy food, clothing, shelter, and other necessities; payments to hospitals, physicians, and others for medical care costs not met under medicare; and social services to help them achieve as much personal and economic independence as possible.

Old-age assistance (OAA)—This program served about 2,065,000 persons 65 and over in September 1967. This is a marked decline from the alltime high of 2,810,000 in September 1950, despite the steady increase in the number of aged people in our population. This is due to the rapid increase in the number of persons receiving old-age, survivors, and disability insurance (OASDI).

All 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands have OAA programs. The national average in September 1967 was about $69 for maintenance.

To encourage dependent people to make a greater effort to earn at least a part of the money they need, new provisions in Federal legislation, effective October 1, 1965, permitted States to allow OAA recipients to keep up to $50 a month in earnings without having their public assistance payments reduced, in addition to $5 a month from any source. Sixteen States have taken advantage of the $50 provision; 15 States, the $5 provision.

According to a 1965 study, the median age of old-age assistance recipients was nearly 77 years, an increase of about 2 years over the median age in 1953. The proportion of those living alone in their own homes increased from 27

*This report on activities of the Social and Rehabilitation Service in the field of aging was received by the committee from Acting Administrator Joseph H. Meyers of that agency.

percent in 1953 to 35 percent in 1965. During the same period, however, the proportion requiring help from others rose from 18 to 27 percent, including a rise from 5 to 9 percent for those living in institutions. In 1965, recipients were older, less mobile, and were increasingly the victims of chronic illness. More than two-thirds of the recipients were women.

Medical assistance—The 1965 amendments to the Society Security Act added a title XIX which authorized Federal grants for State medical assistance programs, programs known popularly as medicaid.

By December 1967, 37 States, Puerto Rico, and the Virgin Islands were operating medicaid programs. About 78 percent of the population aged 65 years or over live in these areas.

In addition, 11 States and Guam were operating programs of medical assistance for the aged (MAA). Three States—Alaska, Florida, and Mississippi—had neither an MAA nor a medicaid program in operation but made medical vendor payments under an old-age assistance program. By 1970 all States will be required to have a medical assistance program under title XIX in order to receive Federal funds for medical vendor payments.

The 39 jurisdictions with federally approved medicaid programs in operation as of December 1967 are California, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Dakota, Texas, Utah, Vermont, Virgin Islands, Washington, West Virginia, Wisconsin, and Wyoming.

In fiscal 1967, approximately $904 million in Federal funds was spent for medical services under medicaid programs.

Among the benefits of medicaid is that it makes possible for the first time Federal sharing in payments to needy aged people in institutions for mental illness and tuberculosis.

Social Services in Public Welfare Agencies

SOCIAL SERVICES

The continuing efforts to assist States in providing social services to aged recipients is reflected in an increase in the number of cases reported by States to 266,000 cases in March 1967 (251,000 in March 1966).* Social services provided by States as reported, included older persons in need of protection; those individuals needing services to help them to remain in their own home, or those needing services when they left mental institutions; those requiring services to help them achieve self-care or self-support; and those needing services because of isolation or estrangement from their families. As in the past, services to help such individuals to achieve health care or improved financial functioning led all other service activities.

As of December 20, 1967, 39 jurisdictions continued to provide social services for 75 percent Federal matching to older adults under titles I, X, XIV of the Social Security Act. During the year, four States withdrew from the program. Three of them were unable to meet the July 1, 1967, requirement for full scope of services; they were Arkansas, Connecticut, and Louisiana. Oregon withdrew to devote greater effort to the AFDC program.

Staff units to develop social services, as well as individual specialists on aging were active in the following States: Alabama, California, Colorado, District of Columbia, Florida, Illinois, Kansas, Maine, Maryland, Minnesota, Mississippi, Nevada, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, Texas, Utah, Vermont, and Washington. In a number of these jurisdictions, the specialist on aging serves a dual capacity; that of specialist on aging for the State department of public welfare and also the executive secretary of the State commission on aging. They are: District of Columbia, Kansas, Maine, Minnesota, New Mexico, Oklahoma, Pennsylvania, and Washington.

Continuing assistance has been furnished States in meeting their requests for program guide materials. For example, a new directory of homemaker service has been released. The directory reflects that homemaker services, nationally,

*See statistical report on social services, Form FS–2069, for the quarters ending Mar. 31, 1966 and 1967, U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, table A.1 (March 1967 figures most recent available).

have tripled. In 1963, homemaker services were available in 93 public welfare agencies. Today there are at least 440 public welfare departments throughout the country which provide homemaker services to their clients; 115 public welfare agencies provided homemaker services to the frail aged needing assistance in home management; 93 agencies through homemaker service provided personal care to this group.

A number of States have employed homemaker service specialists, at the State level, to develop and strengthen homemaker services in public welfare departments throughout the State. They are: New Jersey, Delaware, Colorado, Nevada, California, and Michigan. Funds for these efforts were provided through the section 115 demonstration project grants program.

It is evident that when States have employed homemaker service specialists at the State level to give guidance and support to local communities, increased homemaker services at the local level results.

A pamphlet on volunteer services, recently released, identifies the varied ways in which volunteers can serve older persons through the public welfare department. This may include such activities as friendly visiting services, meals on wheels services, and transportation services, etc.

There has been only a minor increase in the number of caseworkers in States assigned to adult caseloads. A review of the number of caseworkers assigned to older adult recipients in the program (i.e., OAA, AB, and APTD combined) shows that the number of such caseworkers increased from 13,211 in 1962 to 14,363 in 1965, an increase of 1,152.[1] It is expected that this number will increase beginning July 1, 1967, as States which have elected social services for 75 percent Federal matching for adult categories meet the requirement for full scope of services.

MEDICAL CARE

The number of States and other areas with approved medical assistance plans in operation under title XIX of the Social Security Act increased during the period. As of December 1, 1967, 39 States and other areas operated title XIX medical assistance programs:

California	Massachusetts	Oregon
Connecticut	Michigan	Pennsylvania
Delaware	Minnesota	Puerto Rico
Georgia	Missouri	Rhode Island
Hawaii	Montana	Texas
Idaho	Nebraska	South Dakota
Illinois	New Hampshire	Utah
Iowa	Nevada	Vermont
Kansas	New Mexico	Virgin Islands
Kentucky	New York	Washington
Louisiana	North Dakota	West Virginia
Maine	Ohio	Wisconsin
Maryland	Oklahoma	Wyoming

Although social services to assist the aged to secure medical care are an integral part of the title XIX programs, it is too early to identify the extent to which such services have been utilized in communities to assist older persons to overcome some of the normal barriers to securing good health care; i.e., lack of information about the service available to them; their entitlement under the act to such service; their inability to utilize the service, if and when available, because of lack of transportation or lack of funds to pay for such transportation; their failure to take advantage of all the opportunities offered because of fear or anxiety and the like. It is expected that as States become more familiar with the opportunities provided under the 1962 social service amendments there will be greater utilization of these services.

DEMONSTRATION PROJECTS

In 1967 there continued to be a wide variety of demonstration projects funded under section 1115 of the Social Security Act involving the aged. They include

[1] Department of Health, Education, and Welfare, Social and Rehabilitation Service, Assistance Payments Administration, Division of Research. Latest data on which comparable figures available.

several projects to provide homemaker services (Alaska, Kentucky, South Carolina, Mississippi, Illinois); legal services (New York, Delaware); development of a simplified method of determining eligibility in OAA by use of a declaration form (Colorado, California, New York, Louisiana); protective services (Colorado, District of Columbia); and establishment of State specialists on services to the aging (Mississippi).

In July 1967, a significant 3-year demonstration project to show the effectiveness of a new multidisciplined approach in the provision of protective services to older adults in the public assistance program was launched.

The target group consists of aged, blind, and disabled recipients who, for reasons of physical or mental dysfunction, are unable to manage their money or carry out the activities of daily living without significant help from others, and who have no one immediately available who is ready, willing, and able to assist them.

Protective services for this group will consist of a range of social, health and legal services, including recourse to the use of legal procedures, including guardianship and commitment procedures.

The new approach consists of using a special service unit to provide protective services to the individuals in the target group, located in a public welfare department. This team or unit will operate under professional direction and will be composed of a unit supervisor, two caseworkers, two case aides, three homemakers, and two clerks. All older adult cases identified as needing protective services will be referred to this unit. Intensive service activity, through this special unit, will marshall all available social, health, and legal resources in the community on behalf of the older client to meet his need for social and legal protection. A significant feature of the demonstration will be the availability of consultation from an internist, a psychiatrist, and a lawyer, for purposes of diagnosis and planning.

