PROBLEMS OF THE AGING

HEARINGS

BEFORE THE

SUBCOMMITTEE ON FEDERAL AND STATE ACTIVITIES

OF THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

EIGHTY-SEVENTH CONGRESS

FIRST SESSION

Part 2.—Trenton, N.J.

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NOTE.—Thirteen hearings on Federal and State activities in the field of aging were held and they are identified as follows:

Part 1.—Washington, D.C.
Part 2.—Trenton, N.J.
Part 3.—Los Angeles, Calif.
Part 4.—Las Vegas, Nev.
Part 5.—Eugene, Oreg.
Part 6.—Pocatello, Idaho
Part 7.—Boise, Idaho
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PROBLEMS OF THE AGING

MONDAY, OCTOBER 23, 1961

U.S. SENATE,
SUBCOMMITTEE ON FEDERAL AND STATE
ACTIVITIES OF THE SPECIAL COMMITTEE ON AGING,
Trenton, N.J.

The Subcommittee met at 10 a.m., pursuant to call, in the War Memorial Auditorium, Hon. Harrison A. Williams, Jr., presiding.

Present: Senator Williams.

Committee staff members present: Dr. Frank J. Atelsek, research director; Frank C. Frantz, professional staff member; and John Guy Miller, minority staff member.

Senator WILLIAMS. The hearing of the Subcommittee on Federal and State Activities of the Special Committee on Aging will now get underway.

We are privileged to have the mayor of the city of Trenton with us this morning, Mayor Holland.

We will open with Mayor Holland; then we will hear from Governor Meyner; and because of the pressure on them, I will hold my opening statement until after that.

STATEMENT OF HON. ARTHUR J. HOLLAND, MAYOR OF TRENTON

Mayor HOLLAND. Senator Williams, Governor Meyner, other distinguished guests, participants in this hearing, it is an honor for us to welcome this group to our community, because you have come here, we feel, to discuss what has become one of the great social welfare problems of our era. We feel that we welcome you to a community which already has done much to try to meet the need of our older population.

We have several volunteer groups which are dedicated to meeting the recreational needs of senior citizens, and one of these, in cooperation with the State division on aging, under the direction of Mrs. Harger, has undertaken a pilot project to determine what the employment opportunities are for older people who are able to work and are desirous of working.

Our Trenton Housing Authority is in process of completing a beautiful apartment house for older people, and this will in part meet the relocation need of older people in the nearby John Fitch Way urban renewal area, through which we hope, at noontime, to take the Senator, so that he can see at firsthand what the problem is and how we are endeavoring to meet it.

I feel that every level of government has a role to play in meeting this need, in cooperation with, of course, private agencies; and it is our hope that this hearing will be most helpful in determining what those roles can best be and hope they can most effectively be carried out.

So welcome to all of you.

Senator WILLIAMS. I wonder if you could describe the housing. How many units for senior citizens do you propose for Trenton?

Mayor HOLLAND. I can't give you the exact number, but we will have a nine-story building, with 150 units which will be in the Louis Josephson Homes. We are also looking into other areas, to see whether we might place some smaller units.

Senator WILLIAMS. Is that under the public housing program?

Mayor HOLLAND. Yes. Our local authority.

Senator WILLIAMS. This morning we stopped at public housing that is being constructed in the city of New Brunswick, 60 units, magnificently located, right within the regular public housing area. We found that last week many suggested that older people should certainly not be isolated in their housing, but should be worked into the community; and it seems to me there is no better place to work this kind of public housing than in the area where regular public housing for families is located.

Does yours fit into a pattern like that within the community?

Mayor HOLLAND. We have been using both approaches, because, as you are well aware, there are two schools of thought on this; and so far as we are concerned, this whole question of housing is one which requires continuing study. I think you have to take into consideration the local conditions.

Senator WILLIAMS. We thank Mayor Holland and will look forward to the noontime tour of the great strides being made in the city of Trenton.

Our next witness is the Governor of our State, Gov. Robert Meyner.

This is the second time I have come to town with a Senate committee, and this is the second time the Governor has honored us with his presence.

STATEMENT OF HON. ROBERT B. MEYNER, GOVERNOR OF THE STATE OF NEW JERSEY

Governor MEYNER. Senator Williams and distinguished participants in the hearing, as the Governor of a State, I welcome the opportunity to report to a Federal legislative body the steps that the State of New Jersey has taken over the past 8 years to improve and enlarge the opportunities of our older citizens.

It has been my pleasure to serve on the committee in the Council of State Governments that leads with the problems of the aged. From the inception of my administration I have worked to increase the community's participation in the solution of these problems. Those of us at the State and Federal levels of government can inspire and assist, but in the final analysis, the community must initiate meaningful programs. Therefore, we have encouraged the participation of the elderly in all aspects of community activity.

The physical and mental health of our aged had a high priority in all our planning to improve the facilities and the means of paying for more comprehensive medical care for the aged. Assuming good physical and mental health, the aged should have an equal opportunity in employment. An adequate minimum income from all sources is essential if the elderly are to make their proper contribution to society. When we provide these programs, we will give the elderly the independence, mobility, and freedom that they so much want. It is within the context of these five points that I want to discuss some aspects of Federal-State cooperation and, in more detail, State programs that stimulated opportunities for the elderly.

New Jersey was the first State by legislative enactment to create a division on aging. This division has coordinated and stimulated existing agencies to expand programs and develop new ones to meet the needs of the citizens already classified as "elder," as well as encouraging industry, labor, citizens' groups, and Government to help plan programs that would make the next crop of "elder" citizens full participants in community life.

Our American system does not permit us to stand still while we work on tomorrow's problems. We must alleviate the suffering today and plan for tomorrow—both at the same time.

Through our division on aging we are making it possible for local communities, municipal government, and private organizations to change the stereotyped misconception that our elder citizens are a group to be set apart from the rest of the community.

We now realize that the problems of the aged are not different basically from the problems of the rest of the community. We know that these problems are not confined to any one area in the State or to any small segment of society. We know now that our older citizens do not ask for favored treatment, simply because of the passing of time. We know also that the population explosion created by advances in medicine and medical care facilities is in the process of creating such numbers of the aged that we need to focus the attention and the resources of every level of government and of our citizenry on solving some of the more pressing of their problems.

The climate for the solution of these problems has improved and we can look forward to many more activities in the months and years that are ahead. Our elder citizens have been partially responsible for this changing attitude. Through their Golden Age Clubs and other community groups they have made their desires and needs clearly understood. We, in State government, have welcomed the added resources that our retired senior citizens are bringing into community life.

In the field of physical and mental health, New Jersey is one of the leaders of the Nation. For example, in the development of the concept of "continuity of care" for patients, this State has progressed to a greater degree than other States. In April of 1952, we gave this concept concrete form in the passage of the Prevention of Chronic Illness Act. This act was based on a careful study by a commission of citizens and it had the full cooperation of the legislature.

Later on this morning you will hear in more detail about the continuity of care programs from Dr. Johannes F. Pessel, chairman of the Advisory Council on the Chronic Sick, New Jersey State De-

partment of Health. Dr. Pessel represents the kind of unselfish devotion that our citizens have given toward the development of better health services for the elderly.

During the course of this administration, the State health department through its Public Health Council, in cooperation with the New Jersey Health Officers Association, has developed a set of standards entitled "Recognized Public Health Activities and Minimum Standards of Performance for Local Health Departments," which sets up a yardstick, so that local health departments may measure their standards of performance. In these minimum standards are requirements for services to the chronically ill and aged members of the community. With the minimum standards of performance as a foundation on which to develop more services, we wish to commend the action of Congress in passing the Community Health Facilities Act, signed recently by President Kennedy. This act was supported by both New Jersey Senators, and it passed the Senate without a dissenting vote. The funds available under this new Federal law will assist many of our local health departments to implement the minimum standards of performance and to expand needed services to the elderly.

Our department of institutions and agencies is a recipient of several Federal grants for research work. Mr. F. Spencer Smith, chief of our bureau of community institutions, will outline in more detail how the Federal money is being used in the development of hospital facilities. I want to mention one other in detail because of its importance. In New Jersey we are determined that our mental institutions shall not become repositories for our senior citizens. The Federal grant of money in this area is being used to devise plans for the care of patients that will involve local agencies and home care and thus remove them from our State hospitals. This is the type of Federal-State cooperation that we are happy to endorse.

Our older citizens should have an equal opportunity to be gainfully employed. In this respect, our State employment service has added trained counselors to advise older workers and to help them get placed. One of the basic problems confronting the employment service in carrying out its goal is the urgent need for retraining of these people wanting to reenter the labor market. New Jersey has a higher than average number of older single women concentrated in our more urban communities, and so the need for retraining has been accentuated. Since our population is so mobile, we feel that this is an area where leadership needs to be taken by the Federal Government.

As our technological development continues, the number of older citizens who can be placed without retraining will continue to decline and employment opportunities will become fewer. Therefore, we feel that while this State has taken some preliminary steps toard the resolution of this problem, we do need further assistance from the Federal Government.

We need to recognize that older people should have retirement income sufficient to maintain health, mobility, and participation in the community life as independent, self-respecting citizens.

The time has come when this Nation must squarely face the problem of the erosion of savings and retirement income plans because of inflation. While the social security increases granted by the current session of Congress were helpful, they did not basically change our

philosophy of keeping the minimum social security payments virtually at relief levels. No individual can be an independent, self-respecting citizen on $44 a month.

The American people are not beggars. They do not want a handout, but when schoolteachers, civil service employees, and recipients of many private pension plans do not receive an income on which they can live in today's economy, the whole philosophy needs reexamination.

In many cases, when plans for retirement were made in the 1920's and 1930's to take effect in the 1950's and 1960's, the sole reason why these people cannot get by on their retirement incomes is because of the inflation of the dollar. This is a matter of Federal Government policy and control. It would appear to me that we need to examine the possibility of using the escalator clause approach to social security payments and to tie these payments to the cost-of-living index, and not have to depend on Congress to make adjustments when they are needed.

In spite of the fact that New Jersey is one of the most densely populated States in the Nation, we still are known as the Garden State. Our agriculture depends on the importation of migrant workers. Senator Harrison Williams has been in the forefront of efforts to improve the lot of these workers. It is from our own American families that come up from the South—poorly educated, poorly trained in the ways of health maintenance, and earning low incomes—that many indigent elderly come. Congress has expanded the coverage of social security, but there are still many more low-income and seasonal workers who should be covered.

I note that a substantial percentage of even professional people are now ready to come under social security, if they can get it.

Therefore, I would suggest that the Congress and the American people expand the coverage of social security to every American and to use it for what it was intended—a far-reaching instrument for the security of all our citizens and, just as importantly, a floor under our total economy.

In your hearing in Newark the other day, although it was supposed to be a hearing on housing, I note that the persistent, most urgent need voiced by the elderly themselves was for an adequate program of medical care. My position on the provision of medical care for the aged is well known and hardly needs reiteration here. In my address to the First National Conference of the Joint Council To Improve Health Care of the Aged, held in Washington in June of 1959, I said:

> Here is an issue of profound national concern, and it is most encouraging that you in this audience have come to Washington to do something about it. Out of this meeting of minds I am sure much progress will be made.

And progress has been made.

We now have a national administration whose policy calls for the enactment of medical care legislation under the social security system. While the Anderson-King bill is not as comprehensive as many would like to see it, it is an important step forward.

The issue is no longer a partisan one. The unanimity of support, ranging from Business Week magazine and Life magazine to organized labor and many millions of unattached Americans, testifies that this is a problem of such import that we can no longer afford the luxury of irresponsibility on the part of the Federal Government in

this area. I have often said it would be more sound if the persons responsible for treating the aged would strive to make the proposal an efficient, practical, and workable one, instead of opposing the plan.

If our older citizens are to maintain their independence and their right to free choice in the planning of their own future, we need desperately to solve their housing problems. Survey after survey has shown that our elderly do not want to live with their children or to be relegated to homes for the aged and, as a last resort, a nursing home. The elderly want, and should have, housing which they can afford and of a type that meets their needs.

At our most recent conference, 2 weeks ago, on Housing for an Aging Population, we learned we now have with us, helping solve the housing problems of our aging population, the private builders, banking and mortgage concerns, and religious, fraternal, and labor organizations, as well as many divisions of State government. By pinpointing the needs of the elderly, we are now on the threshold of notable progress. In 1950, with an elderly population of 394,000, we had no special housing for them. In 1961 we have an elderly population of half a million, with more than 4,000 public housing units occupied, under construction, or contemplated. This is not enough, of course. It is only surface scratching, but it shows improvement.

The current hearings being held by the members of the Senate Subcommittee on Aging have already developed the concept that housing for the elderly will assume greater importance as the effects of the new Federal Housing Act begin to be felt. We in New Jersey, through our State agency, the division of aging, and the divisions of State government directly concerned with housing, in cooperation with all the elements in the community that have an interest, will see to it that New Jersey remains in the forefront for decent, safe, adequate housing that our elderly can afford.

We welcome the action of the Federal Government in reorganizing the Housing Administration so as to make it easier for applicants for loans to get the necessary information and assistance to launch their programs.

In closing, let me recapitulate. As Governor of the State of New Jersey, I have welcomed the opportunity to report to the people and those in Federal Government having responsibilities in this field, the activities that have been carried on for the past 8 years. We think that the climate has been changing in New Jersey. We think that the time is right for moving forward rapidly in the solution of many of these problems, but I think that it is equally important that those of us who carry these responsibilities speak out on the issues of the day which call for solutions.

We need medical care for the aged under social security. We need to have the social security program expanded to cover every American and we need to reexamine the philosophical base on which we operate. Social security should provide a minimum standard of living so that those who are totally dependent on it may live in decency. It should provide the elderly with sufficient income for health maintenance, adequate housing, and the necessary social services for independent creative living.

This program cannot come about with hit-or-miss planning. This program requires social planning of the highest order. Its imple-

mentation will require statesmanship, not the seeking of partisan political advantage.

We in New Jersey welcomed the passage of such legislation as the Community Facilities Health Act, a comprehensive housing program, and the creation of the Special Senate Committee on Aging.

We in New Jersey will continue to do our utmost to stimulate our communities, our organizations of local government and our organizations of labor and industry, to move forward with the provision of services on the local level.

This cooperation is a two-way operation—our citizenry, when given an opportunity, will speak out and tell those of us in the State and Federal Government about their needs. The Federal Government, on the other hand, gives us guidance and leadership for the development of local and State programs. This cooperation of citizens and their government has made democracy a living thing. Now more of our energies in this democratic process are being applied to the problems brought upon us by lengthening life expectancies.

Your interest in problems of the aging and our relationship to them in New Jersey is evidenced by your hearings in this State. We trust that the evidence that has been presented both in the formal statements and in the comments from the floor will prove useful to you as you prepare new recommendations to Congress concerning programs that affect the aged. If there is any way that those of us from New Jersey can be of further assistance, we shall consider it a privilege to be called upon. Thank you.

Senator WILLIAMS. We are very grateful, Governor, for your strong support for the various programs that we will be giving increased attention to in Washington.

I think you certainly are one of many to be commended for attention to housing for senior citizens. Our State has more senior citizen housing than any other State in the Union. It accounts for one-fifth of all housing of this type in the whole country. And we know there is much more to be done.

In connection with your support for the Anderson-King idea of making social security the vehicle for medical care, we feel that probably this will be one of the major efforts of the coming year. But as a first step, last year the Congress did pass the Kerr-Mills bill, which, of course, requires State implementation. No State is under it automatically, as we all know, as it requires legislative action at the State level.

I wonder if you could, for our record, describe what the status of Kerr-Mills is in the State of New Jersey.

Governor MEYNER. Well, of course, in some respects we were in advance of Kerr-Mills; for instance, in our old-age assistance program, which we make available to citizens only if they have no dependent relatives and if they have no property to take care of them.

We get an agreement to reimburse if they do have property. And we have allowed medical care.

So under the Kerr-Mills bill, we were the recipient of some funds from the Federal Government to take care of programs of medical payments we had already been making.

Our program did not go as far as the Kerr-Mills bill. The Kerr-Mills bill said that certain people having less than a certain income

would be eligible for medical assistance. Well, we had hoped that the social security would encompass medical care; so we waited a few months, hoping that the new administration would be able to get through Congress medical care as part of the social security. When it appeared it could not, we had institutions and agencies prepare legislation which would allow us to participate to a great extent in the Kerr-Mills legislation.

Now, if this legislation was introduced, roughly we think it would cost the State between $250,000 and $300,000 and would cost the counties, which share in this program, some $500,000 to $600,000. That is the whole 21 counties.

I urged very strongly the passage of this bill, and the assembly responded, and they passed the legislation which would allow us to participate to a greater extent in Kerr-Mills. But the senate refused to act. As a matter of fact, when they came back last August for a 1-day special session, I tried to highlight this, that we, in New Jersey, if we didn't get this legislation, would delay taking advantage of this bill.

Even if we get it passed in November or January, it will take 3 or 4 months before we can set up the mechanism by which it can be done; and I am afraid this delay on the part of the senate is hard on our taking advantage of the program at an early date. I think the effective date is January 1.

Senator WILLIAMS. The legislation, then, passed by the assembly now is still in committee in the State senate?

Governor MEYNER. That is correct; and it will mark a delay in our setting up the program, because in order to qualify for the funds, we have got to have the kind of organization to screen these people and to set up programs.

Senator WILLIAMS. Again the committee thanks you for your very strong and very helpful statement.

I would say that the committee did invite your successor to make statements at the hearings. We invited both candidates. We had a statement from Judge Hughes in Newark, and I understand Mr. Mitchell is sending a statement for us to consider.

Governor MEYNER. I was afraid when you made that statement you should have prefaced it by saying, "I have a secret."

Senator WILLIAMS. Thank you, Governor.

Governor MEYNER. Thank you, Senator.

Senator WILLIAMS. Since we convened, I notice many people have come in, and it is a pleasure to welcome you all to these hearings of the Special Committee on Aging. This is an official hearing of this committee of the U.S. Senate, one of 29 hearings scheduled for this fall. Everything said here today will be taken down by an official reporter and printed as a Senate document. Copies will go to all Members of the Senate and House of Representatives, as well as to hundreds of State officials and legislators, press people, and professionals working in the social science fields.