Another special feature of the project is that guidance and supervision of the demonstration which are presently being undertaken by departments of public welfare in two localities—in the District of Columbia and in three rural counties in Colorado (Michigan, Weld and Logan)—will be furnished directly by Federal staff of the Administration on Aging of the Department of Health, Education, and Welfare. The partnership of the Federal, State, and local components is necessary if uniformity in carrying out the project goals is to be achieved.

The unique feature of the rural demonstration is that one unit will span three counties in a State-supervised, county-administered program to see what is involved for public welfare in meeting service needs of older adults without regard to county boundaries.

The Arkansas Department of Public Welfare is presently undertaking a demonstration project in eight Arkansas counties, which will help identify current needs of older recipients for nursing home care. A team, consisting of a physician and a social worker, operating under the chief of medical services of the State agency, will, through visits to nursing homes and, where indicated, a physical examination, determine the health condition of older recipients who are patients in these institutions. The purpose of the project is to determine if the individual needs to be in the institution, and why. This screening procedure will help the agency in its planning for alternative forms of care for older adult recipients of assistance. The project will be of 1 year's duration. It will be financed under the section 1115 demonstration project grants program.

The use of foster family care of the aged, as one of the alternate programs of living arrangements for older persons, has always been considered a valuable resource for older persons. However, many States have felt that this kind of program was a difficult one to mount. The Wisconsin Department of Public Welfare, however, has undertaken, through the Winnebago County Department of Public Welfare, to establish and demonstrate the value of a foster family care program as a resource for older persons leaving the county and State mental hospitals. The project will also establish cost data; criteria for the selection of older persons for whom foster family care would be a suitable living arrangement; and means and resources available for recruitment of foster families to serve the program. The program will serve both current recipients and potential recipients.

The Texas State Department of Public Welfare is continuing its demonstration project which provides comprehensive social services to the elderly in two public housing developments in Dallas and Houston. As part of a comprehensive pro-

gram of services to low-income residents in public housing, the State public welfare agencies in Missouri and Connecticut are also providing special services to a number of aged clients living in these housing projects. The Wyoming Department of Public Welfare is demonstrating the value of case aides in providing a variety of services to the elderly as part of the total project.

The Oregon State Public Welfare Commission is demonstrating the use of the group work method in providing services to elderly clients. Two OAA groups have been established to help the aged client return to active, purposeful community involvement and thereby provide social contact, incentive, and support in coping with social problems facing the aged.

IMPROVED STAFFING AND TRAINING

During the period, inservice training to prepare supervisors and caseworkers working with older persons, has been undertaken at the regional and State level.

A Federal staff member from the central office and the regional staff development specialist have united in working with State staff development directors in New Hampshire and Maine to develop and carry out a training program for supervisors and caseworkers serving OAA recipients. This training program extended over a 1-year period. It consisted of a series of workshops in each State, at planned intervals, in which content material was made available to the participants on all aspects of human behavior in aging; the content of social services available in the program; methods of providing service; barriers to service; and the use of community planning to develop, secure, and extend community resources to clients. The intervals between workshops were utilized by the participants to absorb what was learned and to apply it.

Another approach in training supervisors has been developed in the West Virginia State Department of Public Welfare. This has consisted of developing a 1-week, 25-hour workshop for supervisors, who were then in a position to supervise new caseworkers assigned to their units to work with older persons. By training the supervisors it has helped them to interpret to new workers the problems and needs of clients they serve and services which are available to meet those needs, as well as to give them a better understanding of human behavior in aging.

VOCATIONAL REHABILITATION SERVICES BENEFITTING THE AGING

Although less than 2 percent of the clients in the Federal-State vocational rehabilitation program—aimed at restoring disabled people to productive employment—are 65 or older, rehabilitation services provided to younger persons continue to benefit them when they reach retirement age.

Successful rehabilitation is particularly valuable for persons approaching 65. Of the 154,081 persons rehabilitated in fiscal 1966, 9 percent (13,938) were 55 to 64 years of age and 16 percent (24,845) were 45 to 54.

A special interest of the Rehabilitation Services Administration in the aged is evidenced in demonstration projects which have been established in many communities to coordinate programs of medical, psychological, social, educational, and vocational services for older persons and the chronically disabled.

Two research and demonstration grants concerned specifically with the elderly were awarded in 1967. One involves training disabled older people to work with mentally retarded young adults. The other is a research study to investigate the physiological and behavioral problems affecting the learning capacity of elderly persons as related to their participation in rehabilitation training programs. Both projects are expected to add significantly to our knowledge in the field of aging.

As further aids to helping older persons, two short-term training projects were held in the fall of 1967—at Northeastern University in Boston and the University of Tennessee in Knoxville—to train rehabilitation personnel in special techniques of helping older clients.

FUTURE NEEDS FOR THE AGING

Much remains to be done. State welfare departments are finding it difficult to secure adequate appropriations for staff and for training. Staff turnover is high among caseworkers. The level of service provided indicates a need for caseworkers and supervisory personnel to know more about the biological, medical, and psycho-social components of behavior in the aged.

A variety of reasons are given for high staff turnover: salary differentials in States; the nature of the program itself, which demands a high level of accountability and thus imposes upon workers considerable routine efforts to document facts related to residence, income, and resources for the aged, thus limiting the time they can give to the provision of services; the presence of unfavorable community attitudes regarding public welfare; and problems in working with the aged.

Some specific future needs:

1. The average monthly money payment must be raised. Excluding vendor payments for medical care, it varies from a low of $8.70 in Puerto Rico to a high of $103.60 in Iowa. The national average was $68.60 in September 1967.

2. There is a continuing need for increased numbers of social service personnel to help older persons with a wide range of problems and for more effective utilization of existing personnel.

3. Better housing for the aged is needed to replace homes that are inadequate, unhealthy, or unsafe. A recent report indicated that an estimated 40 percent of aged recipients live in housing with major defects.

4. There is a need to develop more institutions that provide counseling, social services, and maintenance to meet the needs of the aged for protected group living arrangements.

5. Approximately 200,000 older people have been identified who need improved protective services, including both social and legal services.

6. More nursing homes are needed.

7. Continued efforts to develop homemaker services for older persons are indicated. Only limited numbers of the aged receive homemaker services at this time.

8. There is need to develop and expand alternative forms of community-based living arrangements, including foster family care homes, for the aged leaving mental institutions.

FUTURE PLANS

Model demonstration projects.—It is expected that a number of model demonstration projects relating to aging will be financed in selected local departments of public welfare. The models, each of several years' duration, will demonstrate how public welfare agencies can improve social services to the aged. The projects will concentrate on the use of protective services for the aged, neighborhood service centers, foster family homes, and social services in public housing.

Special services to older adults in metropolitan areas.—There will be increased emphasis on the provision of services through neighborhood units to meet the needs of older adults living in metropolitan areas.

Medical assistance program plans for the aged.—Additional States will be encouraged and helped to establish medical assistance programs that will benefit not only the needy aged but all people who cannot afford medical care.

Staff development.—Increased emphasis will be given to the development of regional institutes on services to older adults in the public assistance program. Faculty members from schools of social work will be hired to teach the latest social service methods to key staff in State departments of public welfare.

Standards and guide materials.—Additional guide materials on methods of working with the aged, including older blind and disabled adults are being prepared for use by States.

Cooperative work with other agencies.—Staff will continue to assist in programs and projects of the Committee on Aging, American Public Welfare Association, Family Service Association of America, the National Council on the Aging, the Committee on Aging of the National Urban League, the Administration on Aging, and the National Federation on Settlements and Neighborhood Centers.

Separation of financial assistance and social services.—One of the key elements in the organization of HEW's new Social and Rehabilitation Service is the separation of the determination of eligibility for, and the provision of, financial assistance from the provision of social services. States will be encouraged to follow this pattern in their public assistance programs—including the old-age assistance program—in order to be able to provide money payments with greater dignity for the recipients and to free scarce social service personnel from routine tasks in order to concentrate major efforts on services to help clients solve their problems.

EXHIBIT A: NEWS RELEASE FROM DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, AUGUST 15, 1967

A major realignment of Federal welfare, rehabilitation, and social service programs was announced today by John W. Gardner, Secretary of the Department of Health, Education, and Welfare.

A new agency, the Social and Rehabilitation Service (SRS) has been established to carry out the functions of the Welfare Administration, the Vocational Rehabilitation Administration, the Administration on Aging, and the Mental Retardation Division of the Bureau of Health Services, Public Health Service. The Social and Rehabilitation Service is established effective today. Administrator of the new agency is Mary E. Switzer, former Commissioner of Vocational Rehabilitation and one of the Department's most honored career executives.

"The new agency," said Secretary Gardner, "will join under a single leadership both our income support programs for needy Americans and the social service and rehabilitation programs that many families and individuals need."

The Secretary said that the new agency would make possible a unified approach to the problems of needy Americans, with special emphasis on the family. At the same time, he noted, "the aged, the handicapped and children should continue to be given special emphasis. Assigning each of these groups special status while preserving their administrative integrity within the new Service insures that each will receive the priority attention it needs and deserves."

A stronger emphasis on rehabilitation in the Department's social and welfare programs, Secretary Gardner said, "is in large part due to the foresight and wisdom of one of my predecessors, Senator Ribicoff, when he was Secretary of HEW. It is an emphasis we intend to continue, expand and strengthen."

"We must do a much better job of giving people on public assistance the help, the skills, and the incentive they need to become independent," said the Secretary. "And for the many Americans who will continue to need assistance because of their youth, their age, their disability or other reasons, we must do a better job of enlarging the area in which they can improve the quality of their lives by their own efforts."

Secretary Gardner said that a Social and Rehabilitation Service Commissioner in each of the nine HEW regions will supervise all programs and activities of the Service in his region and give approval to all State plans. "We expect this will make it easier for the States, communities, and voluntary, private groups to deal with the Federal Government on all these matters," the Secretary said.

In partnership with State and local government, and with voluntary agencies and institutions, the SRS will have responsibility for a large number of persons;

About 7.6 million persons (4 percent of the population) receive cash assistance at any given time under federally aided programs. These payments total about $4 billion annually, of which 62 percent comes from the Federal Government, and the balance from State and local governments.

Almost 175,000 persons are rehabilitated for gainful employment each year through vocational rehabilitation programs.

Over 6 million needy persons receive medical services each year through federally assisted programs, including the new title XIX medicaid program.

Over 600,000 children receive child welfare services related to adoption, foster care, or neglect.

Over 450,000 crippled children receive medical services each year with Federal assistance.

More than 250,000 women received family planning help last year through Children's Bureau programs.

More than 700 projects assisted by the Administration on Aging provide services for many of the 19 million Americans over 65.

The combined 1967 appropriations of the HEW components joined in the SRS totaled $4.8 billion in Federal funds. The new Agency would have about 1,900 employees in five major divisions as follows:

Rehabilitation Services Administration.—Responsible for programs aiding the handicapped, disabled social security applicants, crippled children, the mentally retarded, and for services for the blind and the permanently and totally disabled.

Children's Bureau.—Responsible for studies and investigations of the status of children, and for Federal-State child welfare, maternal and child health, and juvenile delinquency programs, for health services to schoolchildren and for family and child welfare services.

Administration on Aging.—Responsible for administration of the Older Americans Act and collecting and disseminating information on the status of older Americans, and for services for the aged (including insurance and assistance beneficiaries) standards for services to OAA beneficiaries, and the foster grandparent program.

Medical Services Administration.—Responsible for medical assistance services by State and local agencies, including title XIX programs.

Assistance Payments Administration.—Responsible for the money-payment aspects of public assistance programs (aid to families with dependent children, old age (blind and disability) assistance), and for the administration of work experience and community work training programs.

Attached are a fact sheet on the components joined in the SRS, and a chart of the new organization.

ITEM 2: REPORT ON VETERANS ADMINISTRATION ACTIVITIES

DECEMBER 21, 1967.

DEAR MR. CHAIRMAN: I am pleased to respond to your request of December 11 by forwarding the enclosed report on Veterans Administration activities during 1967 relating to aging.

As you know, the number of war veterans in the older age groups are expected to increase tremendously in the years ahead. Consequently, the VA is very much concerned in seeking solutions to many of the problems facing these older veterans and their survivors. With this in mind, I am fully appreciative of the work being done by your committee in this direction.

I trust that you will find the enclosed information useful.

Sincerely,

A. W. STRATTON,
Deputy Administrator,
(For and in the absence of)
W. J. Driver, Administrator.

[Enclosure]

DEPARTMENT OF MEDICINE AND SURGERY

1. *VA hospitalization.*—Patients in the older age groups continue to represent a major portion of our hospital load. As of November 30, 1967, there were 26,605 patients 65 years and older remaining in VA hospitals. This is equivalent to 27 percent of all patients in VA hospitals on that date.

2. *Medical research.*—Information regarding the ongoing medical research program in aging is attached. During the year new findings were reported from one of the cooperative studies which has been in progress for several years. Estrogen treatment, commonly used in management of cancer of the prostate, was found to be associated with substantially increased risk of death from heart disease or stroke. Several Veterans Administration hospitals cooperated in this study of approximately 2,000 patients with cancer of the prostate. A report from the cooperative study of antihypertensive agents, to be published in the AMA Journal this month, conclusively demonstrates the value of antihypertensive drug treatment in patients with diastolic blood pressures of 115 mm. Hg or above. The ratio of complicating events in the patients receiving only symptomatic treatment as opposed to the group receiving antihypertensive drugs was approximately 20 to 1.

3. *Medical research information system.*—Information has just been obtained from the recently devised medical research information system which indicates that a deliberate and primary research effort in aging is being made by 317 investigators in the VA at a funding level of $2,686,648. In addition, 792 investigators are making secondary contributions to the area of aging. For example, an investigator might be studying stroke as a deliberate and defined research program but a percentage of this effort might also make a contribution to the area of aging.

4. *VA voluntary service.*—The D.M. & S. voluntary service has continued its efforts to increase the interest of senior citizens in the VA voluntary program. The retired and elderly have become the backbone of the VAVS effort. The retired citizen is eagerly sought for the value of his contribution to the care and treatment of patients. As part of a program to recruit additional volunteers the VA pamphlet, "Senior Citizens We Need You" has been rewritten. An attachment

describing the role of the aged in the voluntary program is submitted for your information. This material was covered in the statement presented by the Director, Voluntary Service Staff to the Special Subcommittee on Aging, Committee on Labor and Public Welfare, U.S. Senate, on September 15, 1967.

5. *Extended care.*—For the predominately medical needs of the aging, the VA has evolved a system of chronic care facilities designed largely to care for the aging as exemplified in our extended care service. The extended care service is composed of elements of various kinds of long-term-care facilities, including intermediate care services for patients who are chronically ill but still require more or less daily medical services; nursing care given in our own VA nursing home care units, in contract community nursing homes, and in State nursing homes where we are able to provide skilled nursing care for veterans who no longer require hospital care; domiciliary care for provision of ambulatory medical services and protective environmental care designed to help return individuals to the community as self-supporting individuals to the extent possible. Still in the process of development is a hospital-based home care program designed to return selected individuals to their homes supported in part by the provision of medical, nursing, dietetic, and rehabilitative services in their own homes but emanating from VA hospitals and clinics.

The VA has developed through its social work service and psychiatry, neurology, and psychology service a well-defined foster home and half-way house program which is designed to permit the return of psychiatric patients, many of them aging, into protective homelike settings within the community and thus to break down the process of excessive institutionalization which might otherwise occur.

If we consider that the needs for medical care could be satisfied by the abovementioned programs, it is still important to care for those elderly citizens who have been ill and suffer little decline in health and who have no serious physical or mental disabilities—but may be experiencing problems in levels of social living and adjustment. Here VA expertise and experience includes both outpatient and institutional program planning and delivery of multidisciplinary services. Social work service plays a major role in assisting the elderly with living arrangements when definitive inpatient medical care has been completed. The VA in attempting to meet the needs of its growing number of aging veterans makes extensive use of the following living arrangements which are geared to the maximization of the individual's level of independent daily activities of living. Such arrangements would be made in VA domiciliaries, VA restoration centers, community care in homes other than the veterans' or homes which includes foster homes, halfway houses, and boarding homes. Social services are also provided in the veterans own homes. The services are directed toward assistance with income, maintenance and continued social participation, and continuing community services relevant to specific needs.

Another group of senior citizens are those subjected to a gradual and expected decline in health but no major physical or mental disabilities. Usually here it is impairment of social functioning and living arrangements. For this group many of the same intra and extra VA settings are available and may be used as veterans needs are identified. Additional resources for this group would include the use of nursing homes both within the VA and within the community.