The creation of our Senate special committee in February of this year, and our hearing here today, stem from the great concern which we in the Senate feel for the difficult problems of our elderly citizens in the contemporary world. That this concern is shared by Government officials and community leaders everywhere is evidenced by the

full schedule of participants which we have for this hearing today, and the many others who requested time to give their views, but whom we were unable to accommodate.

The subject of this hearing in Trenton is "Federal and State Activities on Behalf of Our Older Citizens." We are not here merely to recite the many difficulties which older people face every day. We are here to learn who is doing what about them.

As is so often true, when a problem area appeals so universally for action, we see the development of many different programs by various governmental and community auspices as people of good will and humanity seek to deal with the problem. The point has been reached where we need to take stock of our efforts and to make an accurate, far-reaching inventory of the proliferating programs now underway to help aging and aged citizens of this Nation.

Although, in far too many cases the organizations established for the White House Conference on Aging have been abandoned, some two dozen States, including New Jersey, have permanent State agencies to help older people. There also is a considerable amount of action at the local government and community levels, examples of which we will hear about today.

And at the Federal level, we are conducting new programs or considering the establishment of still others. The need for many of them is obvious, but the question becomes: How can we work together with State, local, and private agencies for maximum effectiveness?

We are here today to receive some answers to that question, and we're sure that they will be very worthwhile answers. New Jersey has already led with many innovations. Our State Division of Aging has looked into such matters as use of leisure time, pedestrian safety among our senior citizens, and housing for the elderly. The interest in housing is well-placed, I might add, because our State has more senior citizen housing than any other State in the Union. It accounts of one-fifth of all housing of this type in the country.

Among the older, well-established Federal programs, it is obvious that several have a great impact on citizens of New Jersey. About 71 percent of our population over 65 are receiving social security payments. In New Jersey these payments average $81 per month, which is somewhat higher than the national average. As of July of this year, approximately 19,000 aged citizens of New Jersey were receiving help from the old-age-assistance program. The average payment under this program was $92 per month, made up of $55 in money payments and $37 in payments to doctors and others for medical care.

Many new programs launched in recent years now should be evaluated and perhaps modified on the basis of experience, to the end that they function more effectively as parts of the total public response to the needs of our elderly citizens.

For example, we should look carefully at our research efforts in gerontology. Our Center for Aging Research at the National Institutes of Health, for instance, is now in its fifth year of operation. As of May, it had given 700 active grants for clinical, biological, sociological, and psychological studies. How far do these studies go? Should we be concentrating more on the effects of urbanism upon our aging as officials are doing on a city level at the metropolitan planning project for older people in Denver, Colo.? There, helped by a 3-year

grant from the Ford Foundation, researchers are striving to achieve a community approach to the needs of the aging. It seems to me that we might well find use for a similar study in New Jersey.

Our home State, incidentally, has already been chosen as the site for a demonstration program on a mental health program for the elderly. We'll hear more about that today. I hope we hear, too, of other pioneering steps to give our experts and our citizens the facts they need to deal adequately with the "quiet revolution" brought about by increased longevity of our citizens.

The chairman of our full committee, Senator Pat McNamara of Michigan, has described the growing social and political impact of our older population and their rightful claims to a share of the prosperity they helped create as a "quiet revolution." This is an apt phrase.

We are aware of the importance of maintaining a meaningful role in society for our retired population. We know the problems of maintaining independent living with reduced financial and physical resources. We can foresee that the proportion of our population in the older age brackets is increasing and will continue to increase.

The responsiveness, humanity, and efficacy with which our community and governmental efforts at all levels can cope with the future of the citizens who have built our present, has great significance for the future of this Nation.

We have gotten underway with the very helpful statement from the mayor of Trenton, and the Governor of our State, and our next witness will be Commissioner John Tramburg, of the New Jersey Department of Institutions and Agencies.

Commissioner Tramburg?

Commissioner Tramburg, you have your associates with you. Would they like to join you at the table?

STATEMENT OF COMMISSIONER JOHN TRAMBURG, NEW JERSEY DEPARTMENT OF INSTITUTIONS AND AGENCIES

Commissioner TRAMBURG. Yes. May I introduce them, sir?

Mr. F. Spencer Smith, chief of the bureau of community institutions, has the responsibility of licensing nursing homes, boarding homes, and the like.

Next, Mr. Irving Engelman, director of the division of welfare, and to his rear, Mr. Ed Hann, chief of the bureau of assistance, and on my right, Dr. V. Terrell Davis, director of mental health and hospitals.

Senator WILLIAMS. Fine. We know that this will be very productive, very helpful. Any way you gentlemen want to proceed.

Commissioner TRAMBURG. I would like to say a word and then get going. I have an appearance to make on our bond issue.

Now that I have got that plug in, Senator: It is a pleasure to join with my colleagues in discussing with you the programs in New Jersey relating to the subject matter which you outlined in your opening statement; and in my introduction I pointed out the areas of specialties that each person here has a responsibility for and the administration of. And whatever is your pleasure, sir, we will be happy to take it in whatever order you would like.

Senator WILLIAMS. Any way you want.

Commissioner TRAMBURG. Suppose we start with Mr. F. Spencer Smith, who, in addition to the licensing facilities that I enumerated, also has in his shop the responsibility for presenting a State plan, on which we each year get a Federal appropriation of Hill-Burton funds for the construction of facilities and for hospitals, nursing homes, chronic care mental health facilities, rehabilitation and diagnostic and treatment facilities.

And having just had such a meeting, I am sure it is very fresh in his mind.

So if you want to start with Mr. Smith——

STATEMENT OF F. SPENCER SMITH, BUREAU OF COMMUNITY INSTITUTIONS

Mr. SMITH. This year New Jersey received about a $4 million allotment of Hill-Burton moneys, and as far as the particular problem of the aging is concerned, we received $381,000 in the chronic disease category and $351,000 in the nursing home category.

There have been applicants for grants from Bergen County for the development of a chronic disease facility, and from Middlesex County this year for a large institution which we would term a county nursing home.

Under this program we have been able to make facilities available for the aged. We have had one unit built in connection with Princeton Hospital, a nursing home operated under the sponsorship of that hospital. The city of Newark has received an allotment for the development and restoration of a building for the chronically ill. Cape May County, Union, and Middlesex, have also received grants of this type.

One of the difficulties which we see in this program is the dearth of applicants among nonprofit groups and associations. We understand that in some States there are applications far in excess of the funds available, but in New Jersey very few nonprofit groups have applied for funds in the nursing home category.

One of the reasons may be that the existing institutions are caught in the shrinking of philanthropic moneys and rising costs. Many homes for the aged are in this category.

We would like to see in New Jersey additional applications for this money, because we feel that this is a field which should be a fertile one for the care of the aging.

Would you like me to discuss also the inspection program?

Senator WILLIAMS. While we are on the two programs, chronic illness and nursing homes, what was the extent of applications under these programs for this year?

Mr. SMITH. This year we had just two applications by counties. Middlesex County asked for a diagnostic and treatment facility, which will be erected in connection with Roosevelt Hospital, which cares for some chronic patients. We had an application from Bergen County for a chronic disease wing; and Middlesex County had a nursing home application. Those were the only applications this year.

Senator WILLIAMS. Did that exhaust the money that was available to our State?

Mr. SMITH. There wasn't enough money, actually, Senator, to meet those applications.

Senator WILLIAMS. And how about in nursing homes? Did we exhaust the funds available under the nursing home program?

Mr. SMITH. In one application.

Senator WILLIAMS. With one application?

Mr. SMITH. One application.

Senator WILLIAMS. What home was that?

Mr. SMITH. That is Middlesex County. As a matter of fact, the Federal moneys were not sufficient to meet 35 percent of the cost of a projected structure there.

Senator WILLIAMS. Well, it is not germane to this inquiry, but it would be helpful to me to know how the regular hospital Hill-Burton programs are going, and how money available relates to the applications that we have.

Mr. SMITH. Each year there are applications by hospitals well in excess of the amount that is allotted by the Federal Government. This may be due to the fact that practically every hospital has a building program. Hospitals are well established in the community, they have widespread community support, and they often have and almost always have their share of the funds readily available to meet the required 65 percent.

This year we have had applications first of all from the State health department for the construction of its laboratories and the new structure to be built nearby. Of course, these laboratories will service the entire State, and they received a grant under a provision of our State plan, which states that public health centers are eligible applicants.

We had two applicants, the Barnert Memorial Hospital in Paterson and St. Joseph's Hospital in Paterson, both for the maximum amount of $750,000. We have an application from a hospital in Hammonton, an area in this State where a hospital is still needed. We are an urban State, but Hammonton is midway between Camden and Atlantic City. It is also midway between Mount Holly and Vineland. And there is a possibility that we will be able to construct a hospital in Hammonton.

Another applicant is the Pascock Valley Hospital in Bergen County. They are planning an addition, and it looks as though we may be able to give help to them.

There would undoubtedly be many more applicants, except that the hospitals have a pretty general idea of how much money will be available and they know which other hospitals are applying. We can always use more Hill-Burton moneys than the amount allotted to us.

Senator WILLIAMS. Do you know whether there has been much use of the FHA mortgage guarantee program for nursing homes?

Mr. SMITH. I had a conference just about a week ago and I find that the FHA has made, I believe, four commitments for the construction of nursing homes, all in areas of the State where nursing home beds are very much needed. And we are hoping that they are going to fill some of the gap in those counties where there is a greater need still.

New Jersey has a peculiar situation there, in that some counties appear overbuilt in nursing homes, and in other counties we need them very badly. I think part of that has arisen from the fact that real estate values in the northern urban counties are so high that it has been a deterrent to the building of nursing homes; and unfortunately, welfare authorities of those counties have had to farm their patients out, sometimes far away from home.

We are hoping that through FHA there will be some more stimulation for construction of nursing homes; not just nursing homes, but nursing homes in the counties where they are so badly needed.

Senator WILLIAMS. All right. Now, I interrupted you on another part of your testimony.

Mr. SMITH. Well, I would like to say that in the nursing home field we believe that proprietary nursing homes in New Jersey meet a high standard. Our standards are reputed to be about as high as any in the country. One reason we have been able to get high standards in New Jersey is that our rate of reimbursement has always been relatively high as compared with other States. I am speaking now of the assistance program, where the rate of reimbursement currently is $190 a month, which is far and away in excess of that paid by many States.

That is one of the difficulties that many States are encountering in trying to build and enforce good nursing home standards; that there is not the companion effort on the part of the States to provide the nursing homes with an adequate reimbursement plan.

I would say also that aside from the 173 nursing homes that we have under license—and there are 6,500 beds in them—we are licensing infirmaries of homes for the aged. This has been a relatively new development. As you know, the home for the aged originally was just a domiciliary type of facility; but in more recent years, with increased longevity, there have been more and more chronic patients; and now a number of homes have infirmaries. Some of them have actually over 50 percent of their populations in infirmaries. We license infirmaries in homes for the aged on just about the same standards as the nursing homes, and we are having some new facilities provided by these nonprofit homes.

We also approve some 22 county institutions, providing almost 3,000 beds. These were the institutions once referred to as welfare houses, and originally actually some of them were almshouses, but they have been converted, and they are all meeting standards comparable to those of the proprietary nursing homes, so that in these three groups of institutions, we have about 10,000 beds.

As far as domiciliary care for the aged, we have still about 3,000 beds in homes for aged. These are residents. And we have 294 shelter care boarding homes in New Jersey, which are approved for some 3,700 people; giving a total of 6,700 domiciliary beds, as contrasted with the 10,000 that are equipped to render nursing care.

I point out that in nursing homes of the three types, the proprietary, the county, and the infirmary of homes for aged, the number of beds actually is only about 1.8 percent of our population over 65. In other words, we care for only a relatively small percentage of the aged in these facilities.

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However, when people are in need of nursing home care, they constitute a very real problem, even though percentagewise the number may be small. What we are trying to do in New Jersey is make certain that these people do have good care, that the homes meet good standards, and that we can maintain a progressive program. As a matter of fact our type of program is being adopted, at least in part, by some other States.

I think that probably covers my subject.

Senator WILLIAMS. That was very helpful.

Commissioner TRAMBURG. Next is Mr. Irving Engelman, who is director of the division of welfare, who has the responsibility for the administration of the four categorical aids under the Social Security Act in the field of public assistance and general supervision for welfare matters in the county-State relationship.

And may I at this time beg off, sir? I have this other commitment.

Senator WILLIAMS. Thank you very much for being with us.

Commissioner TRAMBURG. Sorry I can't stay, sir.

Senator WILLIAMS. Mr. Engelman?

STATEMENT OF IRVING ENGELMAN, DIRECTOR, DIVISION OF WELFARE

Mr. ENGELMAN. Since we are meeting today in New Jersey, and since you, Senator Williams, are from New Jersey, I think it is appropriate to point out that New Jersey has been in the forefront of tangible expression on the part of government in its concern for senior citizens.

New Jersey was one of the first 10 States in the Union to establish a program of old-age assistance. This program antedates the Federal Social Security Act. For 30 years now we have been translating into governmental action the responsibility for devoting attention to the problem of income maintenance for the aging. New Jersey's old-age assistance program has been recognized nationwide as successful and progressive.

It was in connection with the administration of this program, directed first and primarily the problem of income maintenance for the needy aged, that the department of institutions and agencies first began calling attention, many years ago, to the fact that income maintenance in and of itself, no matter how successfully it was operated, did not serve to meet the true needs of the aging population. Very early in the game we called attention to the fact that man does not live by bread alone, and that there was need for governmental agencies and private agencies in the community at large to turn their attention to the other needs of the aged that were necessary to make a good life for retired citizens over and above income maintenance.

Legislatively, at the time, these other functions were not a part of the statutory charge of the public assistance agency. Nevertheless, by dint of circumstances, in this State the county welfare boards found themselves in the position of being concerned with these other requirements of our aging population. They had to deal with those problems on an ad hoc basis, even in the absence of special structures or special legislative charges to find solutions.

Partly for that reason, it was the department of institutions and agencies, through the division of old-age assistance, that gladly urged the establishment in New Jersey of a special division of aging, which would have general oversight over these manifold aspects of the problems of our senior population. I know you will hear later today from representatives of that division.

From the vantage point of administering the public assistance program for the aged, coupled with the welcome development in more recent years of the expanded social security program as the primary source of income maintenance for the aging population, I believe that in New Jersey we have substantially—not completely, no effort is ever complete or perfect—but we have substantially alleviated for our New Jersey senior citizens the problem of primary income maintenance.

In my opinion, the most urgent of the remaining problems, that impinge very strongly on the problem of income maintenance, is today the problem of medical care for the aging.

In New Jersey fewer than 4 percent of the 560,000 or 570,000 persons over 65 are today dependent in whole or in part on the public assistance program as such. Even though for that segment of the aging population medical care is available through the public assistance program, nevertheless we recognize that there are close to 550,000 aged persons in this State who today cannot look to the public assistance program for their medical care problems; nor in my opinion should they look to the public assistance program for a solution to their medical care problems.

So I place that as the highest priority.

Senator WILLIAMS. What percentage do become part of the public assistance program?

Mr. ENGELMAN. Less than 4 percent. By census estimates, there are somewhere between 560,000 and 570,000 persons over 65 in the State today. Only about 19,000 of those are receiving old-age assistance.

A substantial number, perhaps as much as 25 percent, of the 19,000, are in my opinion dependent in a supplementary way on public assistance only because of the impact of their medical care problems. This applies particularly to the group that needs nursing home care or similar types of care, where the costs are beyond even the income that they have from social security or from a combination of social security and other sources of maintenance other than public assistance.

Senator WILLIAMS. Could I interrupt at this point and ask about the Kerr-Mills implementing legislation that the Governor said was introduced, did pass the assembly, but has been stopped in the senate? Would that program be administered under your division?

Mr. ENGELMAN. That program, as the legislation was presented, would also be administered through the same mechanism that is administering the old-age assistance program, which in New Jersey would be a State-county structure, the agency at the local level being the county welfare board, the supervising agency at the State level being the bureau of assistance, which is a unit within the division of welfare for whch I am responsible.

Senator WILLIAMS. So that legislation would be part of New Jersey's welfare program?

Mr. ENGELMAN. That is correct.

Senator WILLIAMS. Is there any way to estimate in general terms the numbers that really face a need for that program and the numbers that possibly would come under the Kerr-Mills program, if it passed?

Mr. ENGELMAN. For the purpose of presenting the legislation to the administration, we had to make some kind of an estimate. We are not very confident of the reliability of the estimates, because we have no previous experience to go by.

However we estimated that in terms of the somewhat limited scope of benefits that this proposed legislation would make available, it might reach within the first year as many as 30,000 persons of the population, the aged population, of 570,000.

Senator WILLIAMS. Well, under the legislation, the basic legislation, the national program, these people have to in general terms meet welfare standards of need, do they not?

Mr. ENGELMAN. Under the Federal legislation, they have to meet a welfare standard but each State may define its own standard for that purpose.

Senator WILLIAMS. For convenience, we generally describe the prerequisite, a description of means, sort of a means test?

Mr. ENGELMAN. That is correct. The legislation which is pending before the New Jersey Legislature does contemplate a means test, on a more liberal basis than our present standard for maintenance under old-age assistance, but nevertheless a means test, a test that would require an individual and thorough investigation of the resources, the family, and so forth, of every individual who applies.

Since I am proceeding on the basis of assigning priorities to these things—and the fact that it has a lower order of priority is not to be interpreted as lessening its significance or its importance—in my opinion the second order of priority is the matter of housing, to which you have already devoted a great deal of attention.

In my opinion the third order of priority is a combination of efforts through all means to provide greater employment opportunities for our senior citizens. It has been my observation, over these many years during which I have been involved directly with the problem of income maintenance for the aged, that one of the saddest things is that many of these people have ability to work, they have the desire to work, they have the capacity to be self-supporting, but the opportunities for them to be self-supporting in that way just do not exist in sufficient numbers.