6. A paper is also attached discussing VA programs for older Americans for calendar year 1968.

THE RESEARCH PROGRAM

AGING

The establishment by the U.S. Government during 1966 of medicare to assist the aging citizen in his medical needs attests to the general concern over the results of the scientific advances: the numbers of individuals who live beyond the sixth and seventh decades has been expanded remarkedly. Census figures indicate that by 1970, 28 million Americans will have passed the age of 60, compared with 24 million in 1960. This has brought into focus the lag in solving the problems of chronic disease and deterioration that increase with advancing age. The problem that faces us now is to assure these larger numbers of elderly citizens healthy and purposeful lives in their later years.

The patient population of the VA reflects the increased utilization of hospital and clinic by this older group. The average age of all veterans is now 47 years.

lished: the calibre of the senior scientist collaborators is such that these laboratories represent a major effort in aging research in the Nation.

The laboratories currently set up are:

1. Bedford VA Hospital—sponsored by Marott Sinex, chairman and professor of biochemistry at Boston University School of Medicine. This laboratory is concerned with changes in RNA and DNA, the substances that are the basis for inheritance. They are investigating one of the theories of aging: that it is a process "programed" at birth by the genes inherited from our ancestors.

2. Baltimore VA Hospital—sponsored by Bernard Strehler, chief of the Biological Research Section of the Gerontological Institute at Baltimore City Hospital (Dr. Nathan Shock, director). This laboratory concerns itself with basic cell biology, and is testing systematically three proposed mechanisms of aging: that mutation of cells (abnormal changes that crop up as cells divide during growth and maturity) is responsible for the changes called aging, and ultimately for determining length of life; that the process that controls growth and differentiation of the body parts (i.e., body height, number and length of fingers, only one liver but two kidneys, etc.) has built into it the changes of aging; and that the accumulation of certain waste materials in the cell have a role in the aging process.

3. Downey VA Hospital—sponsored by Dr. Arthur Veis, Northwestern University. This group is studying the lens of the eye, susceptible to "aging" rather early in life and more readily accessible than many body tissues, as a model for the aging mechanism.

4. Buffalo VA Hospital—sponsored by Dr. Noel Rose, Department of Bacteriology and Immunology, State University of New York at Buffalo. The investigations here center around the theory that aging is caused by changes in body protein, changes to which the body reacts by mobilizing its immense mechanisms by which it defends itself against "foreign" substances. Thus, the body begins to combat immunologically its own aging portions, and hastens their deterioration.

5. Sepulveda VA Hospital—sponsored by Dr. Linus Pauling. The mechanisms of memory and their changes with age are the areas under investigation in this laboratory. The relationship of these mechanisms to normal sleep and to surgical anesthesia is also being pursued.

6. Sepulveda VA Hospital—sponsored by Dr. Albert Tyler, chairman of the Department of Biology, California Institute of Technology. These two laboratories are exploring aging from the developmental biology approach. They are separately headed by independent scientists pursuing different experimental areas. One is concerned with the effects of manipulation of the embryo on the rate and nature of aging, and the effects of aging on the reproductive system. The other is studying the effects of one type of cell on another in the same tissue culture and on transplantation from one animal to another. The mechanisms whereby these interactions influence normal growth, aging, and abnormal growth (cancer) are the focus of the work.

7. Pittsburgh VA Hospital (Leech Farm Road)—sponsored by Dr. Albert Lansing. This laboratory is concentrating on aging of the nervous system and muscle, and in influence of calcium levels thereon. It is an extension of Dr. Lansing's recognized work on calcium and aging that has been a major contribution in the field over the past decade.

It is planned to increase these laboratories ultimately to a total of 20. The rapidity with which those additional outstanding senior scientists who have already been identified can have made available to them the necessary laboratory support is contingent only on the amount of funds which will be available to carry out the program.

Participation of Retired and Older Volunteers in the Veterans' Administration Voluntary Service Program

Older volunteers participate in approximately 25 different services in the medical program of the Veterans' Administration. Assistance by these volunteers is primarily in direct service for patients. Volunteer assistance is also provided in supportive and administrative or leadership services. Brief descriptions of some of these services follow:

Companionship Therapy

The older volunteers have demonstrated they have the time, patience, and capacity to win the confidence of patients through personal relationships. Pre-

scribed companionship or friendship therapy by older volunteers is getting remarkable results in motivating and stimulating patients to realize their potential for restoration and return to community living.

PERSONAL SERVICES

The older volunteer, with his understanding and patience, is providing valuable assistance to the patient by reading to and writing letters for him. In many instances, the older volunteer can converse with the patient in his native tongue. This often prompts the patient to share information with the volunteer that can be helpful to the doctor and nurse in the patient's treatment.

REHABILITATION

The older volunteer is especially helpful in assisting older patients to carry out medically prescribed rehabilitation programs. The older volunteer, relying on his background of experience, provides the necessary encouragement for patients to try and try again, regardless of early failures and time factors, until they successfully accomplish their prescribed goals.

ESCORT SERVICE

The older volunteer helps the patient by escorting him to treatment and other areas in the hospital. This may involve walking with him or assisting him with his wheelchair or cart. The older volunteers are able to establish good rapport with patients since many are in the same age bracket.

PATIENT FEEDING

Older volunteers help patients to feed themselves. This service is particularly helpful with older patients with whom the older volunteers have interests in common.

RECEPTIONISTS

The older volunteers with their maturity, experience, and ability to meet people comfortably have proved to be outstanding as ward receptionists in greeting visitors and patients and in helping them with their inquiries.

GROUP ACTIVITIES

The older volunteers also actively participate in many social, entertainment, and educational activities sponsored and supported by their respective organizations, particularly in the daytime when other members of their organizations are employed. Small to large groups of patients participate, actively or passively, in such activities as ward parties, bingo, dances, live shows, sports, hobby clubs, picnics, off-station events, etc., planned and conducted with the help of volunteers.

SERVICE IN THE COMMUNITY

Following the patient into the community after his discharge from the hospital is considered a basic element in his total treatment as a whole man. Many of the older volunteers, picking up where hospitalization ends, helping the patient primarily with his social and economic needs, are giving readjustment and rehabilitation of patients another dimension beyond hospital walls. Volunteers are helping to locate suitable living quarters and secure employment for patients, providing escort service to church and other worthwhile activities, and visiting "shut-ins." In so doing they are contributing significantly to the patient's rehabilitation in the community. This important service is time consuming. The older volunteers generally have more time available than the younger volunteers.

SUPPORTIVE SERVICES

Many of the older volunteers also serve patients indirectly through assignments which involve little or no contact with patients but do support their treatment and care. Some of these assignments include assistance in laboratories, statistical and technical work, blood program, and planning and conducting special events such as open houses and programs to which the public is invited.

In 1956, the average age of the veteran-patient in VA and non-VA hospital facilities was 49.4 years; in 1966, it was 53.7 years. Thus, a major concern of VA medical authorities is the care and treatment of the older veteran.

This has been reflected in the dramatic rise in the numbers of VA hospitalizations for arteriosclerotic heart disease (hardening of the arteries of the heart), the most common cause of death in the United States. Hospitalization of such cases in the VA rose from just under 12,000 in 1957 to 16,902 in 1966. The average hospital stay of each of these VA patients in 1966 was 34.5 days.

Strokes and other brain damage accompanying aging rose from 6,810 in 1957 to 12,960—almost double—in 1966. The average VA hospital stay for this type of case was 80.7 days.

Patients with aging lung disease (emphysema and chronic bronchitis), excluding tuberculosis, numbered 10,460 in 1957. By 1966 this had more than doubled to 21,283 VA patients, each hospitalized an average of 37.6 days.

Predicated on the fiscal year 1966 average inpatient day cost for general hospital care of $32.46, these three diseases of aging alone resulted in VA inpatient care cost of approximately $78 million during 1965.

Loss to the national economy through the loss of productivity of the affected individuals can be estimated at an almost equivalent amount. Completely immeasurable, however, is the impact on the afflicted veterans and their families in terms of the future that the" Great Society" holds out as a goal for every American.

This, then, is the challenge to and the focus for the VA program of research in aging: to provide the scientific advances whereby these diseases and the many others that afflict the elderly can be controlled and prevented. How is it being met?

Osteoporosis.—Bone disease of the aged.—One of the organ systems whose deterioration with age is a cause of considerable disability is the bone. The weakening and thinning of the aging bone is especially marked in the spinal column, or vertebrae; and commonly leads to collapse of one or more vertebrae in the individuals affected. Such collapse can result in all gradation of symptoms, from chronic disability back pain to complete loss of use of the legs, due to pinching of the nerves of the spinal cord. In 1966, 1,519 patients were discharged from VA hospitals after treatment of osteoporosis. A group of Veterans' Administration physicians, spearheaded by a doctor at VAH Seattle, is attempting to restore strength to these weakened bones in osteoporosis sufferers in a pilot program of new cooperative study. They are treating these individuals with a medication that has appeared to be helpful in some such individuals, but not in others; and comparing the medication treated group with a group given the best standard treatment available without the new medication. The medication is calcium fluoride. The purpose of the study is to test the effectiveness of the medication, and also to attempt to shed new light on the nature of this common but poorly understood disease.

Surgery and the aged individual.—Part of the medical tradition regarding care of the aging individual is their poor tolerance to stresses and procedures that present only moderate risks to younger individuals. Any form of major surgery is one of the stresses frequently cited in this respect. This tradition has been with us since the days of Aristotle; but has been challenged by surgeons in the past two decades, as a result of the remarkable advances in anesthesia, pre- and post-operative care, and general care of the elderly patient. Nevertheless such medical traditions die hard, and the profession requires convincing documentation before it accepts even in part such departures. A group of physicians in Minneapolis have been documenting in detail the health status and course of a group of over 100 older patients who have undergone major surgery. They are in the process of following these patients for a period of months to a year, to see how their course during and after surgery differs from younger surgical candidates, if at all.

The aging process: Inherited or environmental?—One of the major debates among scientists in the aging field is the underlying basis for the aging process. On the one hand, it is claimed that the lifespan of the living cell is an inherited characteristic; and no matter how well we understand what changes take place with aging, or search out means to prevent such changes, one can never get the dog to live much beyond his 15-year lifespan, or man to go much beyond his 100 years of life. This thinking is opposed by a second group of scientists, who think that lifespan may be determined by stresses and strains in the environment to which we are all subject, beginning before birth and going on

through our entire lives. They claim further that if these stresses can be identified and removed, or if their ill effects can be counteracted, there is no reason theoretically that animals or humans should deteriorate at any age. A physician at VAH Hines is currently engaged in some basic experiments in animals, to see whether he can influence the "normal" pattern of buildup and breakdown of hemoglobin, the oxygen carrying substance in the red blood cells, by certain procedures and medication while the animal is still in the mother's uterus. If he is successful, it will suggest that further research may well be able to lead, ultimately, to a lengthening of lifespan.

Mechanisms of aging: Tissue changes with age.—A number of laboratories are investigating the specific structural changes at the microscopic and biochemical level that occur with age. At Martinsburg, W. Va., collagen (the rubbery substance that lines most body tissues, including skin) structure and its changes with age are under study. There is a growing body of evidence that the stiffening of this supporting substance is an important, or perhaps the important, factor in the changes that occur as we age. A scientist in Coral Gables, Fla. is testing the effects of X-ray on the pattern of development of the cells of the chick embryo. This is an effort to determine whether the changes with age may be related to the irradiation we all receive from the cosmic rays that bombard the earth's surface continuously. At Jackson, Miss., the changing pattern of blood supply with age and its effects on function in the different organs of the body are under study. A scientist at Temple, Tex., is studying with the electron microscope the age changes in the lens of the eye, to elucidate the basis for cataracts in the elderly. A physician in Los Angeles is examining the nature of the nourishment and growth of the blood vessels themselves for additional clues in the major problem of hardening of the arteries. At Jefferson Barracks, Mo., work with obese patients with thyroid immunity showed that the hormone-binding antibody, upon treatment with the more active hormone triiolothyronine, disappeared after several weeks and these patients lost unusually large amounts of weight. Several different kinds of skin lesions, thickening of vascular wall, and other changes associated with aging also were seen in these patients.

Psychological assessment of the aged.—A research psychologist at the VA Center, Los Angeles, last year developed a totally automated psychological assessment console which provides precise stimulus, response, and timing controls. This console will be subjected to field trials during the next year to assess its potential for psychological assessment of the aged. The console offers promise for opening up areas of research on aging which previously could not be attempted because of the mass of data required and the lack of reliability of data accumulated in a variety of situations by different examiners since the console is extremely versatile and is aimed at maximizing reliability of measurement while requiring a minimum of professional time.

Normative aging study.—This study has emerged as the largest longitudinal aging study in the country and is now close to completing the recruitment and screening of 2,000 male subjects in all walks of life. This overall number was determined by projected attritional factors and the balance required by statistical theory between number of subjects and number of variables. By January 1, 1968, the second 5-year cycle of data collection will begin, and the end of that cycle will mark the beginning of the longitudinal analysis of the recurring data. In accordance with the doctrine expressed in the September 1966 congressional report "Better Management Needed of Medical Research on Aging," regarding coordination of aging studies, a Joint Scientific Committee has been established with the longitudinal study in the Gerontology Branch of National Institute of Child Health and Human Development. An overall description of the study has been published in the December 1966 issue of the Gerontologist under the title "The Veterans Administration Longitudinal Study of Healthy Aging," authored by Benjamin Bell, Charles L. Rose, and Albert Damon.

The satellite laboratory aging program.—In an effort to focus more intensely on the mechanisms of aging—an understanding of which will ultimately provide the means for retarding or preventing aging-related disease and deterioration—the VA Research Service, in 1964, conceived its satellite laboratory program. Under this unique concept, outstanding non-VA senior researchers are able to undertake investigations of the nature and causes of the aging processes which are related to their particular areas of interest. Laboratory facilities are provided at VA stations in close proximity to the organizations of the collaborating scientists. By the end of fiscal year 1967, eight satellite laboratories had been estab-

92-654—68——20

ADMINISTRATIVE SERVICES

Older volunteers also serve in executive or leadership roles as representatives of their respective organizations. In this capacity they serve on hospital volunteer advisory committees assisting in the planning for the local hospital VAVS program and in providing leadership to the organization's program of volunteer service to veteran patients. This leadership largely entails the promotion of interest in the VAVS program and recruitment of volunteers from the membership to serve in it.

STATEMENT GIVEN TO DR. DUNNER REGARDING PROGRAMS FOR OLDER AMERICANS DURING CALENDAR YEAR 1968

1. For the predominantly medical needs of the aging, the VA has evolved a system of chronic care designed largely for the older veteran. This program is carried out by our extended care service in the Department of Medicine and Surgery. This service is composed of elements of various kinds of long-term care facilities, including intermediate care services for patients who are chronically ill but still require more or less daily medical services; nursing care given in our own VA nursing home care units, in contract community nursing homes and in State nursing homes where we are able to provide skilled nursing care for veterans who no longer require hospital care; domiciliary care for provision of ambulatory medical services and protective environmental care; restoration designed to help return individuals to the community as self-supporting individuals to the extent possible. Still in the process of development is a hospital-based home care program designed to return selected individuals to their homes supported in part by the provision of medical, nursing, dietetic, and rehabilitative services in their own homes but emanating from VA hospitals and clinics.

2. Public Law 88–450 enacted on August 19, 1964, permitted the VA to embark upon a three-pronged program to provide nursing home care to veterans:

a. In less than 3 years over 4,000 nursing home care beds were placed in operation at 62 VA hospitals. During fiscal year 1968 approximately 6,700 veterans will receive nursing home care in these facilities.

b. VA has negotiated agreements with over 2,300 community nursing homes for a total capacity of over 165,000 beds in 48 States and Puerto Rico. Since April 1965 over 18,000 veterans have been authorized care in these facilities. Today, VA has over 2,500 veterans in about 800 of these homes. Approximately 11,000 veterans will receive care in these facilities during fiscal year 1968.

c. Under a grant-in-aid program, VA has assisted the States in developing their own nursing home care program. Twenty States are now operating 2,600 VA-approved nursing care beds with an average daily census of about 1,800 veterans. The matching Federal program of assisting States in constructing nursing home care facilities in State homes has met favorable acceptance. Fifteen project applications have been received. These projects involve construction of 1,632 beds with Federal assistance amounting to almost $11 million.

3. The above programs will provide an average daily census of about 8,500 veterans with nursing home care, requiring expenditures of almost $38 million in fiscal year 1968.

4. In our 16 domiciliaries and six restoration centers, approximately 13,444 aging veterans will be cared for during fiscal year 1968. Of 647 veterans in our restoration center program, 320 (or 50 percent) will be successfully restored either to employment or to independent living in the community.