Unless you have some further specific questions at this point, I would be glad to pass the ball over to one of the other members of this panel.

Senator WILLIAMS. All right. We will move on to the next member of the panel.

Mr. ENGELMAN. I will ask Mr. Hann, who is the chief of the bureau of assistance, and presently directly responsible for the administration of the old-age assistance program, and who would be responsible for the administration of any Kerr-Mills implementation, to supplement what I have said.

STATEMENT OF EDWARD F. HANN, JR., CHIEF, BUREAU OF ASSISTANCE

Mr. HANN. Senator, Mr. Engelman has already indicated that the old-age assistance program in New Jersey predated the Social Security Act. He also indicated it is known basically as an income maintenance program. However, one facet which I would like to mention is that the grants of assistance paid are really not an investment in people unless you recognize the full needs of the individuals and attempt to develop services for them.

This can basically be done in two ways. One is through a programing of services, and the other is through developing of staff who are alert to the need for services and qualified to provide them.

We have been concentrating on this, in the first instance, by arranging for staff participation in programs such as those of the American Public Welfare Association and other meetings with respect to problems of aging.

In addition to that, we have developed a statewide training program which would be available not only at the State but also at the county level for the personnel who are engaged in this program.

This has to do with both formal training and informal seminars which are conducted in order that they can better appreciate the needs of the aging population as well as the other people on the welfare rolls.

I might say we are, as of this month, reactivating for our personnel at the county level a centralized orientation program, and although this was started out on a voluntary basis, it has already been necessary to schedule three sessions because of the number of people interested.

We are hoping through this double approach to the problem to add to the income maintenance factor the factor of service, which will make it fully appreciated and fully valuable as far as the overall program for the individual is concerned.

Senator WILLIAMS. Thank you.

Our final panelist?

STATEMENT OF DR. V. TERRELL DAVIS, DIRECTOR, DIVISION OF MENTAL HEALTH AND HOSPITALS

Dr. DAVIS. Senator Williams, I am Dr. V. Terrell Davis, of the division of mental health and hospitals.

Those of us in the field of the care of the mentally ill welcome this new interest on the part of many of our citizens in the care of the aging, because we, too, have been concerned about the care of the aging for many years.

Of the 20,000 patients in the State and county mental hospitals in New Jersey, as in many of our States, over one-third are over 65 years of age; and of the roughly 10,000 patients duly admitted to these institutions each year, again over one-third are over 65 years of age.

We in the division of mental health and hospitals feel that there are definite advantages to being in what we speak of as an umbrella department of institutions and agencies, where we work regularly and day by day with the division of public assistance, because housing for the aged is a problem which does affect the mental health and mental well-being, and without adequate housing patients are more apt to need mental care.

Medical care in general, such as we have been talking about today, is also a factor which, when not adequate to the needs of the individual in the community, very often results in admission to mental hospitals.

And finally, as Mr. Engelman mentioned, the lack of constructive, interesting, stimulating activity for the elderly person contributes to the deterioration which does not necessarily have to accompany aging process.

With this large group of patients in our mental hospitals, our attention was directed particularly to the geriatric group, or the patients over 65 years of age, in our long-range planning to meet the needs for the care of the mentally ill. The capital construction committee in the division of mental health and hospitals last spring decided that we could perhaps best approach the immediate needs if we could find a solution by diverting a significant number of these 4,000 patients a year who are admitted to our mental hospitals, over 65 years of age.

An examination of the patients in this admission group indicated that a significant number of them required, in a smaller facility in the medical center in the community, where they would remain closer to home, and where the ties to the community and the problems of dislocation and breakdown of family connections would not be as significant as they are now, when it is necessary to be transferred many miles away from the community to a large State hospital.

From the management point of view, the advantages of keeping the problems of providing the medical care for these complex nursing problems in smaller units distributed throughout the State is another thing which we feel would be an advantage.

I think it would help to put the total program in perspective, if we point to the mention made earlier by the Governor of our concern with the continuity of care and our concern with comprehensive medical care. Many of us have questioned our fragmentation of medical services, where the individual receives service by one agency up to a point, and then that agency drops the ball, and sometimes it is picked up effectively and efficiently, and sometimes gaps and delays contribute to a disadvantage to the patient. And the comprehensiveness of medical care also is something which many of us feel offers opportunities for further gains.

But in thinking of the patient over 65 years of age, there are a number of different programs which we think make up the total picture. Psychiatric units in our general hospitals are developing, and these will be able to handle some of the types of problems which I have referred to.

We have in New Jersey a family care program under our mental hospital program, in which individuals are placed in individual homes, or another variation of this is where individuals are placed in groups

in what might be called halfway houses, where they do not require nursing services, but where the main problem is the lack of any families.

One of the problems of the aged is that they, many times, have outlived their friends, relatives, and contemporaries, and find themselves in a state of loneliness which contributes to their mental and physical problems.

In addition, there are boarding homes, as Spencer Smith pointed out, and it has been possible in many instances, where an individual has recovered sufficiently from his mental illness, through our liaison with the public welfare agencies to place these older individuals in boarding home situations, where the boarding home fee can be paid by the public assistance program.

Then there are the nursing homes, which again, as Spencer Smith has pointed out, we are fortunate in having in significant numbers, of high quality. But again, the nursing homes, as they exist today, are not in a position to supply the specialized type of psychiatric nursing that some of these individuals over 65 years of age require.

It is our hope that with the establishment of a pilot project, through the devising of this specialized facility, we can perhaps blaze the trail for the expansion of this particular area, and possibly either in connection with hospitals or as an expansion of the nursing home programs.

Senator WILLIAMS. How many State hospitals are there for the mentally ill?

Dr. DAVIS. There are four State hospitals and the Neuro-psychiatric Institute at Princeton.

Senator WILLIAMS. Are these hospitals generally fully occupied?

Dr. DAVIS. These hospitals are more than fully occupied. There is a factor which I discovered in the State budget manual would indicate, if you read it carefully, that Trenton State Hospital has a capacity of 3,600, and there are only 3,300 patients there. Unfortunately, somewhere in the transposition of figures a figure was taken as the capacity of the original buildings; and when new buildings were built with the last bond issue, these were added on to the inflated figures.

With the 3,300 patients we have at Trenton State Hospital, I believe there is a significant degree of overcrowding there, which we hope to relieve. Basically, we run about 25 percent more patients than should be accommodated in the buildings that we have.

But we are not asking at this time for additional beds for these hospitals, because of the trend which has been in effect for the last 5 years of a decreasing average census. We have gone down about 2,000 patients in the last 6 years. We feel that there is the possibility of going down further, and we hope that by diverting the admissions into some such facilities as we have comtemplated, we can continue to live within the existing structure.

Senator WILLIAMS. The population over 65 in our State is about 10 percent of the population of the entire State. Is that right?

Dr. DAVIS. I believe those are the figures.

Senator WILLIAMS. You used the figure 560,000?

Mr. ENGELMAN. Yes. The population is something over 6 million at the present time; so it is about 9 percent, between 9 and 10.

Senator WILLIAMS. And yet the patients in our mental hospitals over 65 come to a third of all of your patients. Is that right?

Dr. DAVIS. That is right. About 7,000.

Senator WILLIAMS. So any shortage of facilities is particularly acute among people in the group over 65?

Dr. DAVIS. Yes.

Senator WILLIAMS. What arrangements for payment to the community hospital approach that you suggest do you consider workable? What kind of a program?

Dr. DAVIS. This we haven't gone into. We are working on the assumption that we will have to work out a payment based on similar formulas for payment to those which exist now for patients in State hospitals.

One of our problems in State hospitals heretofore has been the fact that patients are admitted to State hospitals because there is a formula for reimbursing for payment of the cost, which doesn't exist in municipal hospitals or proprietary hospitals; and we feel that this works to the disadvantage of everybody; and the legislation recommended by the New Jersey Mental Health Legislative Commission does have provisions in there which would make it possible, as we can work out the administrative details, to reimburse, for instance, the Martlin Medical Center in Newark for the operation of a psychiatric facility, where the county and the State would reimburse the municipal hospital in the same manner that the county and the State defray the cost in the county and State institutions.

At the present time, the city fathers in the city of Newark feel that they cannot afford to undertake a treatment program in the Martlin Medical Center, because they don't get reimbursed for it; but on the other hand, it is costing them a considerable amount of money. It is wasting a lot of time of the profesionals as well as of the patients, because they have to be processed at the Martlin Medical Center and then move either to the Trenton State Hospital or to the Essex Couny Hospital a week later, before they get any treatment.

Senator WILLIAMS. One final question, Dr. Davis. Do any of the private programs for medical care, Blue Cross and others, cover psychiatric care in general hospitals.

Dr. DAVIS. Yes, they do. The New Jersey program does cover psychiatric care for a period of, I believe, 20 days.

Senator WILLIAMS. Is there anything further, gentlemen?

We could keep you here a lot of time and get a lot of benefit from it, but we do have a long list of people that we want to reach this morning.

Thank you very much.

Dr. DAVIS. Thank you.

Senator WILLIAMS. Dr. Johannes Pessel is our next witness.

Doctor, you are chairman of the Advisory Committee on Chronic Illness of the New Jersey Department of Health?

STATEMENT OF DR. JOHANNES F. PESSEL, CHAIRMAN, ADVISORY COUNCIL ON THE CHRONIC SICK, NEW JERSEY STATE DEPARTMENT OF HEALTH

Dr. PESSEL. I am, Senator.

Senator WILLIAMS. The Governor had some warm words of praise for you earlier. We are very glad to have you with us.

Dr. PESSEL. Thank you very much.

As you well know, I am a practicing internist, and as such I can hardly dissociate the aging from chronic illness; and we thought that perhaps we could best aid by telling you of our experiences here in New Jersey by the program of chronic illness that has been established here.

As has been pointed out in psychiatry, so it is in medicine, that the health problems among the elderly are much greater and are prone to be of a rather prolonged nature.

The problem of adequately providing for prevention, detection, and control of chronic sickness and for rehabilitating the chronic sick is one which has assumed such proportions that it must receive the attention of the appropriate agencies of the Government.

Chronic illness, because of its nature, should not be treated in the acute hospital, except during its acute manifestation, or during its complications. The acute hospital has too many demands for the more complex and complicated procedures (now so well known) to load itself with long-lasting, slow recovering problems and processes needing little or no special care.

This fact has created the modern nursing home now so well improved and manned by adequately trained personnel. The increasingly high standards of these homes have been brought about by careful supervision and helpful suggestions by our State departments. The best and greatest service of a nursing home can be obtained by a close association and liaison with the acute hospital, preferably under the same roof, or controlled by the same board of directors. This allows for quick, easy interchange of patients at various times and stages of their illnesses between hospital, nursing home, and home. The surroundings of the nursing home are frequently less hectic and much more pleasant and homelike for the convalesent patient, and often aids in a speedier recovery.

The same fact or facts have been instrumental in the development and increase in "home care" for the patient in our State. These facts induced New Jersey to pioneer in the development of services for total care of the chronically ill and it now has facilities and services which by comparison can be called superior, although, of course, much needs to be done. New Jersey passed its Prevention of Chronic Illness Act in April 1952.

And I have it here, in case you would like to have a copy for your file.

(The above-mentioned act follows:)

PREVENTION OF CHRONIC ILLNESS ACT, APPROVED APRIL 28, 1952

26:1A–92. Prevention of Chronic Illness Act

This act shall be known and may be cited as "The Prevention of Chronic Illness Act."

Title of Act:

AN ACT concerning public health, providing for the prevention and control of chronic illness; establishing a Division of Chronic Illness Control and an Advisory Council on the Chronic Sick within the State Department of Health; and prescribing the functions, powers and duties of such division and such council.

26:1A–93. Declaration of public policy

The growing problem of prevention, detection and care of chronic illness, which is of such character as not to be exclusively medical, educational or welfare, has now reached such proportions in this State as to require the participation of the State and of the agencies administering public health, education and welfare within the State and it is hereby declared to be the public policy of this State that the responsibility therefor must be shared by the State and the counties and the several municipalities and health districts and the voluntary agencies and institutions within the State and the public at large.

26:1A–94. Division of Chronic Illness Control established in Department of Health.

There is hereby established within the Department of Health a Division of Chronic Illness Control for the prevention, early detection and control of chronic illness and rehabilitation of the chronic sick of this State.

26:1A–95. Supervision; director

The Division of Chronic Illness Control shall be under the immediate supervision of a director, who shall be a physician qualified in public health, and who shall be appointed by and serve at the pleasure of the State Commissioner of Health.

26:1A–96. Duties of division

The division shall administer and provide for the carrying out of the programs required to perform the general functions provided by this act to be performed by the State and for the carrying out of the general policies formulated by the Advisory Council on the Chronic Sick as approved by the State Commissioner of Health and it shall perform such other duties as may be delegated to it by the State Commissioner of Health.

26:1A–97. State Department of Health; duties

The State Department of Health shall within funds appropriated and available therefor be charged with the responsibility of carrying out the obligations herein assumed by the State as its share of the task of providing for prevention, early detection and control of chronic illness and rehabilitation of the chronic sick and it shall also:

(a) Arrange for joint discussion of the general problem of the chronic sick with representatives of all State agencies and departments engaged in health, welfare and education and with representatives of the several counties, municipalities and health districts, general and special hospitals, voluntary agencies and institutions, and the medical, dental, nursing and allied professions, for the purpose of formulating an adequate program for dealing with the problem of the chronic sick and to determine a formula for the ultimate division of the governmental share of the cost thereof between municipalities, counties and the State;

(b) Plan for the provision of adequate visiting nurse and housekeeping aid services by appropriate public or private agencies throughout the State, to the end that the nursing and medical care being furnished the chronic sick in their own homes shall be improved in every manner possible;

(c) Collect and prepare all available information designed to acquaint the professions and the public with the best and most modern methods of preventing chronic sickness and its early detection and control, and caring for and rehabilitating the chronic sick, and arranging for the distribution thereof through all possible media so that the greatest number of persons may benefit therefrom;

(d) Collect, prepare and distribute information including statistics which will afford the general public greater insight into the significance, character and magnitude of the problem of prevention of chronic sickness as well as insight into the problem of the care and rehabilitation of the chronic sick in order to secure a more active interest of the general public in such problems;

(e) Perform and encourage research activities as to the best and most modern methods of prevention, discovery, treatment and cure of chronic diseases and the care and rehabilitation of persons affected and for the analysis of such data and for the dissemination of such information to the professions and agen-

cies engaged in providing for the chronic sick, as well as to the general public;

(f) Ineffectuation of (e) study the problem of prevention and detection of all types of chronic disease by laboratory, statistical and community co-operative methods and by such other methods as may be deemed advisable;

(g) Assist in promoting and strengthening of child and adult health programs for the purpose of preventing or retarding the development of chronic illnesses;

(h) Maintain and expand co-operative relationships with all professional and public and private agencies responsible for and interested in, the prevention and detection of chronic illness and in the care and rehabilitation of the chronic sick.

26:1A–98. Advisory Council on the Chronic Sick

There shall be within the Division of Chronic Illness Control an Advisory Council on the Chronic Sick, which shall consist of nine members. The Commissioner of Education, the State Commissioner of Health and the Commissioner of Institutions and Agencies shall be exofficio members. Six members shall be appointed by the Governor from among those residents of the State who have special knowledge, experience or interest in the prevention, detection or care of chronic illness or rehabilitation of the chronic sick, at least one of whom shall be a physician from a recommended list supplied by The Medical Society of New Jersey. Each appointive member shall serve for a term of three years and until his successor is appointed and qualifies, except that of the six members first appointed hereunder two shall serve for terms expiring December thirty-first, one thousand nine hundred and fifty-three, two shall serve for terms expiring December thirty-first, one thousand nine hundred and fifty-four, and two shall serve for terms expiring December thirty-first, one thousand nine hundred and fifty-five. The Governor shall designate the terms of the first appointees hereunder. All terms of appointive members except those of the first appointees hereunder shall commence January first. Any vacancy in the appointive members of the council occurring other than by expiration of term shall be filled in the manner as the original appointment but for the unexpired term only. No person who has been appointed a member for two consecutive full terms shall again be eligible for appointment until after the expiration of one year following the expiration of his second consecutive term. The members of the council shall serve without compensation but shall be entitled to receive their actual traveling and other expenses incurred in the performance of their duties.

26:1A–99. Committee of technical advisors

The Advisory Council on the Chronic Sick shall appoint annually with the approval of the State Commissioner of Health a committee of technical advisors whose services may be called upon in the development of policy and technical programs at both State and local levels. The membership of the committee of technical advisors shall consist of representatives from the public health, education, welfare, medical, dental, nursing and hospital administration professions, and such others as seem necessary and appropriate but not exceeding eleven members. The technical advisors shall serve without compensation but shall be entitled to receive their actual traveling and other expenses incurred in the performance of their duties.

26:1A–100. Recommendation by Advisory Council as to money needed annually

The Advisory Council on the Chronic Sick shall annually recommend to the State Commissioner of Health the amount of money which, in its judgment, will be required to provide and pay for necessary services for the detecting and controlling of chronic sickness, for visiting nursing services, for housekeeping aid services and for the rehabilitation of the chronic sick. The State Commissioner of Health shall take into consideration the recommendations so made in formulating his budget requests for appropriations for said services.

26:1A–101. Propriety of services; agencies approved and amounts recommended

The Advisory Council on the Chronic Sick shall, before the first day of July in each year, recommend to the State Commissioner of Health:

a. The order of priority of the services to be rendered with available funds appropriated for the next fiscal year for the services described in section nine of this act.

b. The specific public and private agencies approved by it, to perform specific recommended services, together with the amounts recommended therefor.

26:1A–102. Distribution and expenditure of moneys appropriated

The State Department of Health shall administer the distribution and expenditure of moneys appropriated for the purposes described in section six of this act in such manner and in such amounts as the State Commissioner of Health with the approval of the Director, Division of Budget and Accounting in the Department of the Treasury shall determine to be most feasible, practicable and beneficial for the recipients thereof pursuant to the policies formulated by the Advisory Council on the Chronic Sick and in accordance with the formula of participation determined upon by said council as approved by the State Commissioner of Health but no such money shall be paid to any physician as salary or fee for treatments administered to the chronic sick excepting where such treatments may be administered for research purposes approved by the State Commissioner of Health, nor shall direct assistance in cash or merchandise for the general support of needy persons be paid therefrom.

26:1A–103. Annual report by State Department of Health; recommendations

The State Department of Health shall on or before the first day of October in each year report to the Governor setting forth in detail the scope and type of activities required to implement the program authorized by this act for the ensuing fiscal year, including recommendations of methods which might be utilized to encourage greater participation in said program by the counties, municipalities, health districts and the several private and public agencies engaged in said field and it shall include therein its recommendations as to the sum or sums of money to be included in the department's annual budget for the performance of the functions set forth in this act.

26:1A–104. Department of Education to assist in disseminating information

The Department of Education shall assist the Department of Health in disseminating information designed to acquaint and give to the general public greater insight into the problems of chronic sickness and the prevention of chronic illness.

26:1A–105. Federal moneys

The State Department of Health is hereby authorized and empowered with the approval of the Governor to apply for and negotiate with the Federal Government or any officer or agency thereof for the purpose of securing an allotment of any Federal moneys that might be made available to the State for the purpose of this act. Such funds when received shall be subject to disbursement by the State Department of Health in the same manner as other funds of the State are disbursed.

26:1A–106. Department of Institutions and Agencies as agency for rendering welfare assistance

Notwithstanding the provisions of this act, the Department of Institutions and Agencies shall continue to be the sole State agency for the rendering of welfare assistance to the permanently and totally disabled and to needy persons in such other categories of assistance as is now or may be authorized hereafter by law.

This legislation was the product of careful study by a commission of citizens, including members of the health professions, appointed by the Governor, and was followed by a large Governor's conference.

The declaration of policy of this act is a classic in the field of governmental action for the chronically ill and aged, and I quote:

> The growing problem of prevention, detection, and care of chronic illness which is of such character as not to be exclusively medical, educational, or welfare, has now reached such proportions in this State as to require the participation of the State and of the agencies administering public health, education, and welfare within the State and it is hereby declared to be the public policy of this State that the responsibility therefor must be shared by the State and the counties and the several municipalities and health districts and the voluntary agencies and institutions within the State and the public at large.

This act created a division of chronic illness in the State department of health for prevention, early detection, and control of chronic illness and rehabilitation of the chronic sick of this State. It provided, among other things, methods of grant-in-aid to local agencies. The methods and concepts developed by this act are remarkably similar to the Community Health Facilities Act just passed by the Congress and signed by President Kennedy. The funds made available under this new Federal law are being administered in New Jersey by this division as a normal and usual part of its operation. As an example of the effectiveness of the New Jersey law, last year New Jersey with its own State tax dollars in the amount of $248,000, augmented by $47,000 of Federal funds provided grant-in-aid assistance to 20 community hospitals, 9 visiting homemaker services, and 9 other community agencies.

The grants helped local agencies to initiate or strengthen many projects including programs to evaluate hearing and speech defects and to rehabilitate the alcoholic; comprehensive restorative procedures to the status of independency of many individuals; home care services; diagnostic services for convulsive disorders, for early detection of glaucoma, and for low vision rehabilitation; screening tests for the early detection of diabetes and pulmonary diseases (by routine X-ray examination of hospital patients); specialized techniques used in diagnosis and treatment of cancer and cardiovascular disease; homemaker services; and research and special studies in glaucoma, arthritis, and heart disease.

Scientific equipment (for example E.E.G. apparatus) was purchased for loan to 10 different hospitals during the year; 69 hospitals and community agencies are using equipment placed by the division since 1953 to improve their facilities for the "prevention, early detection, and control of chronic illness and the rehabilitation and restoration of the chronic sick."

The list of these activities is a long and interesting one, and I should like to enter an excerpt from the 83d annual report of the State department of health into the record.

(The excerpt referred to above follows:)

Division of Chronic Illness Control

Chronic illnesses require diversified community services to get the patient back into the community. During the year, the Division has continued to stimulate development of dynamic, comprehensive and coordinated programs for the "prevention, early detection and control of chronic illness and the rehabilitation of the chronic sick." (Chronic Illness Law 26: 1A–92.) We have also tried to strengthen medical and ancillary services.

Activities have been centered in demonstration, casefinding, coordination and consultation services, educational programs, and evaluation studies. Financial assistance has been provided to community hospitals and a few other agencies through grants-in-aid for paramedical personnel specially trained in the techniques and newer aspects of chronic illness control. Also, through the loan of scientific equipment, new methods of diagnoses and control are demonstrated and made available to practicing physicians for the benefit of their patients.

Continuity of Care

Services to the chronically ill are provided through many agencies. Coordinated rather than fragmented efforts are needed to reduce duplication of services and fill gaps.

Two Workshops on Continuity of Care were held in previous years. From interest developed at these workshops, a committee on Continuity of Patient Care has been organized in Union County where the first Workshop on a county level was held in May, 1960 with assistance from this Division and the Metropolitan District office. Eighty persons, representative of a cross-section of professional and non-professional leadership in health and welfare programs, were in attendance.

Cooperative Community Projects

The Division has sought to initiate and strengthen chronic illness control programs in community hospitals and other local agencies. As in the past, assistance has been provided by (1) the loan of scientific equipment to selected community hospitals for demonstration of the newer techniques in diagnosis and control of chronic disease and restoration of the chronic sick; (2) grants-in-aid for paramedical personnel such as specialized technicians, social workers, physio-therapists, etc.; and, (3) consultation services and educational pro-

grams (listed on page 16) for professional personnel to promote understanding of current knowledge of chronic illness and new developments.

Grant-in-aid assistance, amounting to more than $295,000, was provided to 20 community hospitals, 9 visiting homemaker services, and 9 other community agencies. The grants helped local agencies to initiate or strengthen many projects including programs to evaluate hearing and speech defects and to rehabilitate the alcoholic; comprehensive restorative and home care services; diagnostic services for convulsive disorders, for early detection of glaucoma, and for low vision rehabilitation; screening tests for the early detection of diabetes and pulmonary disease (by routine x-ray examination of hospital patients); specialized techniques used in the diagnosis and treatment of cancer and cardiovascular disease; homemaker services; and research and special studies in glaucoma, arthritis, and heart disease.

In re-negotiating the grant-in-aid contracts for the year 1960-1961, approximately 15 percent of the total amount was assumed by the local agencies, thus releasing this amount of money to promote other chronic illness programs or similar programs in other geographical areas. In some instances, hospitals expanded their programs to include additional skilled personnel or to make services available to a larger segment of the population without additional financial assistance from this Division. Such expansion is regarded as an assumption of further financial responsibility. In addition to providing a needed service in the community, the programs subsidized in selected hospitals and community agencies serve to demonstrate the possibility of reducing the chronic illness burden and to encourage other communities to inaugurate similar programs without financial assistance from the state.

Scientific equipment was purchased for loan to 10 different hospitals during the year. Sixty-nine hospitals and community agencies are using equipment placed by the Division since 1953 to improve their facilities for the "prevention, early detection and control of chronic illness and the rehabilitation of the chronic sick."

Table 1.

GRANT-IN-AID CONTRACTS: 1959-1960

Name of Agency and Type of Service

ALL SOULS HOSPITAL, MORRISTOWN:
Rehabilitation service for alcoholics.

ATLANTIC CITY HOSPITAL:
Diagnostic and consultation service for convulsive disorders.

VISITING HOMEMAKER SERVICE OF ATLANTIC COUNTY:
Homemaker program.

BERGEN PINES COUNTY HOSPITAL, PARAMUS:
Rehabilitation service for alcoholics.

CHR-ILL HOMEMAKER SERVICE, ESSEX COUNTY:
Homemaker program.

DONNELLY MEMORIAL HOSPITAL, TRENTON:
Rehabilitation service for alcoholics.
Comprehensive restorative services program.

EAST ORANGE BOARD OF HEALTH:
Study of latex fixation serologic test for detection of rheumatoid arthritis.

ESSEX COUNTY BOARD OF FREEHOLDERS:
Comprehensive restorative services program at Essex County Hospital—Belleville.

HELENE FULD HOSPITAL, TRENTON:
Cooperative study of hospital and nursing services for stroke patients.

HUNTERDON MEDICAL CENTER, FLEMINGTON:
Routine chest x-ray of in-patients, out-patients and hospital personnel.
Screening tests for diabetes and other chronic disorders.
Evaluation and correction of hearing and speech defects.
Diagnostic and consultation service for convulsive disorders.
Screening tests for cancer.
Evaluation of vectorcardiograms.
Cytology teaching center.

VISITING HOMEMAKER SERVICE OF HUNTERDON COUNTY:
Homemaker program.

MIDDLESEX GENERAL HOSPITAL, NEW BRUNSWICK:
Rehabilitation service for alcoholics.
Routine chest x-ray of in-patients, out-patients and hospital personnel.
Cardio-pulmonary function laboratory.
Screening tests for diabetes.

VISITING HOMEMAKER SERVICES OF MIDDLESEX COUNTY:
Homemaker program.

VISITING HOMEMAKER SERVICE OF MONMOUTH COUNTY:
Homemaker program.

VISITING HOMEMAKER SERVICE OF MORRIS COUNTY:
Homemaker program.

VISITING NURSE ASSOCIATION OF NEWARK:
Study to evaluate nursing needs of cardiac patients.

NEWARK EYE AND EAR INFIRMARY:
Evaluation and correction of hearing and speech defects.
Glaucoma detection and research.

NEWCOMB HOSPITAL, VINELAND:
Rural cardiology service.
Diagnosis and evaluation of eye defects.

NEW JERSEY DIABETES LEAGUE:
Summer camp for diabetic children.

NEW JERSEY HOSPITAL ASSOCIATION:
Hospital dietary consultant services.

HOSPITAL CENTER AT ORANGE:
Comprehensive restorative services program.
Cardio-pulmonary function laboratory.
Home care program.

VISITING NURSE ASSOCIATION OF THE ORANGES AND MAPLEWOOD:
Study to evaluate nursing needs of cardiac patients.

B. S. POLLAK HOSPITAL, JERSEY CITY:
Cytology teaching center.

Screening tests for cancer.
Pulmonary neoplasm study program.

PRESBYTERIAN HOSPITAL, NEWARK:
Cytology teaching center.
Screening tests for cancer.
Isotope laboratory.
Cancer training sessions.
Diagnostic and consultation service for convulsive disorders.

ROOSEVELT HOSPITAL, METUCHEN:
County-wide rehabilitation service for alcoholics.

RUTGERS UNIVERSITY:
Homemaker training courses.

SAGE* HOMEMAKER SERVICE, SUMMIT:
Homemaker program.

ST. FRANCIS HOSPITAL, TRENTON:
Evaluation and correction of hearing and speech defects.

ST. MARY'S HOSPITAL, PASSAIC:
Routine chest x-ray of in-patients, out-patients and hospital personnel

ST. MICHAEL'S HOSPITAL, NEWARK:
Rehabilitation service for alcoholics.
Cardiac consultant services.
Comprehensive restorative services program.

ST. VINCENT'S HOSPITAL, MONTCLAIR:
Anti-Coronary Club.

SETON HALL COLLEGE OF MEDICINE AND DENTISTRY, JERSEY CITY:
Scientific studies in the field of arthritis.
Rehabilitation service for alcoholics.

*SAGE stands for Summit Association for Gerontological Endeavor.

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SHORE MEMORIAL HOSPITAL, SOMERS POINT:
Rural cytology service.

SOMERSET HOSPITAL, SOMERVILLE:
Comprehensive program of restorative services.

VISITING HOMEMAKER SERVICE OF SOMERSET COUNTY:
Homemaker program.

VISITING HOMEMAKER SERVICE OF CENTRAL UNION COUNTY, CRANFORD:
Homemaker program.

VISITING NURSE ASSOCIATION OF WEST ESSEX:
Study to evaluate nursing needs of cardiac patients.

WEST JERSEY HOSPITAL, CAMDEN:
Rehabilitation service for alcoholics.
Cardio-pulmonary function laboratory.

Table 2.

Scientific Equipment Loaned to Hospitals to Promote Chronic Illness Services
July 1, 1959—June 30, 1960

ATLANTIC CITY HOSPITAL:
Cancer Control Services.

HELENE FULD HOSPITAL, TRENTON:
Work Classification Unit.
Comprehensive Restorative Services Program.

HUNTERDON MEDICAL CENTER, FLEMINGTON:
Comprehensive Restorative Services Program.

JERSEY CITY MEDICAL CENTER:
Diagnosis and Evaluation of Eye Defects.

MIDDLESEX REHABILITATION AND POLIO HOSPITAL:
Comprehensive Restorative Services Program.

NEWCOMB HOSPITAL, VINELAND:
Cancer Diagnosis and therapy.

ST. ELIZABETH HOSPITAL, ELIZABETH:
Cancer Registry.
Cytology Program.

SETON HALL COLLEGE OF MEDICINE AND DENTISTRY, JERSEY CITY:
Arthritis Studies.
Post-graduate Physicians—in tissue pathology and cytology.

SHORE MEMORIAL HOSPITAL, SOMERS POINT:
Cancer Registry.

WEST JERSEY HOSPITAL, CAMDEN:
Comprehensive Restorative Services Program.

Professional Training

To spread knowledge of new developments, the Division has continued to support lectures, seminars, courses, and consultation services to physicians and paramedical personnel. These efforts have been carried on in cooperation with community hospitals, medical societies, professional organizations, the Academy of Medicine, the Academy of General Practice (accredited), and Seton Hall College of Medicine and Dentistry. A listing follows:

ST. MICHAEL'S HOSPITAL, NEWARK:
Courses:
Recent Advances in Internal Medicine and Endocrinology (10 bi-weekly sessions).
Advanced Clinical Electrocardiography (22 weekly sessions).
Recent Advances in Clinical Cardiology (12 bi-weekly sessions).

ACADEMY OF MEDICINE—CHRONIC ILLNESS COURSE:
Newcomb Hospital, Vineland (6 sessions).
Warren Hospital, Phillipsburg (4 sessions).

WEST JERSEY HOSPITAL, CAMDEN:
Chronic illness course (4 monthly sessions).

NEWCOMB HOSPITAL, VINELAND:
Services of a consultant cardiologist in the development of a rural cardiac facility.

BRIDGETON HOSPITAL:
Services of a consultant cardiologist in the development of a rural cardiac facility.

HELENE FULD HOSPITAL, TRENTON:
Arthritis workshop.

HUNTERDON MEDICAL CENTER, FLEMINGTON:
Cytology symposium.

PRESBYTERIAN HOSPITAL, NEWARK:
Cancer symposium.

NEWARK:
Diabetes symposium.

PRINCETON:
Diabetes symposium.

SUMMIT:
Continuity of care workshop.

Alcoholism Control

Alcoholism continues to be a major public health problem affecting approximately 1 of every 4 adults in New Jersey. The impact is felt by many more. It has been estimated that 1 alcoholic directly affects the lives of

approximately 15 individuals; i.e., members of the family, friends, and fellow workers.

Mark Keller and Vera Efron, researchers at the Yale Center of Alcohol Studies, New Haven, Connecticut, have estimated that there are 4,712,000 alcoholics in this country—a rate of 4,520 alcoholics per 100,000 adult population, age 20 years and over. According to Keller and Efron, New Jersey has an estimated 232,000 alcoholics with the rate of 6,060 per 100,000 population.

Rehabilitation Services

Developing treatment and rehabilitation services continues to be a major function of the Program. Although no new services were established during the year, efforts were made to strengthen staffs of existing clinics. Additional part-time workers were added to the clinics at West Jersey Hospital, Camden; Donnelly Memorial Hospital, Trenton; and Roosevelt Hospital, Metuchen. As the patient load in clinics increases, we plan to add additional personnel rather than establish new facilities. Superior services can be offered, where more clinic personnel are available, and additional services, such as group therapy, can be added to the treatment program. Interrupted service can be prevented in event 1 social worker leaves the program.

During this past year, it was necessary to discontinue temporarily the services at Bergen Pines County Hospital because personnel could not be recruited and it was not possible to cover the service effectively with state-paid personnel. As soon as qualified social workers can be obtained, the service at Bergen Pines will be reactivated, and a new service will begin at Mountainside Hospital, Montclair.

The program at Seton Hall College of Medicine and Dentistry has gotten underway in the area of research, medical treatment, and physician education. The 2 studies, Pantothenic Acid, Fatty Liver and Alcoholism, and Effect of Ethanol on Plasma Free Fatty Acids in Man, were conducted in the Divisions of Hepatic Metabolism and Nutrition of the Department of Medicine. Physician education consisted of formal lectures on alcoholism and its medical complications to visiting physicians, the resident and intern staff, and third- and fourth-year medical students. The residents, interns and medical students rotated through a clinic where alcoholics are followed, in a ward where patients with delirium tremens are admitted and treated, and a research ward where the above investigations have been carried out. As soon as additional staff; i.e., a clinical psychologist and psychiatric social worker, can be obtained, an out-patient treatment center for alcoholics will be initiated in the Department of Psychiatry.

There were 1,570 individual patients seen during this fiscal year. Of these, 882 were seen in the out-patient clinics, of which 528 were first admissions. The 882 made a total of 4,622 individual visits to the 4 full-time and 4 part-time clinics. There were 688 persons who attended weekly group sessions in 5 tuberculous hospitals, 1 county workhouse, 1 county jail, and the In-patient Treatment Unit at the New Jersey Neuro-Psychiatric Institute.

During the past 3 years, we have been working with representatives of the Board of Freeholders and community agencies in Mercer County to establish a comprehensive program for alcoholics in the county. On June 1st of this year, the first employee, a social worker, was employed by the county to develop a program for inmates with an alcoholism problem at the Mercer County Workhouse. The Workhouse Program is the first phase of the county-wide service which will include the establishment of a Half-way House (transitional facility) for the alcoholic who is homeless or otherwise unattached. This will be the first facility of its kind in the state and it can serve as a demonstration for other counties to study.