ITEM 3: REPORT ON U.S. ATOMIC ENERGY COMMISSION

Hon. HARRISON A. WILLIAMS, Jr.,
Chairman, Special Committee on Aging, U.S. Senate

DEAR SENATOR WILLIAMS: In response to your request of December 11, we are enclosing a list of research projects supported by the Atomic Energy Commission which we consider to be oriented toward elucidation of the problem of aging. The fiscal year 1967 cost of these projects was approximately $5,046,038.

As mentioned previously, the Commission's biomedical research program includes a significant effort in the related areas of somatic and genetic effects of

irradiation at all levels from subcellular to the whole organism. These have not been included, although their results contribute to a better understanding of the aging process through the elucidation of the late effects of irradiation.

Research in the aging problem area necessarily progresses slowly though we believe steadily. Sufficient data have now accrued in a variety of species of irradiated animals ranging from mice to dogs that we have a much clearer picture of how the life table is affected. Because of this we are considerably less reluctant to attempt extrapolation to man. Presumably the same method of extrapolation may be applied to other treatments which can be shown to affect the longevity of populations.

The remarkable technological progress in the area of molecular and cellular genetics promises to provide the methodology necessary to evaluate the role of somatic mutations in the aging process. No definitive conclusions can yet be reached but we believe progress is being made at an accelerating rate.

We trust that this information may be of help to the committee.

Cordially,

GLENN T. SEABORG,
Chairman.

[Enclosure]

FISCAL YEAR 1967 EXPENDITURES FOR AGING

Argonne Cancer Research Hospital—$100,000

The Late Effects and Metabolism of the Bone Seeking Radioelements—principal investigator, Hasterlik.

Argonne National Laboratory—$782,000

(1) Theoretical Biology—principal investigator, Sacher.

(2) Acute and Chronic Lethal Effects of External Radiation—principal investigators, Sacher, Grahan, Vogel, and Stearner.

(3) External Radiation Toxicity Effects on Cells and Physiological Mechanisms—principal investigators, Sacher, Lesher, Fry and Kollmorgen.

(4) Experimental Pathology and Radiocarcinogenesis—principal investigators, Finkel and Biskis.

Atomic Bomb Casualty Commission—$741,000

(1) One Hour Glucose Challenge as a Measure of Aging—principal investigator, Darling.

(2) Achilles Tendon Reflex and Aging Phenomenon—principal investigator, Darling.

(3) Chemical Evaluation of Aging—principal investigator, Darling.

(4) Morphologic Evaluation of Aging—principal investigator, Darling.

(5) Growth and Development—principal investigator, Darling.

(6) JNIH–ABCC Life Span Study—principal investigator, Darling.

(7) JNIH-ABCC Life Span Study of Children Born to Survivors—principal investigator, Darling.

(8) Mortality in Children Exposed in Uetero—principal investigator, Darling.

(9) Mortality and Sociodemographic Characteristics of Survivors—principal investigator, Darling.

(10) ABCC–JNIH Pathology Studies—principal investigator, Darling.

Boston University—$9,480

The State of Histone in the Aging Animal—principal investigator, Sinex.

Brookhaven National Laboratory—$558,000

(1) Biological Research Effects of Radiation on Aging in Mice—principal investigator, Curtis.

(2) Medical Studies on the People of the Marshall Islands Accidentally Exposed to Fallout—principal investigator, Conard.

(3) Early and Late Effects of Radiations of Different Quality and at Different Dose Rates—principal investigator, Bond.

California, University of, Berkeley—$40,368

Electrophysiological and Biochemical Studies of the Effects of Radiation on Brain Activity and Development—principal investigator, Timiras.

California, University of, Lawrence Radiation Laboratory—$87,000

Growth and Senescence of the Soft Tissues and Skeleton in the Normally Aging Female Rat—principal investigator, Durbin.

California, University of, Los Angeles, Laboratory of Nuclear Medicine and Radiation Biology—$137,000

(1) Late Effects, Radiobiology—principal investigator, Bennett.

(2) Effect of Aging and Irradiation of the Brain Lipids—principal investigator, Mead.

California, University of, San Francisco—$48,000

Study of the Renal Changes in Aging and Irradiated Mice and Dogs—principal investigators, Wood and Gutman.

Case-Western Reserve University—$10,847

A Study of the Physiological Function and Histological Changes of Thyroids Irradiated with Radioactive Iodine—principal investigator, Dobyns.

Chicago, University of—$9,693

Histopathological Changes in Mice and Guinea Pigs Extended Low Level Exposure to Neutrons and Gamma Rays—principal investigator, Rust.

Georgetown University—$13,336

Histologic Study of Oral Tissue Specimens of New Jersey Dial Painters—principal investigator, Bernier.

International Atomic Energy Agency—$5,365

Dosimetry in Human Radioepidemiology, with Special Reference to Skeletal Dose Rates in Thorotrast Cases—principal investigator, Dudley.

Jackson Laboratory, Bar Harbor, Maine—$78,083

Genetic Control of Aging and Radiation-Induced Life-Shortening in Mice—principal investigator, Yuhas.

Jefferson Medical College of Philadelphia—$31,000

The Effect of Embryonic Irradiation on Adult Life Expectancy and Adult Pathology in Mice and Rats—principal investigator, Brent.

Los Alamos Scientific Laboratory—$12,000

Effects of X-Irradiation to Consecutive Generations of Male Mice on Voluntary Activity of Their Offspring—principal investigator, Spaulding.

Masonic Foundation for Medical Research and Human Welfare—$30,000

A Study of the Effects of Age and Ionizing Radiation on Nucleic Acid Metabolism and Protein Synthesis in Visceral and Central Nervous System Tissues—principal investigator, Wulff.

Massachusetts Institute of Technology—$245,707

Radium and Mesothorium Poisoning and Dosimetry and Instrumentation Technique in Applied Radioactivity—principal investigator, Evans.

Massachusetts Institute of Technology—$13,536

Beryllium Case Registry—principal investigator, Hardy.

Michigan State University—$19,431

Factors Responsible for Changes in Radiosensitivity of Embryonic Tissues—principal investigator, Mericle.

New England Deaconess Hospital—$210,000

Acute and Chronic Radiation Injury—principal investigator, Warren.

New Jersey College of Medicine—$30,566

Histopathologic and Autoradiographic Studies of Chronic Human Radium and Thorium Osteitis—principal investigator, Sharpe.

New Jersey Department of Health—$47,878

Epidemiological Investigation of the Radium Dial Painters—principal investigator, Kandle.

New York University—$55,000

The Tumorigenic Action of Beta Radiation on the Rat Skin: The Effect of Varying Size and Continuity of the Area of Irridiation Skin on the Incidence of Epidermal Tumors—principal investigator, Albert.

Northwestern University—$28,000

An Electron Microscopic and Autoradiographic Study of Intestinal Radiation Death in the Mouse—principal investigator, Hampton.

Oak Ridge National Laboratory—$734,000

(1) Long Term Effects of Irradiation—principal investigator, Upton.

(2) Growth and Senescence of the Immune Mechanism—principal investigator, Makinodan.

Oregon Medical School, University of—$93,000

The Structure and Function of Proteins, Macromolecular Aging, and Transformation of Dormont Non-Dividing Cells into Activity Dividing Cells—principal investigator, Rigas.

Pacific Northwest Laboratory, Battelle-Memorial Institute—$40,000

Late Effects of Irradiating Skin—principal investigators, Palotay and Ragan.

Pittsburgh, University of; Hanford Occupational Health Foundation; Union Carbide Corporation; Social Security Administration—$462,000

Study of Mortality Patterns in AEC Contractor Installations in Terms of Different Environmental Exposures—coordinating investigator, Mancuso.

Rochester, University of—$47,000

A Study of the Biological Effects of Ionizing Radiation with Reference to the Mechanisms Involved in Damage at the Molecular, Cellular and Tissue Levels—principal investigator, Hempelmann.

Rochester, University of, Atomic Energy Project—$284,000

(1) Effects of X-Irradiation on Spermatogenesis in Dogs—principal investigators, Casarett and Eddy.

(2) Pathologic Mechanisms of Permanent and Delayed Radiation Effects—principal investigators, Casarett and Eddy.

(3) Radiobiologic Studies with *Drosophila*—principal investigator, Baxter.

(4) Pathological Effects of Strontium-90 in Developing Rat Embryo—principal investigator, Hopkins.

Tulane University, Delta Regional Primate Research Center—$45,000

The Late Effects of Strontium-90 in the Monkey—principal investigator, Tuttle.