Educational Activities

One of the major educational activities during the fiscal year was a 3-day workshop on Alcoholism Education for teachers who are responsible for curriculum development and classroom instruction in New Jersey schools. The workshop was held at the Princeton Inn in Princeton and was attended by 47 teachers who are responsible in some way for the health education of approximately 65 percent of secondary school students. Speakers and group leaders were recognized authorities.

A technical assistance grant from the United States Public Health Service supported the workshop. The proceedings were printed and distributed.

A second 2-week workshop on alcohol education for teachers and school nurse teachers was co-sponsored with the Montclair State College. For the third year, Trenton State College held a similar workshop. Forty persons attended the 2 programs which ran for 30 hours and offered 2 semester hours credit.

Scholarships to the Summer School of Alcohol Studies at Yale University were granted again this year to 10 individuals. This is a 4-week course to meet the needs of a number of people. Specialists in various fields—medicine, religion, education, and public health—address the student body. Forty-seven individuals have attended the course on scholarships from this Department. Included in this group are social workers, psychologists, probation officers, parole officers, police officers, physicians, teachers, and clergymen.

Showing films has been effective educationally. During the year, there were 613 film showings with 30,774 in attendance. The 5 films available for loan are suitable for both teenage and adult groups.

Twenty-eight lectures were given by Program personnel and personnel of the clinics before nursing schools, social and welfare agencies, professional organizations, and clergy.

Program Emphasis

There will be continued effort to recruit social workers in order to offer services where needed and not now provided. The shortage of qualified psychiatric social workers continues as a pressing problem. We plan to continue placing recently graduated workers in clinics with experienced psychiatric social workers. With the new 3-year program at the Rutgers School of Social Work, we will also try to place graduates of this course.

Educational efforts of the Program will be continued. If alcoholism is to be successfully combated and prevented, it will be through better understanding of the problem by the general public and members of the professional disciplines who work with the alcoholic and his family.

Arthritis and Allied Disorders

Disability and limitation of activity from arthritis and rheumatic disorders affect an estimated 400,000 persons over 14 years of age in New Jersey. Arthritis is the second most common defect or disease encountered on routine physical examination. It accounts for more work-days lost yearly than accidents or injury.

Because of its chronic and episodic nature and the lack of specific means for its prevention, cure or sustained control, arthritis has often been a neglected disease category. This is evidenced by the existence of only 13 hospital clinics devoted specifically to its treatment in our state.

The New Jersey Arthritis Project was initiated in March, 1958 to stimulate increased interest in arthritis, to develop scientific knowledge, and to promote programs of coordinated services and activities related to all aspects of arthritis care. Its membership represented 44 state-wide agencies and professions, and its objectives laid the groundwork for the Arthritis Program in this Division.

Program Activities

Clinical Laboratory Services: The Arthritis Unit of the Seton Hall College of Medicine carried out, with the assistance of personnel and equipment

from this Division, 2,740 special types of laboratory tests on 1,126 patients with various kinds of arthritis and rheumatic disorders as an aid to diagnosis and specific management. These may be summarized as follows:

Types of tests performed:	
Joint fluid analysis	160
RA factor tests	580
Rheumatology research tests	2,000
Total	2,740
Clinical categories of patients tested:	
Rheumatoid arthritis	673
Degenerative joint disease	171
Rheumatic fever	83
Gout	88
Other	111
Total	1,126

Special Laboratory Tests: A research project dealing with the application of the Hyland slide test for the RA (rheumatoid arthritis) factor in human sera was begun in January, 1959, at the East Orange Health Department Laboratory. All sera submitted for routine examinations were tested for the RA factor, and the individuals with reactive sera were followed for evidence of arthritis by means of a questionnaire sent to their physicians. The project will be continued to a total of 5,000 individuals tested, and the reactive sera will be further evaluated with special tests in the Laboratory of the Arthritis Unit of the Seton Hall College of Medicine. The results may be summarized as follows:

	1958-59	*1959-60*	*Total*
Number of tests performed	1,668	3,240	4,908
Number of sera screened	1,592	3,178	4,770
Number of negative sera	1,571	3,162	4,733
Number of reactive sera	8	9	17
Number of weakly reactive sera	13	7	20

Arthritis Workshop: A demonstration and workshop session on "Keeping the Arthritic Working" was held at the Helene Fuld Hospital in Trenton in April, 1960, and was attended by 67 persons. Valuable assistance in planning and conducting the workshop was given by persons in the Central Health District office, the Division of Consultation Services, and the Department of Institutions and Agencies, as well as by representatives from the medical professions and specialty societies, labor, industry, community organizations, and voluntary agencies. The Proceedings of the Workshop will be distributed to the participants.

The usefulness of the workshop session extends beyond its immediate educational and informational value. Joint discussion of problems of mutual interest by members of community service agencies and organizations has led to new activities in arthritis care.

Rehabilitation: The Comprehensive Rehabilitation Service initiated in 1958 at the Hospital Center at Orange was planned to assist in the care of 3 long-term chronic disease entities, namely, arthritics, hemiplegics, and amputees. The objective was to continue restorative services within the patient's home. With aid for personnel from this Division and with other assistance from state and community agencies, the Service assisted, during the calendar year 1959, in the rehabilitation of 33 arthritics.

Outlook: We will continue and extend aid to community facilities for provision of care to arthritics, chiefly through the media of hospitals, clinics, and laboratories. This aid will include evaluation and standard maintenance. Provision of special consultation service in the field of arthritis is under consideration. Educational and informational activities will be continued through an extended workshop program, and the purchase and distribution of informational documents. Directories of Services for Arthritis are planned for those dealing with the management of persons with this disorder.

Cancer Control

Aging, Cancer, and the New Medical Program for the Aged

Medical care programs for elderly persons probably will be developed in the very near future. This behooves public health cancer control programs to consider what this aid offers to the elderly, to medicine, and to public health. The main question is, how is this help to be used for the greatest good of the elderly?

How can this aid be mobilized so that it will be used, among other things, for active treatment of cancer patients and not just terminal care? This is a burning question.

As is well known, there is an increasing proportion of people over 65 years in the general population. We can anticipate a higher incidence of cancer in this population.

This does not exclude the fact that various types of cancer have a significant spread among all age groups, even young children.

One can postulate that a fairly large portion of the funds made available for care for the aged under any plan should be used in the diagnosis, treatment, and care of cancer in the older age group, 65 and upward.

Older people suffer catastrophic disease other than heart disease, require more frequent and increasingly longer hospitalization, and require more

terminal care than any other age group. This group is less able to care for themselves under conditions of catastrophic illness than younger age groups. They usually have less economic support, less family help, and can take less physical strain under these unusual conditions. They must seek aid from welfare, private, or religious sources.

Lung Cancer and Smoking

Within the last year, there have been developed data which confirm smoking as one of the etiological factors in lung cancer. This correlation was first made by various statistical workers in the field. There is now agreement about this in England, Sweden, and Norway as well as in the United States. Smoking is not only related to lung cancer but to other medical illnesses; this aspect should be emphasized as well as the cancer angle.

Whether one can quickly change the habits of individuals who have been smoking for 20 years or more is debatable, but many habitual smokers have quit. There is justifiable concern about the education of the present-day teenagers and young adults who should be so convinced of this relationship that they will refrain from smoking or break the habit if already established.

A sustained educational effort should be undertaken by family physicians, schools, and voluntary and governmental agencies to condition youth to refrain from smoking and if they have started to smoke, to break the habit. Families, teachers, athletic coaches, ministers and priests, as well as doctors have a real educational "Gibraltar" ahead of them.

Young people are confused. They discover that many, who tell them not to smoke, are smokers themselves.

Hospital and Medical Trends

The small community hospital and the doctors' offices are still the first lines of attack in cancer control. Eventually, treatment may be done in fewer places by those best equipped for all phases of treatment, including surgery, radiation, and chemotherapy.

Follow-up and continued care will be the province of the family doctor and the community hospital. There probably will be a pooling of resources, including medical resources.

Cancer projects and programs are located in selected community hospitals. These are developed by the grant-in-aid of funds or by the loan of equipment to hospitals depending on the need and the stage of development of the project.

Cytology Training Program

Training of cyto-technicians which takes place at the Presbyterian Hospital of the United Hospitals, Newark is an annual project. These technicians are sent for the course by hospital pathologists in the state. The course is held 2 days a week for 45 weeks.

Table 1.

1959-1960

HOSPITALS SENDING TECHNICIANS FOR TRAINING

County	*Hospital*	*Number of Persons*
Hudson	St. Mary's Hospital, Union City	1
Hudson	Christ Hospital, Jersey City	1
Sussex	Alexander Linn Hospital, Sussex	1
Union	St. Elizabeth Hospital, Elizabeth	1

Programs for Early Detection and Special Study (Cytology). Cytology smears are made on all hospitalized patients upon admission. The conventional Papanicolaou techniques and his classification for diagnostic purposes are utilized. See Tables Nos. 2, 3, 4, and 5.

Table 2.

CYTOLOGICAL SMEARS

HUNTERDON MEDICAL CENTER, FLEMINGTON

1959-1960

Vaginal Smears

Number of patients	1,670
Number of slides	3,261
Number of positive findings ...	8
Number of suspicious findings..	2

Table 3.

CYTOLOGICAL SMEARS

POLLAK HOSPITAL, JERSEY CITY

1959-1960

Sputa

Total number of patients 576

A series consists of 3 sputa specimens from each patient.

Four slides are prepared from each specimen—12 slides per series.

	Number of slides
548—patients had 1 series	6,576
19—patients had 2 series	456
7—patients had 3 series	252
2—patients had 4 series	96
576	7,380

Breakdown as to classification			
Total	Negative Class I, II, II-III	Suspicious III	Positive III-IV, IV, IV-V, V
576	331	103	50 65 20 7 = 142

Class description:

Class III-IV: Cells seen suggestive for malignancy.
Class IV : Cells seen that are fairly typical for malignancy.
Class IV-V : Cells seen that are classical for malignancy, but few in number.
Class V : Cells seen that, classical for malignancy and in abundance.

Table 4.

CYTOLOGICAL SMEARS

POLLAK HOSPITAL, JERSEY CITY

1959-1960

Miscellaneous Specimens

Total Slides	*Specimen*	*Total No. Patients*	*Negative I, II, II-III*	*Suspicious III*	*Positive III-IV, IV, IV-V, V*
592	Bronchial	146	53	30	25 30 8 0 —(63)
476	Chest fluid	81	26	13	12 25 1 4 —(42)
34	Esophagus	7	4	1	0 2 0 0 —(2)
36	Gastric	8	5	3	0 0 0 0 —(0)
2	Biopsy (liver)	1	0	0	0 1 0 0 —(1)
18	Urine	4	2	0	2 0 0 0 —(2)
6	Cervix	3	2	1	0 0 0 0 —(0)
42	Ascitic fluid	8	6	0	0 2 0 0 —(2)
1,206					

GRAND TOTAL OF SLIDES: (Tables 2 and 3)

Sputum	7,380
Other specimens	1,206
	8,586

Class description: See Table 3. for explanation.

Rural Cytology Project. The purpose of this small pilot study was to determine whether or not doctors would do more Papanicolaou smears on patients in their offices on a routine basis when given a formalized kit, which contained everything they needed for this test, except the fluid in the jars. This kit was prepared to be kept on the instrument table always ready for use.

This effort was not so successful as we had hoped it would be. Once the material was used in the kit, it was not replaced by the nurse and apparently the doctor did not request the refilling of the kit.

Generalized inferences can be made from this small group of doctors, and from the small number of patients presented.

Radiobiology and Nuclear Medicine. The Radiobiology Department of the Presbyterian Hospital of the United Hospitals of Newark is supported in part by the Cancer Program of this Department. This support is carried out by means of grant-in-aid funds to the hospital for the employment of highly trained personnel (physicist). The increase in the services rendered by the Radiobiology Department is shown by the large patient load in isotopes and in deep X-ray therapy. (See Table No. 5.)

Table 5.

RURAL CYTOLOGY STUDY

1959-1960

Data—Participating physicians 4

Total Number of smears done this year 72

One physician presented 58 of the 72 and another presented 10 of the 72.

The remaining 4 were distributed between the other 2 physicians.

Age Distribution of Females Screened

20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	85-89	no age
2	3	3	10	14	14	13	6	1	4	1	1

Diagnoses

Routine	53	Fibroid	2
Chronic-cervicitis	6	Bleeding from Cervical	2
Cervical polyp	2	Ulcerated cervix	1
Estrogen effect	1	Repeat Pap. smears	2
Probable menopause	1		

PAPANICOLAOU CLASSIFICATION

C	I	II	III	IV
1	62	3	5	0

Nursing Activities of Program

The Program provides a clinical experience in cancer for nurses. This program is planned and organized by the Public Health Nurse Consultant and the nursing staff at Presbyterian Hospital. Seventy-one nurses and 5 social workers participated in this activity during the past year. In the spring of 1960, the Public Health Nurse Consultant circularized the public health nursing agencies and hospitals to find out whether this activity should be continued. Two hundred and thirty nurses from public health nursing agencies and hospitals requested participation in this program.

The Public Health Nurse Consultant visited tumor clinics in 18 hospitals throughout the state. These visits have been helpful in acquainting the Consultant with resources for cancer patients and with the types of therapy given in different areas of the state.

Three hospitals where terminally ill cancer patients are cared for were visited by the Consultant.

Consultation was given to nurses at the Hammonton Cancer Detection Clinic and to nurses in 3 private agencies. The Consultant discussed cancer nursing at 7 in-service educational programs for nurses with a total of 100

in attendance. She also talked about the public health nursing responsibilities in cancer control at a meeting of the board of directors and nurses from a Visiting Nurse Association.

Nursing accomplishments included:

1. Completion of a kit of appliances to be used for demonstration of nursing procedures involved in the care of cancer patients.
2. Publication of the article "A Clinical Experience in Cancer for Public Health Nurses," written by the Public Health Nurse Consultant in cooperation with the Program Coordinator.
3. Completion of the Public Health Nursing Follow-up Cancer Control for the Public Health Nursing Service Guide.

Table 6.
CLINIC LOAD
1959-1960

Presbyterian Hospital of the United Hospitals, Newark (Including Black-Stevenson Clinic)	*Number Patients*	*Number Treatments*	*Number Clinic Visits*
Presbyterian Hospital Case Load			
Diagnosis			
Evaluations for cancer	2,344		
Malignant 1,763			
Non-malignant 581			
Black-Stevenson Clinic			
Clinic visits—follow-up			2,090
Radiation Treatment			
*Patients receiving radiation therapy	323		
Patients not suitable for any form of cancer treatment	106		
*Number of therapy treatments		7,379	

*—These figures give an example of what the work load means to a community hospital when an adequate cancer service is developed.

A. Each treatment involves following team for each visit. Physician, physicist, nurse, technician, and clerk. A single total course of treatment for each particular cancer lesion requires daily treatments lasting from 6 to 8 weeks.

B. An evaluation of the progress of the patient following treatment is carried out by an elaborate follow-up clinic system, which continues for 5 years and more.

C. This includes follow-up on patients receiving therapy as well as follow-up on patients not in treatment at this time.

Table 7.

WORK LOAD IN ISOTOPES

At Community Hospitals Where Cancer Program Has Projects

1959-1960

Hospital	*Type of Material Used*	*Purpose of Procedure*	*Number of Patients*
Presbyterian Newark		*Diagnosis:*	
	I^{131}	Hyperthyroid	35
		Hypothyroid	62
		Euthyroid	58
	AS^{74}	Brain Scan for tumor localization	14
	Triolein	Fat malabsorption	22
	Oleic Acid	Fat malabsorption	21
	Co^{60}, B12	Pernicious anemia	16
	RISA	Blood volume	1
			229
		Therapy:	
	I^{131}	For hyperthyroidism	39
	P-32	For polycythemia	5
	P-32	For bone metastases (Breast Cancer)	6
			50
West Jersey Camden		*Diagnosis:*	
	I^{131}	Uptakes	126
		Thyroid scanning	11
		Therapy:	
	I^{131}	Cardiac Therapy	1
		Hyperthyroidism	7
		Thyroid carcinoma	10
		Palliation:	
	Au^{198}-Gold	Abdominal carcinoma	3
Saint Barnabas Newark		*Diagnosis:*	
	I^{131}	Thyroid study	25
	Triolein	Fat absorption	1
	RISA	Blood volume	27
		Therapy:	
	P^{32}	Polycythemia	1
		Palliation:	
	Au^{198}-Gold	Pleural effusion	1

Table 8.

RADIOLOGICAL HEALTH PROGRAM IN CANCER

Presbyterian Hospital of the United Hospitals, Newark—1959-1960

Monitoring of Equipment and Personnel

Equipment	*Number of Tests*	*Personnel*	*Number of Persons*
Calibration for X-ray Machine	7	X-ray with Badge	12 Monthly
Stray Radiation Surveys:		Cobalt and X-ray Therapy	
Radium Room	4	with Badge	12 Monthly
Cardiac Catheterization	2	Radioisotope with Badge	5 Monthly
Calibration of Cobalt Machine	1	Operating Room Staff with	
Calibration of Cobalt Grenz		Badge	6 Monthly
Ray Machine	1	Heart Institute for Cardiac	
Standardization of Survey		Catheterization with Badge	10 Monthly
Instruments	4	Radiation Therapy and Radio-	
Standardization of Pocket		isotope with Pocket Dosi-	
Dosimeters	4	meters	8 Monthly
Stray Radiation Survey of New			
Cobalt Teletherapy Facility	1		
Lead Rubber Absorption	1		

Table 9.

RADIOLOGICAL HEALTH PROGRAM IN CANCER

Monitoring of Equipment and Personnel

Hospital	*Machines Monitored*	*Personnel Monitored*
West Jersey Camden	None	22 continuously
Saint Barnabas Newark	Isotopes laboratory working area surveyed	No number given

Research

National Cooperative Child Health Study—Leukemia—Lymphoma Study

This is the continuation of a federal research grant activated February 1, 1959. It is part of an epidemiological study being conducted by the National Cancer Institute of the National Institute of Health at 14 different centers. The diseases included in the study are the lymphoma-leukemia group (200-205 International Classification of Diseases) in the age group 0-16 years.