Utah, University of—$50,000

Long Term Effects of Prenatal X-Irradiation on Cerebral Cortex—principal investigator, Brizzee.

Washington, University of—$28,047

Lymphocyte Formation, Life Span, Fate, and Potential for Repopulating Hemopoietic Tissues of Irradiated Animals—principal investigator, Everett.

Wayne State University—$19,701

Biochemical Studies on the Ocular Lens in Relation to Cataractogenesis—principal investigator, Kinsey.

[From the Congressional Record, Friday, Sept. 29, 1967]

STATEMENT BY WILBUR J. COHEN, UNDER SECRETARY OF HEALTH, EDUCATION, AND WELFARE ON SOCIAL SECURITY FINANCING

September 28, 1967

Mr. Charles Stevenson's article on "How Secure is Your Social Security" in the October issue of the *Reader's Digest* is misleading, and, in my opinion, creates anxiety and fear about the financing of our social security system that are groundless.

I state categorically that: The social security system is soundly financed. Present and potential future beneficiaries of social security will get the benefits provided by the social security law.

I

Mr. Stevenson begins his article by saying our "social security insurance is in trouble." This is not so.

The subtitle of Mr. Stevenson's article says that "Recent disclosures are raising grave doubts as to how much—if anything—today's taxpayer will get back when his time for retirement comes." Use of the words "disclosures," "grave doubts" and "if anything" can only result in worry to millions of people who are now drawing social security benefits or expect to draw them in the future. This worry is wholly without factual basis.

The article seeks to depict Chairman Wilbur D. Mills and the ranking minority member, Representative John W. Byrnes, of the House Committee on Ways and Means as profoundly alarmed about the basic design and fiscal integrity of the social security program and about the course that the program is taking. The facts, however, are that as recently as 5 weeks ago these men jointly supported legislation in the House of Representatives, the Social Security Amendments of 1967 (H.R. 12080), which builds upon the present social security program and, with careful attention to actuarial soundness, makes needed improvements in the benefits of the program.

The implication that Representative Byrnes, the ranking minority member of the Committee on Ways and Means, agrees with the charges made by Mr. Stevenson files in the face of the fact that Mr. Byrnes was a co-sponsor of the social security bill now before Congress and is contradicted by his remarks on the floor of the House of Representatives during the debate on the bill. At that time he stated:

"I personally do not feel that the burdens imposed by this bill are greater than the taxpayers will be willing to pay. After all, today's taxpayer is tomorrow's beneficiary. I was very glad to join the chairman of our committee in sponsoring the social security bill—a bill which gives due consideration to the needs of our elderly citizens as well as those who are called upon to pay the taxes."

Representative Byrnes went on to say that: "Everyone paying taxes today can do so with the knowledge that he is participating in a sound program of social insurance which will provide commensurate benefits in the event of his death or disability."

The House Committee report on H.R. 12080, which was signed by 24 out of 25 of the members of the Committee on Ways and Means, bears ample witness to the care and thoroughness which the Committee has devoted to assuring the continued soundness of the social security program.

The proposals contained in H.R. 12080 were considered during 18 days of public hearings over a period of 6 weeks, and during 64 executive sessions over a period of 16 weeks. Following debate, the House approved the bill by the overwhelming non-partisan vote of 415 to 3. The bill reaffirms the soundness of the contributory, wage-related social security program.

The soundness of the social security system has been examined a number of times by groups of independent, nongovernmental representatives of business, insurance, labor, and the public.

In 1957, under the Eisenhower Administration, an Advisory Council on Social Security Financing was appointed by Secretary Flemming. It reported as follows:

"The Council finds that the present method of financing the old-age, survivors, and disability insurance program is sound, practical, and appropriate for this program. It is our judgment, based on the best available cost estimates, that the contribution schedule enacted into law in the last session of Congress makes adequate provision for financing the program on sound actuarial basis."

Among the members of the Council who made this statement were the President of a Federal Reserve bank, two actuaries—one from a private insurance company and one from a university—and representatives of business, labor and professional groups.

The most recent Advisory Council on Social Security, again made up of outstanding experts in the field, examined thoroughly all of the issues connected with the "security" of social security. Like the preceding council they concluded, in their report of January 1965, that the social security program is soundly financed and that its income—out into the long range future—will be sufficient to meet its obligations.

Both Advisory Councils took note of such charges as those made in the article to the effect that social security taxes are used for purposes other than social security, that the trust funds contain only IOU's, and that the system is 'in the red" by hundreds of billions of dollars. Both Councils found these charges to be without foundation.

II

The article says that the social security program puts a "squeeze on the young." This is not so. The fact is that even without taking into account that social security benefits have been and will continue to be increased from time to time as changes occur in wage levels and cost of living, young workers as a group will get social security protection worth 20 to 25 percent more than they will pay in social security contributions. This is the case under present law and would be the case under the House-passed bill and under the Administration's proposal.

Young workers could not buy comparable insurance protection from private insurance companies at anywhere near the amount they pay for their social security protection.

The article takes no account of the fact that the benefits provided by the present social security law are very much lower than the benefits that will actually be paid when today's young workers reach retirement age. As wages rise—as they have throughout the history of the country—benefits can be increased *without increasing the contribution rates*. This is because the contributions are a percentage of covered payroll and because, as wages go up, income to the system increases more than the corresponding liabilities.

As a matter of fact, if benefits were *not* increased as wage levels rise over the years, the contribution rates scheduled in present law would be too high, and they could be reduced. Whether benefits are increased or contribution rates are reduced the result would be the same, namely, more protection in relation to contributions than is shown by analyses that assume no change in wage levels and in benefits.

The calculations referred to in the article assume that the covered employee would have within his control an amount of contributions paid by his employers equal to the amount of his own social security contribution. This assumption rests on a misconception of the nature of the social insurance program and indeed the nature of private group insurance. If such an assumption were used, the whole fabric of private group life insurance, annuity insurance, and other forms of group insurance in this country would have to be regarded as inequitable.

As a general rule, under private group insurance plans the employer contribution is not allocated to each employee in an amount related to the employee's own contribution. On the contrary the employer contribution, as in the case of social security, is what makes it possible to pay larger benefits to workers and their survivors who are in the upper age brackets when the group insurance plan goes into effect than could be paid only on the basis of the worker's own contributions.

I believe it bears repeating that even without taking into accout the fact that benefits will be increased in future years, even young workers covered under social security will get insurance protection worth 20 to 25 percent more than the value of their contributions, and moreover, they will actually do much better than that when account is taken of the fact that social security benefits can and will be increased as wage levels go up without any need to increase the contribution rate.

In deciding whether younger people get their money's worth it must be kept in in mind that social security provides not only retirement protection but also survivors and disability insurance protection. While Mr. Stevenson's figures do take into consideration the fact that social security provides protection against loss of income due to death and disability and also provides hospital insurance protection at age 65, most of his discussion ignores the importance of these parts of the program. That importance may be illustrated by an example: The value of the social security survivors insurance protection provided under the House-passed bill in the case of the worker whose earnings are about the median earnings of regularly employed men ($550 per month) who dies at age 35 leaving a wife aged 32 and two small children is about $56,000. Were this worker to become disabled at age 35, the value of the disability insurance protection to him and his family would be about $59,000.

Social security is a sound and equitable program for the young and the old.

III

Mr. Stevenson's article contains nearly two columns on the so-called *Nestor case*, decided by the U.S. Supreme Court in 1960 (pp. 76–77). Mr. Stevenson distorts the legal issues. He has several quotes which to a lawyer and a general reader would appear to be from the Court's decision. But they are *not*. He not only does not quote from the Court decision but fails to mention that the Court decision reversed the contention of the Justice Department brief (prepared in the Eisenhower Administration) that the program is not an insurance program. What the U.S. Supreme Court actually said was:

"The Social Security system may be accurately described as a form of social insurance, enacted pursuant to Congress' power to 'spend money in aid of the general welfare,' whereby persons gainfully employed, and those who employ them, are taxed to permit the payment of benefits to the retired and disabled, and their dependents."

The fact is that the Supreme Court decision rejected many of the contentions made in the brief and stated that: "The interest of a covered employee under the [Social Security] Act is of sufficient substance to fall within the protection from arbitrary governmental action afforded by the due process clause."

Thus, as the Supreme Court stated, although the Congress can modify rights granted under the statute, it cannot do so in an arbitrary way. The right to benefits under social security, as the Court has said, is protected under the due process clause of the United States Constitution against denial or diminution by arbitrary Government action.

IV

The article attempts to show that social security is unsound by referring to "unfunded outstanding obligations" of $350 billion and stating that under the Administration bill this amount will rise to $417 billion. (pp. 79–80). The $350 billion referred to is the amount that would be needed—if social security were a private, voluntary insurance program—to pay off all obligations on the assumption that there would be no new entrants into the system. The idea of there being a huge unfunded liability in the social security system is wholly meaningless and irrelevant for any practical purposes. There is no need in a Government program such as social security for funding on the basis referred to in the article. It would not only be unnecessary but also unwise to build up such a huge accumulation of social security funds. No life insurance expert nor social security expert, nor business nor labor organization, and no Advisory Council or Committee of the Congress has ever recommended such funding.

The most recent Advisory Council on Social Security—an independent group of experts in the field which reviewed all aspects of the social security program over a period of 18 months—stated in its 1965 report:

"The Council is in agreement with the previous groups that have studied the financing of the program that it is unnecessary and would be unwise to keep on hand a huge accumulation of funds sufficient, without regard to income from new entrants, to pay all future benefits to past and present contributors. A compulsory social insurance program is correctly considered soundly financed if, on the basis of actuarial estimate, current assets plus future income are expected to be sufficient to cover all the obligations of the program: the present system meets this test. The claim sometimes made that the system is financially unsound, with an unfunded liability of some $300 billion, grows out of a false analogy with private insurance, which because of its voluntary character cannot count on income from new entrants to meet a part of future obligations for the present covered group."

V

The article is in error in saying that the social security changes recommended by President Johnson would take persons out of poverty "partly by raising the Federal income taxes" of other people over 65 (p. 79). Under the President's proposal, over 2 million persons would be removed from poverty (1.6 million aged 65 and over and 0.5 million under age 65) by the increase in the amount of the social security benefits—especially the increase in the minimum benefits from the present $44 a month to $70. There is no truth in the statement in the article that the method of removing these people from poverty would be through raising income taxes.

The article speaks disparagingly of the improvement of social security benefits for the purpose of reducing the number of persons on assistance or relief. But this has been the objective of the social security program since it was enacted in 1935! This was the original congressional intent. In fact, the carrying out of this intent has been one of social security's greatest achievements. The proportion of the aged on welfare has decreased from about 22 percent in 1950 to about 10 percent today. We hope to decrease the proportion to 5 percent. Increasing the level of social security benefits will aid in this objective.

VI

One more of the many inaccuracies contained in the article is the allegation in the article that social security contributions are put into the "Treasury's general fund" (p. 76). The fact is that the contributions are automatically appropriated by law to the social security trust funds, which are kept separate from one another and from the general funds of the Treasury and can be used only for the payment of the benefits and administrative expenses under the social security program.

VII

Mr. Stevenson says that the Government is discouraging beneficiaries from augmenting their incomes by collecting social security contributions with no comparable increase in benefits and by withholding benefits from those beneficiaries who earn over $1500 a year. (p. 79)

The purpose of the social security program as determined by the Congress is to pay benefits when there is a loss of earnings because of death, disability, or retirement. The law prescribes a test—generally referred to as the retirement test—for determining whether such loss of earnings has occurred. The amount of the retirement test and whether there should be any retirement test is certainly a question which warrants discussion.

What Mr. Stevenson didn't say in his article is that eliminating the retirement test would increase the cost of the program by $2 billion a year. The additional cost would be incurred to pay benefits to about 2 million people, many of whom are fully employed and earning as much as they ever did. The vast majority of social security beneficiaries—some 20 million other persons—either are unable to work or cannot find a job and therefore would not be helped one iota by the elimination of the retirement test. Would this be an intelligent and equitable way to spend $2 million a year additional?

The author's statement that beneficiaries who work and pay social security contributions get "no comparable increase" in benefits may give the impression that this work cannot increase their benefits or that, if it can, the benefit increases are insignificant. The fact is that the beneficiary who works can get a benefit increase if he has even just a single year in which his earnings are more than his earnings in any one of the past years that were used in computing his benefits.

In short, Mr. Stevenson didn't tell a full or fair story on the retirement test.

VIII

The article concludes that further study of and basic changes in social security are called for. Some of the concluding remarks are repetitions and of misleading assertions made earlier and some go further.

The article raises a number of questions about what will happen to the social security program in the future after whatever "temporary tinkering the House and Senate may do regarding the President's program"—as if the House and Senate are not comprised of the elected representatives of the American people

and as if the President is not responsible to the American people. It is through such processes as the article calls "tinkering"—studied proposals such as those made by the President, and congressional deliberation and debates—that this Nation builds its public programs, orders its economy, and carries on the affairs of Government, and this will doubtless be true in the future.

The article goes on to suggest, on the basis of the increases in social security contribution rates that have been enacted over the years, that private pensions may not be able to remain "afloat." Such scaremongering ignores the fact that social security has not prevented the rapid growth of private pensions. Private pensions have made tremendous strides since the 1930's, when social security began. There were only about 400 private pension plans in 1935 when social security was enacted. Today there are over 60,000!

With regard to Mr. Stevenson's proposal to establish a "blue ribbon commission," over the years since the Committee on Economic Security submitted its report to President Roosevelt and the original Social Security Act was enacted in 1935, there have been numerous independent studies of social security by advisory councils composed of highly respected and knowledgeable citizens. For instance there was an Advisory Council Report in 1939, 1948, 1959, and 1965. Since 1956, studies by advisory councils have been provided for in the social security law itself, and there have been periodic studies by these councils. Through the councils, consisting of representatives of employees, employers, the self-employed, and the general public, the social security program has had the benefit of a great deal of intelligent and thoughtful examination. Under the law, the next advisory council, scheduled to be appointed in 1968 (under the bill recently passed by the House, it would be appointed in 1969), will review all aspects of the social security program, including the status of the social security trust funds in relation to the long-range commitments of the program and will make a report of its findings and recommendations to the Board of Trustees of each of the social security trust funds and to the Congress.

IX

Mr. Stevenson has not clarified any fundamental issues. He has not pointed out the great unmet social needs. What he has done has been a great disservice to the millions of social security beneficiaries and the millions who are counting on social security benefits in the future. He has obfuscated and confused the major policy issues in social security. A critical and constructive review of social security would be welcome. A glib and superficial attack on a program so important to millions of Americans is not a contribution to the American people.

COMMITTEE HEARINGS AND REPORTS

(One asterisk indicates committee's supply exhausted; copies are available for purchase from Superintendent of Documents, Government Printing Office, Washington, D.C. 20402. Two asterisks indicate all supplies exhausted.)

Action for the Aged and Aging, Report No. 128, March 1961.**
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- Part 2. Newark, N.J., October 16, 1961.
- Part 3. Philadelphia, Pa., October 18, 1961.
- Part 4. Scranton, Pa., November 14, 1961.
- Part 5. St. Louis, Mo., December 8, 1961.

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- Part 1. Washington, D.C., December 11, 1963.
- Part 2. Los Angeles, Calif., January 9, 1964.
- Part 3. San Francisco, Calif., January 11, 1964.

Subcommittee on Involuntary Relocation of the Elderly:**
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Part 2. Newark, N.J., October 26, 1962.
Part 3. Camden, N.J., October 29, 1962.
Part 4. Portland, Oreg., December 3, 1962.
Part 5. Los Angeles, Calif., December 5, 1962.
Part 6. San Francisco, Calif., December 7, 1962.
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Part 3. Hartford, Conn., November 20, 1961.
Part 4. Boston, Mass., December 1, 1961.
Part 5. Minneapolis, Minn., December 4, 1961.
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Part 2. Cleveland, Ohio, February 15, 1965.**
Part 3. Los Angeles, Calif., February 17, 1965.
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Part 3. Port Charlotte, Fla., November 7, 1961.
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Part 6. St. Joseph, Mo., December 11, 1961.
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Part 8. Cape Girardeau, Mo., December 15, 1961.
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Part 1. Washington, D.C., June 22–23, 1967.—$1.00

Part 2. New York, N.Y., October 19, 1967.—70¢

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Long-range program and research needs in aging and related fields: Washington, D.C., December 5–6, 1967. (Cat. No. —.)

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"Amend the Older Americans Act of 1965—S. 2877 and S. 3326", May 24, 25, and June 15, 1965.

"Older Americans Act Amendments of 1967—S. 951", June 12, 1967.

"Older Americans Community Service Program—S. 276", September 18 and 19, 1967.

"White House Conference on Aging in 1970—S.J. Res. 117", March 5, 1968.

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