The study uses the case-history method, applying this to children having the lymphoma-leukemia group of diseases, with comparisons to be made of the characteristics found in the various groups of children and their families.

The data to be studied are obtained through personal interviews with the mother of the index or control child.

The principal control group with which the index cases will be compared are neighborhood controls (selected by a standardized method for this study). The second control group consists of the siblings nearest in age to the index children.

After an index case is chosen and permission from the attending physician has been secured, an appointment for interview is made with the index mother at her convenience. When this mother is interviewed, the neighborhood control is sought.

A register is maintained to facilitate assignment of a family number to each family interviewed, whether it be index or control.

Verification of certain medical data is checked on mother and all children. This entails communication by letter or telephone with doctors, dentists, and hospital record librarians. A physician personally checks hospital records in those hospitals within a reasonable distance, in state and out of state.

To date, 35 index cases and 30 control cases have been interviewed. Twenty-four cases, 12 index and 12 controls, have been completed and forwarded to the National Cancer Institute for processing and analysis.

Rural Cytology—(See Table 5, page 26).

Chronic Illness Survey "Follow-up" Study—Hunterdon County

A review of the status of the original population surveyed under the Commonwealth Fund Chronic Illness Study in Hunterdon County, which started in 1952, was undertaken by the Cancer Program Coordinator. This would be necessary as a preliminary to any clinical follow-up on this same population.

The questionnaire used was designed with some assistance from the Public Health Statistics and the Heart Programs.

There were 769 charts reviewed by 3 part-time physicians and the Coordinator of the Cancer Program during this year. An analysis of the data is now in progress.

Death Certificates: The Program Coordinator acts as liaison between hospitals and the Public Health Statistics Program in furnishing copies of death certificates from cancer. These photo-copies are furnished to hospitals through this Program in an attempt to complete hospital records and to assist

in maintaining the case registries for completeness of follow-up on cancer patients in and out of state.

Table 10.

DEATH CERTIFICATES SEARCHED

County	Number of photocopies of death certificates furnished	Number of searches made—certificates not found
Atlantic	15	4
Camden	41	168
Essex	62	8
Monmouth	57	94
Out of State	16	—
	191	274

Table 11.

PATHOLOGICAL TISSUE SERVICE

Cancer funds support pathological tissue laboratory in Department 1959-1960

Item	*Number*
Slides processed	10,810
Specimens—special stains	1,251
Specimens—contributed	364
Slides distributed throughout state	8,684
Photographs from cancer specimens	396

The Human-Dog Study of the Lymphoma-Leukemia group of diseases is continuing. 5.12 percent of all of the tissue work in the Pathology Laboratory was devoted to the Lymphoma-Leukemia Human-Dog Study.

Specimens from dogs processed	46
Slides made from above specimens	254

Cancer Registry Activities

The Cancer Program is continuing its efforts to establish hospital cancer registries in the state so that more accurate statistics and follow-up can be made. Cancer registries are valuable tools for evaluating the effectiveness of the teaching programs for physicians as well as for study of survival rates under different types of techniques of diagnosis and treatment.

Forty-seven of the 92 accredited hospitals in New Jersey have cancer registries. The Department loaned 6 of these to hospitals that have met the requirements. Two were loaned during this year.

First Meeting in State of Tumor Board Chiefs

The Program Coordinator met with Tumor Board Chiefs to discuss the value of cancer registries in hospitals and to attempt to increase interest in this valuable follow-up tool. Only 12 physicians attended.

Fifty-five persons attended a meeting conducted by the Cancer Program for Cancer Registry Secretaries and Medical Record Librarians in hospitals.

Questions presented at these 2 meetings indicate the need for supervision and training of the persons who maintain these registries.

Professional Education

Symposium: Fifty physicians attended a Cytological Symposium at Hunterdon Medical Center, Flemington. This symposium was organized by the Cancer Control Program and co-sponsored by the New Jersey Society of Pathologists in cooperation with Hunterdon Medical Center.

Subjects discussed demonstrated the extension of application of cytology to fields other than, but related to, cancer.

Approximately 150 physicians and radiologists attended a meeting at Presbyterian Hospital, Newark, co-sponsored by the Cancer Control Program. Dr. Vera Peters of the Cancer Institute of Ontario emphasized modern trends and management of breast cancer. Important fact shown was that conservative surgery followed by carefully administered radiation is the proper procedure. (Cytology Training—See Table 3, Program Activities.)

Staff Education

Program Coordinator attended approximately 19 sessions to keep up-to-date on current scientific knowledge and experience in the field of Cancer. Program Coordinator also made approximately 100 visits to hospitals and agencies for general survey and future development of possible cancer programs. (See "Nursing" section.)

Public Education

The Cancer Control Program cooperated with the Women's Auxiliary to the Medical Society of Mercer County in a cancer film showing program. The film, "Breast Self-Examination" was shown to 210 women and discussed by 7 physicians.

Film showings are an excellent method of non-professional education. During the year, 3 films on cancer were shown as follows:

Table 13.

CANCER FILM SHOWINGS

Name of Film	*Number Showings*	*Number Attended*
Breast Self-Examination	11	381
Man Alive	81	2,993
Cancer	91	3,611

Publications

"A Clinical Experience in Cancer Nursing for Public Health Nurses."

Work in Progress

"Manual for Cytology Technicians."

Distribution of Pamphlets

During this year, the following pamphlets on cancer were distributed. Requests from students, especially for pamphlets relating to smoking and lung cancer, indicate the growing concern of this problem.

Table 14.

DISTRIBUTION OF PAMPHLETS

Name of Pamphlet	*Distributed To*	*No. Distributed*
Breast Self-Examination	Physicians for selected patients	1,080
Lung Cancer and Smoking	Physicians and selected non-professionals	7,000
When a Family Faces Cancer	Public Health Nurses	25
Cancer Nursing	Public Health Nurses	20
Directory of Cancer Clinics in New Jersey	Tumor Board chiefs in hospitals and physicians	20
Cigarettes and Health	Public health agencies	20
Treating Cancer-Surgery, Radiation, Chemotherapy	Physicians	25
Miscellaneous cancer pamphlets	Professionals and non-professionals	200
(Some New Jersey Cancer Society pamphlets)		9,440

Diabetes—Endocrine and Metabolic Disorders

A summary of the activities of the Diabetes Control Program during the year 1959-1960 is as follows:

1. Case-Finding Activities
   a. The Seventh Annual State-wide Diabetes Detection Drive was observed during November 15-21, 1959. This was a joint effort of the Medical Society of New Jersey, New Jersey Diabetes Association and the State Department of Health. Twenty-one County Medical Society Diabetes Detection and Education Committees were organized. The theme of this project was "Early Detection of Diabetes Means Prevention." A pamphlet based on this theme was prepared and mailed to all New Jersey physicians. Emphasis was made on blood screening, but individual county and local projects used urine tests as well. All techniques of community education, including radio, television, newspaper and periodical publicity were utilized. Public forums on diabetes were held in several areas of the state. The details of material distribution and test results are attached. (See workload data, Tables 1 and 3.)

   b. A number of short-term case-finding projects was completed in small industries as a combined activity with the Venereal Disease Program. Split samples of blood were obtained for these studies from a single vein puncture. (See Table 3.)

   c. Blood tests for diabetes were offered to state employees in the Trenton area and in the Newark area during Diabetes Detection Week. Urine tests were made available to state employees throughout New Jersey. (See Tables 1 and 3.)

   d. The diabetes case-finding unit continued to operate successfully at the Middlesex General Hospital. This Center has utilized blood tests, screened by the Hewson Clinitron. A unique feature is the fact that participants are screened within the hospital and in the community. Personnel are sent into the field for local projects throughout the county. The unit has emphasized industrial employees, service clubs, and other organized groups. The Diabetes Control Program provided the Clinitron, glassware, and Sheppard Tubes, as well as a grant-in-aid to partially cover the cost of technical services. (See Table 3.)

e. The Diabetes Detection Unit at the East Orange Health Department was loaned a Clinitron and other equipment to institute a blood screening program.

f. The home case-finding project of the Mercer County Nursing Agencies has continued. The visiting and public health nurses perform urine tests for glucose, utilizing glucose oxidase test sticks. (See Table 2.)

1-A. Additional District Case-Finding Activities

a. Metropolitan State Health District

(1) Twenty-seven health officers participated in the Diabetes Detection Drive by making Dreypaks available to local citizens and through the distribution of educational leaflets. An outstanding example of a community's participation in this program may be illustrated by that organized by the Irvington Health Department. Twenty-seven drug stores served as distribution and collection points for bottles and specimens during the week. Health education displays and materials were placed in strategic locations throughout the town. Several druggists created special window and counter displays for the observance. One thousand six hundred and forty-nine specimens were collected, of which 39 were positive reactors. Twenty-seven Certificates of Service were awarded by the health department to drug stores for meritorious service and cooperation in the 1959 Diabetes Detection Program.

(2) The Diabetes Program referred to this District a number of diabetic suspects for nursing follow-up. In all cases, the nurses were successful in having the patient placed under the care of a physician or clinic.

b. Southern State Health District

(1) The majority of the part-time Health Officers in the District participated in the Diabetes Detection Drive as did the different visiting nurse associations. Approximately 2,100 Dreypaks were submitted for examination to the Departmental Laboratory.

All visiting nurse associations agreed to use Dreypaks on a year-round basis, to assist in case-finding.

(See workload data and tables for statistical information.)

2. Activities Related to Long-term Control of Diabetes

a. Activities related to patient and family

(1) A grant-in-aid was provided to the New Jersey Diabetes League for the salary of a full-time teaching nurse at the summer camp for diabetic children at Johnsonburg, N. J. District personnel have assisted the camp through consultation.

(2) The Diabetes Control Program and the Poison Control Service instituted a state-wide compaign to warn diabetic patients and their relatives of the dangers of accidental ingestion of Clinitest tablets. A resumé of the problem was published in the *Journal of the Medical Society of New Jersey* and in *Public Health News*. Warning notices were sent to all New Jersey Poison Control centers and were distributed to all hospitals in New Jersey through the cooperation of the New Jersey Hospital Association.

(3) The Diabetes Control Program distributed a considerable amount of educational material to diabetic patients and their families. (See workload data.)

b. Activities involving the community

(1) Educational activities in this category have been primarily related to case-finding programs during Diabetes Week and other diabetes detection programs.

(2) Requests are received frequently from the general public for diabetes literature. A group of well written pamphlets and brochures on the subject of diabetes is sent on request.

(3) The diabetes film called "The Story of Wendy Hill" was shown to various community groups. There were 37 showings and 1,269 persons attended.

(4) The Program Coordinator participated in Diabetes Programs on radio stations WBCB, Levittown, Pennsylvania and WBUD, Trenton.

(5) An information document, "Diabetes and the School Child," was prepared at the request of the Inter-departmental Committee, Departments of Education and Health. This booklet will be distributed to all school nurses and interested parents

of diabetic school children. It will be available to teachers, physicians, and public health personnel.

c. Activities involving professional personnel

(1) On October 21, 1959, the Seventh Annual Symposium for Physicians entitled "Lipids and Diabetes" was held in the main auditorium of the Prudential Insurance Company of America in Newark. Approximately 100 physicians attended the meeting.

(2) On May 11, 1960, the Second Annual Spring Symposium entitled "Pre-Diabetes and Diabetes in Pregnancy" was held at the Princeton Inn. About 200 attended.

Table 1.

WORKLOAD DATA

All Data on a Fiscal Year Basis

Diabetes-Endocrine and Metabolic Disorders

Description of Workload Data	*1958-1959 Actual*	*1959-1960 Actual*
DREYPAKS		
Number Distributed	102,231	107,231
Number Returned for Testing*	7,804	8,105
Number Positives	99	90
BLOOD SCREENING		
Number sheppard tubes distributed	3,304	5,773
Number of tests performed	3,623	7,138
Number of positives	129	118
EDUCATIONAL MATERIALS DISTRIBUTED		
Professional	38,350	25,633
Lay Public	101,884	187,906
Posters	2,869	4,510
Miscellaneous	1,000	1,000
REPORTS AND FOLLOW-UP LETTERS AND QUESTIONNAIRES	10,164	14,121
REQUESTS FOR PHN DIABETES FOLLOW-UP VISITS	—	14
MERCER COUNTY VISITING NURSE ASSOCIATIONS PROJECT		
Uristix (125 strips—bottle) distributed	—	81
Number of tests performed	—	931
Number of positives	—	13

* These figures are not referable to the number distributed since they include only those Dreypaks returned to the State Laboratory for testing. Many were tested locally and were not returned. Follow-up tests were performed on positive reactors by personal physicians.

Table 2.

RESULTS OF DREYPAKS TESTED*
Fiscal Year 1959-1960

	Number Dist'd	*Number Returned*	*Positive Reactors*	*Newly Diagnosed Diabetics*	*Known Diabetics*	*Potential Diabetics*	*Diagnosis Not Determined***	*Negative*
State Employees	5,062	473	5	1	2	0	2	0
General Public & Industries	102,447	7,649	85	33	18	8	12	14
Totals	107,509	8,122	90	34	20	8	14	14

* These figures include only those Dreypaks returned to State Laboratory for testing.
** Diagnosis not determined because of lack of patient and/or physician cooperation.

Table 3.

RESULTS OF URISTIX TESTING—MERCER COUNTY
Fiscal Year 1959-1960

	Number Tested	*Positive Reactors*	*Newly Diagnosed Diabetics*	*Known Diabetics*	*Potential Diabetics*	*Negative*	*Follow-up Incomplete*
Mercer County Visiting Nurse Associations	931	13	3	2	1	6	1

Table 4.

RESULTS OF BLOOD SCREENING
Fiscal Year 1959-1960

	Number Tested	*Positive Reactors*	*Newly Diagnosed Diabetics*	*Known Diabetics*	*Potential Diabetics*	*Diagnosis Not Determined**	*Negative*	*Follow-up Incomplete*
INDUSTRIES								
Stacy Laundry	29	1	0	0	0	1	0	0
Trenton Folding Box	72	0	0	0	0	0	0	0
Heinz Co., Salem	189	0	0	0	0	0	0	0
Blakely Laundry	126	1	0	0	1	0	0	0
Morgan Bros. Laundry	53	0	0	0	0	0	0	0
STATE EMPLOYEES								
Trenton Area	1,320	4	3	0	0	0	1	0
Newark Area	1,881	74	9	14	0	3	30	18
GENERAL PUBLIC								
MCOSS Hobby Show	101	3	1	2	0	0	0	0
Lit Brothers Store	121	5	0	5	0	0	0	0
HOSPITALS								
Middlesex General	3,876	36	11	13	2	3	1	6
Totals	7,768	124	24	34	3	7	32	24

* Diagnosis not determined because of lack of patient and/or physician cooperation.

Diseases of the Nervous System and Special Senses

Chronic diseases of the nervous system include disorders ranging from strokes, New Jersey's third leading cause of death, to epilepsy, which numbers over 50,000 victims in our state. Intensive research has so far failed to reveal means of preventing most chronic disorders of the nervous system, but their early diagnosis followed by prompt and adequate treatment can greatly reduce the debility and dependency which are their common accompaniments. It is recognized that social and emotional aspects of nervous system diseases are often as devastating as their physical limitations.

Neurological Disorders

Program Activities

Electroencephalograph machines placed by this Program in 17 hospitals throughout the state, continue to assist in early and accurate diagnosis of chronic neurologic disorders. A total of 4,749 examinations on 4,663 patients was reported in 1959, an increase of 17 percent over 1958. The clinical classification of patients studied, and the results of interpretation of records, are as follows:

Table 1.

CLINICAL DIAGNOSIS OF PERSONS WHO HAD ELECTROENCEPHALOGRAPH EXAMINATIONS

	Number	*Percent*
Conclusive Disorder	1,959	42
Trauma	335	7
Tumor	177	3
Cerebrovascular Disorder	211	4
Other Neurological Disorders	907	19
No Neurological Disorder	1,074	23
Total	4,663	

Table 2.

INTERPRETATION OF ELECTROENCEPHALOGRAPH EXAMINATIONS

	Number	*Percent*
Normal	2,351	
Abnormal	2,377	58
Focal	644	
Diffuse	880	
Compatible with Convulsive Disorder	1,296	31
Other	387	
Total	4,749	

The Convulsive Disorder Consultation Service continued as a user of the above electroencephalograph facilities in 8 community hospitals, 235 persons being served. This Service evaluated 361 persons in 48 clinic sessions held in 6 community hospitals. By this means, intensive in-service training in convulsive disorders is made available to District nursing staff and state supervised public health nurses. The Public Health Nurse Supervisors assist local nurses with follow-up of patients seen in these clinics.

As a result of cooperative planning with the Convulsive Disorder Consultation Service, the *Division of Motor Vehicles* has adopted a procedure planned by this Program for the issuance of motor vehicle licenses to persons with well-controlled convulsive disorders, after an appropriate investigation and medical evaluation, administered by the Motor Vehicle Division. This has resulted in licensure of 14 of 21 applicants with seizures in the second half of fiscal year 1959, the denial of 2, while 5 cases are pending.

The Division of Vital Statistics has submitted to this Program the names of 60 persons reported to the State Department of Health during 1959 as epilepsy. Epilepsy has been a reportable disease in New Jersey since 1911, when it was made mandatory to report to the Department of Health all cases of mental deficiency and epilepsy.

The "Continuation of Care" program of the Comprehensive Rehabilitation Service established at the Hospital Center at Orange in 1958, with assistance from this Division, served 28 patients with chronic neurologic disorders in calendar 1959 with a program designed to continue restorative services in the home. The clinical classification of these patients is as follows:

Poliomyelitis	6
Multiple Sclerosis	8
Parkinsonism	2
Traumatic	6
Infectuous	3
Spina bifida	1
Metabolic	2
Total	28

Future Trends

While awaiting advances in knowledge regarding prevention and management of the chronic neurologic disorders, much can be done now to enhance and expand existing services. Continuance of a program of education through symposia on electroencephalography will be supplemented by conferences on neurologic subjects. A State Directory of Services for Epileptics is planned for the use of all those dealing with the management of persons with this dis-

order. Extension of rehabilitation services for the neurologically disabled is a continuing goal.

Glaucoma

As a cause of progressive visual disability, glaucoma ranks second only to cataracts. Recent investigations have indicated that about 2 percent of the population over the age of 40 have glaucoma. Upon this basis, it can be estimated that in New Jersey 30,000 individuals have glaucoma, with an even greater prevalence expected in the older age group.

Blindness from glaucoma is preventable if the condition is discovered in its early stages and prompt treatment is instituted. Since the primary cause of glaucoma is not known, finding individuals with unsuspected glaucoma and bringing them to treatment is imperative if we are to prevent complete sight loss. Screening for glaucoma has been established as a valuable method of discovering this insidious condition before the person has any noticeable signs of eye trouble.

This Division has encouraged and supported programs for the early detection and treatment of glaucoma at the Medical Center, Jersey City; and at Newcomb Hospital, Vineland. A program of community screening and research is being conducted at the Newark Eye and Ear Infirmary Unit of the United Hospitals of Newark with assistance from this Division through a grant-in-aid and loan of scientific equipment.

During this year, the Department of Visual Rehabilitation of the Newark Eye and Ear Infirmary rendered services to 133 in-patients. Out-patient visits numbered 1,860. An analysis follows: Visual fields 163; low vision 50; tonography 167; glaucoma 927; orthoptic evaluation 211; orthoptic therapy 342. The 927 glaucoma visits were medical therapeutic sessions involving approximately 175 individuals.

In addition, an eye testing program was conducted at the Essex County Health Fair where 800 individuals were screened. Those participants who failed the test were referred to their family physician or ophthalmologist.

Hearing and Speech

It has been conservatively estimated that 3,000,000 children in this country have hearing problems. About 2 percent of them have a loss sufficient to warrant special medical care and educational help and about 30,000 have such a serious degree of hearing loss to be classified as deaf. Among the adult population, 12 million individuals are believed to have hearing impairments varying from slight to total. Early and accurate diagnosis of these disorders may result in therapeutic measures consistent with improvement of hearing

capacity, maximal use of residual hearing, and alleviation of emotional and socio-economic problems.

Continued assistance and guidance have been provided by this Division to promote and develop integrated facilities for the diagnosis and rehabilitation of individuals with hearing and speech problems. In order to demonstrate the importance of integrated services, comprehensive hearing and speech centers have been established in the following hospitals: Bergen Pines County Hospital, Paramus; Hunterdon Medical Center, Flemington; Newark Eye and Ear Infirmary; and St. Francis Hospital, Trenton. The Atlantic City Center will soon be reactivated at the Children's Seashore House. In addition, interest in the establishment of such facilities has developed at Cooper Hospital, Camden, and Warren Hospital, Phillipsburg, and it is anticipated that services will soon be available to residents of those areas.

These hearing and speech centers demonstrate the importance of an adequate otolaryngological examination and paramedical team evaluation of the total needs of the patient in a community hospital setting.

The following is a summary of the services rendered at the Hearing and Speech Centers:

Table 3.

SERVICES AT HEARING AND SPEECH CENTERS

	New Patients	*Patient Visits*	*Referred for Further Medical Consultation*
Hunterdon Medical Center	243	1,910	22
Newark Eye and Ear Infirmary	940	2,868	374
St. Francis Hospital	377	2,429	37

A speech screening program for school children was carried on in 6 schools of Hunterdon County. As a follow-up, a speech program was outlined for those children with speech difficulties to determine the possible relationship of hearing loss and speech problems.

Hearing screening tests were administered to 1,600 individuals at the Essex County Health Fair through the auspices of Hearing and Speech Center of the Newark Eye and Ear Infirmary. Those individuals who failed the test were referred to their family physician or otolaryngologist.

Heart and Circulatory Disease Program

Morbidity and Mortality Aspects

Deaths due to diseases of the heart and circulatory system account for the major portion of all deaths in the state.

DEATHS IN NEW JERSEY 1958

From all causes	57,552
From diseases of the circulatory system	27,080
From vascular lesions affecting the central nervous system	5,378
From congenital malformations of the circulatory system	324
Total deaths from heart and circulatory diseases	32,782

These causes represent 58.7 percent of all deaths.

New Jersey ranks among the highest of all states in deaths from heart disease.

Heart and circulatory diseases account for more than 65 percent of all chronic illnesses. Two of every 3 chronically ill patients have some heart or circulatory difficulty either as a primary or contributory condition.

Heart disease kills more men in their most productive period than any other disease. Of the total deaths from diseases of the circulatory system, the largest majority, approximately 22,000, are caused by arteriosclerotic heart disease. It is estimated that there are at least 4 to 5 times as many annual cases of heart attacks as deaths.

One in 6 patients in chronic disease institutions suffers residual effects of a paralytic stroke.

Patients with chronic heart and circulatory disease disabilities require extensive care in rehabilitation procedures. The cost for such procedures is high and causes economic hardship in many families or is a high financial burden on local and state health, welfare, and educational organizations.

New concepts of prevention and treatment appear to make this a disease preventable in part or in whole or can defer the age of onset.

Administrative Aspects

The staff consists of a full-time Program Coordinator physician, 2 part-time physicians, and a full-time public health nurse consultant specially trained in cardiology.

Roughly one-third of the budget was spent for direct Program costs including educational, medical and non-medical material. The remaining two-thirds was given as grants-in-aid to New Jersey hospitals to help finance the following:

a. Facilities for diagnosis and treatment of heart disease.
b. Research projects in the prevention of coronary heart disease.
c. Advancement in newer techniques of diagnosis and therapeutics in cardiovascular disease.

Highlights of Program Activities

An Anti-Coronary Club was planned and initiated in a community hospital. Its purpose is to determine if lowered fat diets will help prevent attacks of coronary heart disease (heart attacks). The Club consists of a group of men 20 years through 50 years of age who have experienced heart attacks. Dietary analysis of their food habits, together with detailed medical and laboratory analysis, have begun on the present group of 75 patients. Eventually, this group will consist of 150 to 200 men who will be followed for 5 years.

The project's head is one of the hospital staff's part-time physicians. Other personnel consists of a part-time physician, a full-time dietitian, a part-time nutrition consultant, and a full-time administrative clerk.

Preliminary findings indicate the following:

a. Fifty percent of the men in the study were overweight. Weight reduction to ideal weight was accomplished in most cases.
b. Slight modification of the average man's eating habits results in substantial, significant reductions in blood cholesterol levels.
c. These changes in dietary habits accomplished and maintained through continuous supervision of the patient by frequent conferences and analysis of his eating pattern.

The Program aided in the strengthening of a number of hospital centers for the accurate diagnosis and treatment of congenital heart defects. These centers have stimulated physicians to provide earlier and more accurate diagnosis of congenital heart conditions. The number of cases treated surgically in New Jersey is increasing yearly.

Assistance was provided to 5 hospitals in a total amount of $36,600 to help finance in part or in total, cardiac physiologists (2 of these being physicians specially trained and interested in research) and biochemists. Because of the change from hopelessness to hopefulness in the treatment of congenital heart disease, the number of cases for referral to these centers for accurate diagnostic evaluation has markedly increased in the past year.

The Crippled Children Program of the State Department of Health provided assistance to finance a limited number of cases requiring cardiac surgery for whom other financial arrangements could not be made. This portion of the Program is expected to be expanded in the coming year.

A real solid beginning was made into prevention of the crippling aftereffects of stroke patients by the following:

a. Advocating the concept of the continuity of care as a physician, hospital, and community responsibility.

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b. Promoting the training of physicians and public health nurses in the early treatment of stroke patients.

c. Promoting more rehabilitative and restorative services for the stroke patient.

In connection with the excellent booklet, "Strike Back at Stroke," approximately 2,000 (as in addition to the 6,000 previously supplied) copies were distributed to physicians, hospitals, clinic nurses, public health nursing organizations, physiotherapists, and to non-medical personnel.

Demonstration projects at a number of chronic illness institutions were initiated and maintained in which the value of rehabilitation training was demonstrated with particular emphasis on the eventual saving to the health and welfare organizations in the decrease of hospitalization time and thereby hospitalization costs required.

The post-graduate education of physicians continued. Post-graduate courses were financed in conjunction with a Newark hospital in cardiology, the courses including refresher and advanced electrocardiographic diagnosis, phonocardiographic diagnosis and in some of the newer diagnostic techniques and treatment of heart diseases.

The nursing consultant continued the established pattern of working with the county chapters of the New Jersey Heart Association in establishing program meetings for nurses. More than 1,000 nurses participated in these discussion meetings held throughout the state in cooperation with the District offices. The personnel of the Program participated in committee activities of the New Jersey Heart Association.

Plans for the Coming Year

a. To conduct a study with the New Jersey Heart Association to determine how many rheumatic fever patients there are in a test area and if all of these patients are taking prophylaxis (oral penicillin) regularly to prevent further attacks of rheumatic fever which cause crippling heart disease and earlier deaths.

b. To show through a New Jersey hospital study if the devastating aftereffects of stroke in patients can be prevented by the coordinated efforts of a hospital staff (physicians, nurses, physiotherapists, and medical social workers) and the services of a local visiting nurse association.

c. To demonstrate the effectiveness of a new laboratory procedure (the fluorescent antibody technique) as a tool in the early diagnosis and antibiotic treatment of streptococcal infections.

d. To increase the scope of the Anti-Coronary Club Project. The services of the nutrition staff of the project will be made available to practicing physicians for the dietary evaluation of referred patients.

e. To promote the concept of the proper early treatment of the coronary-prone, high-risk individuals as a preventive measure against coronary heart disease, through education of medical and non-medical personnel.

f. To plan an anti-obesity campaign on a county-wide basis in cooperation with the Nutrition Section of the Division of Special Consultation Services to demonstrate the most effective methods of approach.

g. To plan and conduct a series of workshops for physicians, nurses, hospital administrators, medical social workers and other interested personnel on the continuity of care of the stroke and congestive heart failure patient.

h. To conclude a study of the nursing services to patients with heart disease. In 3 voluntary public health nursing agencies of Essex County, staff nurses are recording information of the services concerning 450 patients. It is anticipated that analysis of the data obtained will provide much needed information of the needs of home nursing care and the methods of approach.

Homemaker Services

The rising incidence of chronic illness along with increasing life span, as well as other trends in present-day living, have created an increasing need for various kinds of help in the home. Homemaker service has demonstrated its value as one of the important basic resources for preserving and strengthening family life, whether it is primarily focused on serving children, the aged, the chronically ill, the physically handicapped or the emotionally disturbed.

Homemakers are women who, after a short period of training, are available for hire on an hourly basis in households which have a problem resulting from illness or other disruptive condition.

Four new homemaker services, Burlington County, Cape May County, Hudson County, and Ocean City, began operation during the past year. This brings the total of functioning Homemaker Services in the state to 16, serving the needs of 14 counties and making these services available to more than three-quarters of the population.

Grant-in-aid assistance was provided to 9 of these services to demonstrate the importance of a full-time, qualified director. The other 7 services were supported entirely by local agencies.

The 16 services, as listed below, provided 239,273 hours of service to 3,614 families:

Atlantic County Homemaker Service, Inc., Ventnor.
Chr-Ill Homemaker Service, East Orange.
Homemaker Service of Monmouth County, Long Branch.
Homemaker Service of Somerset County, Inc., Somerville.
Jersey Cape Homemaker Service, Inc., Cape May Court House.
Passaic County Homemaker Service, Inc., Paterson.
Princeton Community Homemaker Service, Princeton.
SAGE Visiting Homemaker Service, Summit.
Visiting Homemaker Service of Bergen County, Inc., Englewood.
Visiting Homemaker Service of Burlington County, Inc., Mount Holly.
Visiting Homemaker Service of Ocean City, Ocean City.
Visiting Homemaker Service of Hudson County, Inc., Jersey City.
Visiting Homemaker Service of Hunterdon County, Inc., Flemington.
Visiting Homemaker Service of Middlesex County, Inc., New Brunswick.
Visiting Homemaker Service of Morris County, Morristown.
Visiting Homemaker Service of Central Union County, Cranford.

The Training Course for Homemakers, conducted by Rutgers University Extension Division and subsidized by this Division, was given 13 times and was attended by 260 Homemakers. More than 900 women have participated in these courses since they were initiated 6 years ago.

The motion picture entitled "Home Again" which was initiated by this Division and made by the Mental Health Film Board, in cooperation with other agencies, was shown 88 times during this year.

In order to coordinate facilities, stimulate local interest, and maintain standards of service, the Visiting Homemaker Association of New Jersey, Inc., was organized and incorporated as a non-profit organization during this fiscal year. This Association will replace and take over the work formerly carried on by the State Consultant Committee on Visiting Homemaker Service. The Association is actively recruiting for the services of an executive director whose salary will be provided by this Division on a grant-in-aid basis.

Nutrition in Institutions

The Dietary Consultation Service which has been provided to community hospitals, nursing homes, homes for the aged, and county units since 1957 was continued through March of this year. This project was carried on through the New Jersey Hospital Association with grant-in-aid assistance from this Division for the salary of a well-trained nutritionist experienced in hospital problems. The nutritionist visited 48 hospitals, ranging in size from 26 to 622 beds, and 24 other institutions including homes for the aged, county geriatric units, and nursing homes. A written report was prepared and pre-

sented to the administrator of each institution outlining existing conditions and listing specific suggestions for improving the food service to patients.

Restorative Services and Home Care

The problem of rehabilitating the long-term patient is one of tremendous magnitude. Mere prolongation of life is an empty achievement unless the sick and the handicapped are helped to regain the maximum level of physical, economic, social, and emotional self-sufficiency. Unless adequate maintenance rehabilitation is continued, the danger that a partially disabled person will deteriorate eventually to a state of total dependency is real.

In order to demonstrate that comprehensive restorative services programs are reasonable investments calculated to offset the greater cost of chronic dependency and progressive degeneration of human resources, support of such programs has been continued in several community hospitals. Grants-in-aid for the salaries of paramedical personnel have been provided to the following hospitals during this year: Donnelly Memorial Hospital, Trenton; Essex County Hospital, Belleville; Hospital Center at Orange; St. Michael's Hospital, Newark; and Somerset Hospital, Somerville.

In addition, equipment has been purchased for loan to Hunterdon Medical Center, Flemington; Middlesex Rehabilitation and Polio Hospital, New Brunswick; and West Jersey Hospital, Camden, to implement or expand comprehensive restorative services programs in these institutions.

Tangible results have been achieved in the Restorative Services Program at Donnelly Memorial Hospital which began operation in August, 1959. Since that time, 29 patients who had been considered permanent residents of the hospital have been returned to community living. This has been accomplished through the cooperative efforts of the staff, relatives, interested individuals and community agencies.

The Hospital Center at Orange has extended its Program to include Home Care services, thus providing a continuum of service, essential to adequate patient care. Consultation has been given to the program by this Division and by the District office, both on the planning level and in the actual operations. During the calendar year 1959, 140 patients were referred to this Program with the following diagnosis: Arthritis 33; blindness 1; cardiovascular 59; fractures 14; neurological 28; primary muscle disorders 3; and miscellaneous 2. Of these, 111 patients have been discharged with the following goals attained: Full ambulation 12; partial ambulation 42; self-care 12; maintenance 43.

Through the efforts of the District Consultant, Medical Social Rehabilitation, interest in the development of Home Care Programs has been stimulated in 3 hospitals in Essex, Hudson, and Union Counties. Establishment of such Programs offers a promising solution to the shortage of hospital beds and the increasing congestion of hospital facilities.

Continued support through grant-in-aid assistance has been provided for the services of a medical social worker to demonstrate the value of casework services in problems of a personal or environmental which interfere with obtaining the maximum benefits from medical care. Five hospitals, Donnelly Memorial, Trenton; Helene Fuld Hospital, Trenton; Hospital Center at Orange; St. Michael's Hospital, Newark; and West Jersey Hospital, Camden, report a total of 1,392 patients receiving casework services during the year. This involved more than 6,166 casework interviews.

Screening in Hospitals

Detection of incipient chronic disease is a basic preventive measure to arrest the progress of the disease and frequently avert disabling sequelae. Screening programs, utilizing simple, inexpensive tests for the early detection of many chronic diseases, have proved to be a relatively rapid and effective method of presumptively identifying major chronic impairments.

This Division has participated in screening programs through the loan of chest x-ray equipment to 10 community hospitals and, in 1 instance, with a grant-in-aid for technical personnel. Among 37,478 persons x-rayed, as reported by 15 hospitals, 13 percent had presumptive positive findings as follows:

Cardiovascular disease	41 percent
Tuberculosis	6 percent
Tumor	6 percent
Other pulmonary	47 percent

Hunterdon Medical Center continues to assume a greater share of the demonstration multiple screening program. Of 2,410 persons screened, presumptive abnormalities were recorded from the following tests:

Chest x-ray	170
EKG	70
Blood pressure	300
Diabetes	60
Hematocrel	440

State Employees Health Program

Screening tests for diabetes were made available to state employees again this year. This program is carried on by this Division in cooperation with the State Personnel Council.

Three thousand two hundred and one employees participated in the blood testing program, of whom 78 were positive reactors. Dreypaks were returned by 473 individuals of whom 5 were positive reactors. Details of this screening program are included in the diabetes section of this report.

Looking Ahead

Health agencies in their never-ending effort to devise and apply effective methods of preventive medicine have grown concerned with the overall health problems of a community of individuals. Emphasis should be placed on the health problems of the community as a single entity rather than a composite of different individuals in various stages of health. Methods of prevention, therapy and rehabilitation may be effectively applied within the community only through a skillful integration and administration of all the health resources. Ideally, the optimum physical, mental, social efficiency and well-being of each individual, young or old, rich or poor, may be reached through a comprehensive health service.

The activities of the Division of Chronic Illness Control, traditionally concerned with demonstration case-finding, coordination, and consultation, will also be directed to improve and integrate the health resources of the community so that every service for the "prevention, early detection and control of chronic illness and the rehabilitation of the chronic sick" may be available to every member of the community without unnecessary duplication of effort and greater economic burden.

Because of the great need and demand for services in the home, special efforts have been made to develop homemaker services throughout the State. "Homemakers" are mature women selected for their personality, dependability, good health, and special interest in working with families where there is illness in the home.

These workers have had chest X-rays and blood tests and are covered by workmen's compensation and public liability insurance. In addition to experience in their own homes, the applicants who have been accepted by the local committee receive a special training course. This is arranged with the cooperation of the Division of Chronic Illness Control, New Jersey State Department of Health, and the Extension Division of Rutgers—the State university. (We now have many graduates and teachers from this course.) The course helps them to adjust quickly to the family they are helping, to be familiar with special diets, child care, and the usual appliances. They cooperate as part of a team with the physician and nurse. There are now about 3,000 "homemakers" in the United States in organized programs, and over 1,000 of them are in New Jersey. The expenditures for all homemakers' services in New Jersey are now more than a half million dollars ($508,758) annually. Of this, 76 percent are paid for by the patient or his agent. The average cost per visit varies somewhat in different communities.

In New Jersey all the homemaker services are local, voluntary agencies. They are run by local, responsible, trained citizens through their own boards, with only guidance and technical assistance from the State. At present, 15 of the 21 counties in New Jersey have some such service.

Last year almost 250,000 hours of service were provided to 4,300 patients and their homes and families; 516 persons were discharged from hospitals because of the availability of homemaker service, and 296 were not institutionalized because of the availability of homemaker services.

Patients with heart disease and strokes, homes with new babies, postoperative care, accidents, cancer, aging, arthritis, diabetes, cataracts, et cetera, were served in roughly that order. Many of these were much happier, because they were in their own homes, surrounded by their loved ones.

The families served by the homemakers present all of the constellation of the problem of the chronically ill and aging. Here are two brief, actual cases, and I quote the homemaker's notes:

Age 66—Parkinson disease operation. Patient ready to leave the hospital would have to go to nursing home if homemaker could not come in to help her. Husband is able to continue work since wife has homemaker to care for her and the home.

Age 81; husband 83—cardiac and old age complications of husband. Need homemaker to tidy house and prepare meals. Patient is unable to do the usual daily pickup and cooking. Homemaker is taking care of the household tasks and preparing the meals. The family is eating well and is able to remain in their own home and together with this help.

Using Federal and State dollars, the division of chronic illness control also has in operation, for example, these services designed particularly to improve the care of patients in nursing homes:

(1) Three full-time nurses and two visiting nurse associations, all with special training in rehabilitation, are working directly in nursing homes for the purpose of developing rehabilitation aspects of patient care.

In other words, these people go out to the various nursing homes and give them periods of instruction in their own nursing homes.

(2) Regular training courses are conducted at the hospital center at Orange for the training of nurses in rehabilitation.

That is one of the things the department has been greatly interested in.

(3) A course for administrators of nursing homes will shortly be given by Columbia University, here in New Jersey, under the direction of the health department.

(4) Programs are in operation whereby patients may get comprehensive restorative and rehabilitative services in an organized way in a hospital, in nursing homes, or at home, depending on the need.

These are only examples of what I believe is a sensible, effective New Jersey system. Here government provides technical skills, leadership, and modest amounts of temporary grant-in-aid whereby local initiative can flourish and through which permanent, local programs adapted to the particular locality are nurtured and quickly become self-supporting and able to operate on their own. This is, as the declaration of policy of the Chronic Illness Act said, a real sharing of responsibility and a teamwork operation of doctors, hospital, voluntary agencies, dedicated citizens with only modest support from government.

I wish to acknowledge with thanks the aid of Dr. Roscoe Kandle, commissioner of health, and his staff in helping me prepare this data.

Senator WILLIAMS. Well, I certainly want to commend you, Doctor, for the work that you are doing with your advisory committee on chronic illness.

I think there are two or three facts, here, that we should underscore, because they show so much is being done in our State. Now, the fact that there are 3,000 homemakers in the entire country, and 1,000 of them are right here in New Jersey, is most significant; and the fact that 516 persons were discharged from hospitals because of the availability of this homemaker service.

Dr. PESSEL. That is correct.

Senator WILLIAMS. And I would judge that if it could be expanded further and made even more meaningful, some of the pressure on our hospitals could be relieved.

Dr. PESSEL. It is being expanded, not only here, but many of the other States have come here as visitors and as students and are carrying home the same structure that we have instigated here.

Senator WILLIAMS. Well, this is most encouraging, to know that our State is this responsive to one of the persistent problems of older people, chronic illness.

Dr. PESSEL. Thank you.

Senator WILLIAMS. Mentioning other States, we have borrowed a very distinguished resident from our neighboring Commonwealth of Pennsylvania, Mr. James Michener, who will be our next witness. Mr. Michener has kept people of all ages young at heart, and he has some advice for those of us who are in our fifties, to make them more

vigorous. The New York Times article of a month or so ago had, as I recall, two prescriptions for cardiacs—climbing the Himalayas and piloting jet aircraft at 20,000 feet at the speed of sound.

Do I recall correctly?

STATEMENT OF JAMES MICHENER, AUTHOR, RESIDENT OF TINICUM, BUCKS COUNTY, PA.

Mr. MICHENER. You do, sir.

It is very good to see you, Senator.

Senator WILLIAMS. I haven't seen Mr. Michener since we were together about a year ago on a political evening.

I commend you on your success.

Mr. MICHENER. My interest, Senator, in this problem stems from the fact that both because of my work in Asia and because of the fact that I married a very distinguished American citizen of Japanese ancestry, I am sort of thrown into two cultures in seeing this problem of the aging, and I think I may be in a position to assess the strengths and weaknesses of the two patterns these two large areas of the world have in caring for this problem.

Our own is rather well known; that is, the individual family of the older person quite frequently does not want the older person to live within the family, but makes an economic sacrifice so that the older person may live well in some other system, either in a home of her own, as in the case of my own family, or in some kind of group living, as in the case of some brilliant examples I have seen recently in Colorado and in Utah. That is our pattern.

The pattern in Asia is a radically different one. There, the family holds it as a responsibility to care for every member of the family until the time of death, and it is quite likely that the home you visit in Japan or China or southeast Asia in order to meet with a person of your own age, will also have people in their eighties and people just out of the cradle. The entire family lives together. And a great many of the problems that I have heard discussed here this morning and elsewhere simply do not arise under this system. If you are living within this system, it is your gravest responsibility to see that your parents and your parents' brothers and a very extended range of your relatives live either with you are right near you, and you assume full responsibility for them.

Government programs are not necessary under that system. Some kind of Government assistance is sometimes given, but it is the responsibility of every family to keep all of its members together, and care for them.

Now, this has certain advantages, obviously, in that the unit is kept together as a unit. The heartache of old age has certainly diminished in these countries.

There is a solidity of life experience which is very appealing to me. I have a feeling that the generations should work and live together. And I think that if one looks only at the externals, Senator, one comes to the feeling that the Old World way of handling this problem has many advantages over the way that we use.

But I believe that this is only a superficial judgment, because the weaknesses of the Asian system are manifold, and the strengths of our system are many, indeed.

To go to the weakness of the Asian system, the fundamental one is this: that because all of the generations live together in the family, the weight of family opinion rests more heavily with the older people than with the vigorous younger people. And it is not at all unusual, in Japan—or China, before the revolution—or in the other parts of Asia that I know, to have a man of 35 or 40 married to a woman, say, 3 or 4 years younger, who makes no decisions for himself at all, until the full family discussion is held, and they tell him pretty much what to do.

This is a constant inhibition of the younger and more vigorous members of the society. And I have talked with dozens of these men, and I know the very heavy burden that they are under; not an economic burden in taking care of their parents; this is simply an accepted fact that is never up for discussion.

I would like to stress that. I know in the case of my own family, there has recently been an instance where an elderly member needed some assistance. And to hear these Japanese people get on the telephone and talk for hours about how to handle this, and whose responsibility it was, and all of them fighting for the responsibility, but never a question as to the fact that it should be done, is very heartening indeed; and it moves me to think that there is a degree of spiritual responsibility there that we don't have.

But the other side of the picture is very destructive.

The strength of our system is that at a relatively early age, say, in the early twenties a man like you or me is thrown on his own resources. He sets up his own household with his own wife. He raises his own children. There is not that dead hand of the older generation on him. And I think that much of the energy that America has had and much of the vitality that our people have in looking for new ways and doing great new things stems from the fact that we do turn our people loose at a younger age and tell them: "All right. This is your life. You make it. You make the decisions. You rise or fall."

And as between the two systems—having thought about this a great, great deal, I think that our system is the preferable one. I think that young people should be turned loose. I think that the dead hand of the past generation should not weigh too heavily upon us. I think that families should start out in their own homes with a minimum of incumbents. And I think that the freedom of action and vitality that results is one of the great strengths of our Nation; and I would hate to see this diminish.

As a novelist, as a humanitarian, I can only say that it is tragic that we have not at the same time figured out some way to take care of our older generations more effectively. If we could do just a few things, there, I think that we could retain the strength of our system, and yet acquire the wisdom and the humanity of the oriental system.

Those things would be the kind of health care that we have been talking about, certainly housing, at an advantage for older people, certain kinds of group living, perhaps, group medical care, group

activity. If we could do those things, then I would think that we would have come close to achieving the best of the two systems.

Senator WILLIAMS. We are very grateful for your contribution to the hearings. This has been a recently created committee of the Senate. We are having hearings this fall in 29 cities in the country. In Philadelphia last week Senator Clark had a hearing. And it is our mission to find those ways where we can more effectively take care of the problems of older people within the system in which we live, which is pretty much a family-fragmenting system.

I would be interested in this: Is the Asian system of total family applicable both in rural and in urban areas of Asia?

Mr. MICHENER. In the rural areas, of course, it is almost universal. In the urban areas, it is much more honored than you would suspect. In Tokyo, for example, which I know quite well, a large number of the people I met live within a large family unit.

I recently had an investigation of some 35 women of 40 years old. I happened to be working on a problem like that. And in every instance, they came from a large, unified family. And of the 35 women—33 of them had older members of the family working with them in the kitchen and keeping the house going. So that even in large cities it is more common than it would be here.

Senator WILLIAMS. In this country probably it only persists as a system of living on our diminishing family farms.

Mr. MICHENER. Yes. And I think therefore that as a society—I don't say necessarily as a government, but as a society—we really ought to give attention to this problem.

Senator WILLIAMS. I was very much impressed this morning, in the city of New Brunswick. We went to an area where there has been regular public housing, and now, within the same area, they are creating a magnificent building of 60 family units for elderly people, elderly housing under the public housing program. And I can just imagine the happiness these folks will have when they are in their homes and look out these great windows and there are the kids in the playgrounds. They are part of all generations. I would imagine it should be a great success.

Mr. MICHENER. I am very strongly in favor of the approach from the housing angle, because our system will simply not permit us to have the large family unit that I know so well in Asia. It just isn't part of our system. And I have become quite convinced that it wouldn't be good if we could make it part of our system.

I think, therefore, that wise people take the system they have and try to perfect it and eliminate its discrepancies.

Senator WILLIAMS. Well, if we can make our housing programs more responsive, if we can have an insurance program for medical care, and if we can improve these programs that have been mentioned here, I would think that we will be working toward the noble objectives that you have addressed yourself to.

We are very grateful to Mr. Michener for coming over and being with us today.

Mr. MICHENER. Thank you.

Senator WILLIAMS. I thought I saw Mayor Joseph Regan of Edgewater in the audience a moment ago. Edgewater is quite a distance from Trenton.

We are grateful for your contribution to the hearings, Mayor Regan.

STATEMENT OF HON. JOSEPH REGAN, MAYOR, EDGEWATER, N.J.

Mayor REGAN. I would like you to meet Mrs. John Rosenberry. She is the director of our senior citizens program.

Senator WILLIAMS. Won't you be seated there at the table and give us the benefit of your experience with the program?

Mayor REGAN. Senator, I am going to be very brief.

We are happy to be here this morning; mainly to try to pass on to the committee the actual putting in operation of a senior citizens program at a local level, at a nominal cost, mainly through the cooperation between the local mayor and council and the senior citizens of our community.

Now, early in 1957, we conceived the idea of creating a senior citizens program in the borough of Edgewater. And rather than take up your time, Mrs. John R. Rosenberry is our senior citizens director, and she has a short statement that will take about 5 minutes, that she would like to read into the record, which is self-explanatory.

Senator WILLIAMS. Fine.

Mrs. Rosenberry, will you proceed?

STATEMENT OF MRS. JOHN ROSENBERRY, DIRECTOR, SENIOR CITIZENS PROGRAM OF EDGEWATER

Mrs. ROSENBERRY. The report of the Edgewater, N.J., senior citizens program:

We believe that the Edgewater senior citizens program is perhaps the first of its kind to be established in the State of New Jersey. Because others may be helped by knowing what we have done to keep the program moving successfully, we are glad to offer this committee a brief summary of our activities.

In the winter of 1957, Mayor Joseph F. Regan of Edgewater had the understanding of the needs of senior citizens, and the interest, to try to help them. He started the Edgewater senior citizens program in January 1957, by appointing an advisory committee of three prominent Edgewater residents: Mr. Alfred Koski, borough clerk, Mr. Edward Breen, postmaster, and Mr. William Wall, then school principal. Later the recreation director, Mr. Ray Colantoni, was added. Mayor Regan was a member ex officio. I, Mrs. John R. Rosenberry, myself a senior citizen, with many years experience in club and civic work, was appointed director of the senior citizens program on a part-time basis, to serve three afternoons and one evening a week. The members of the advisory committee served without pay.

The basic aim of the advisory committee was to help our older people help themselves, and to encourage them to believe that they still have a part in the life of the community, instead of feeling that they were "on the shelf." Membership was open to residents 50 years of age and older. The areas where we believed it was both possible and most important to help our senior citizens were employment, recreation, health, and counseling.

The members of the advisory committee met with the director one evening a week for 6 months to formulate and set in motion the principles and mechanics for an effective program. In the opinion of the director, this careful preparation, together with the firm and interested

sponsorship of the Edgewater mayor and council, have been largely responsible for the success of the program.

The report, in booklet form, which we prepared for the New Jersey Governor's Conference on Aging, held in Trenton on April 16, 1959, describes the steps taken to set up the program in Edgewater. A copy of this booklet is attached.

A vital first step was registration. Every senior citizen we knew of in Edgewater was sent a registration card that asked them to tell us whether they could use help in one or more of the areas of employment, health, recreation, and counseling. Out of Edgewater's total population of about 4,000 people, we have had nearly 200 senior citizen registrations.

First, we attacked the problem of getting employment, full or part time, for those who wanted it. Through our personalized employment and homemaker service, 35 applicants have been helped to find work. As one part of this effort, many families in town have been supplied with good help in caring for aged or chronically ill members of the family. Such placement of senior citizens interested in this kind of work gives us double benefit for the aims of our programs.

Second, we set up our recreation program, which also includes community services and crafts. The borough provided a meeting place in the centrally located Public Works Building; over the years we have transformed this into an unusually attractive clubroom. The club, which we call the Pleasant Valley Club, meets there on Friday evenings each week, every week of the year. There is a membership of 80. The four officers, a loyal and enthusiastic group, constitute the executive committee. They meet with the director once a month to plan events for the coming month. We have a variety of programs, including movies, speakers, parties at Halloween, Valentine's Day, St. Patrick's Day, et cetera, a turkey dinner at Christmas, bus trips, boat rides, and picnics. The bus transportation for three outings in the summer is provided by the borough.

Much time and effort is given to community services. Members collected 250 pairs of used eyeglasses for the Eyes for the Needy project. They have helped with Community Chest and Red Cross drives. The director organized a regular auxiliary hospital group of 16 members, which meets every Wednesday afternoon to make dressings and sew for Englewood Hospital. In the spring, they have a benefit card party and give $100 a year to the hospital.

We have an active crafts program. A sewing group meets once a week. We have had classes in hatmaking and jewelry work, and are just starting a class in painting.

The cost to the borough in maintaining this program has been small. Wherever possible, existing departments and facilities within the borough are utilized. The recreation director, the social welfare director, the department of public works, the board of education, and the board of health, have all helped.

Third, the problem of helping our senior citizens in the area of health has been a real challenge. We have had several health projects. During the past year our local school physician, who is also the doctor for the baby-keep-well service, volunteered his services several times to give physical examinations free to club members. He was

screening for heart conditions and high blood pressure. Some half dozen members were thereby alerted to their high blood pressure, and were advised about diet and medication. We believe this is an excellent example of preventive medicine.

Recently, with the cooperation of our local Lions Club in providing transportation, we took 28 members to Englewood Hospital for the glaucoma eye screening tests.

Fourth, in a wide variety of areas as needed by the individual senior citizen—for example, housing problems, social security questions, and so on—we have been able to give counseling, advice, and referral service.

We believe that these examples will show how, through local effort and local support, with the freedom to move in the directions our aged themselves demonstrate they require, and by getting the entire community to work with us—we have made our group's slogan, "Good Years for Our Senior Citizens," a reality in Edgewater.

Senator WILLIAMS. Thank you very much for this description of a magnificent program in Edgewater.

Has your experience been followed in many other communities, that you know of?

Mrs. ROSENBERRY. You say been followed in many other communities? I do not think it has been followed by any other community in our county, and I doubt very much if it has in the State, to the degree to which we have pursued it.

In certain areas I know that other Golden Age Clubs have received money from their town funds to aid in certain ways, perhaps, in recreation, or perhaps the town has provided a meeting place. But I do not know of any other town that has gone into it to cover quite as many areas.

Senator WILLIAMS. This record will be widely distributed all over the country, and I wouldn't be surprised but that many people will see some promise for their community through the experience in Edgewater.

There is one thing that ocurs to me. I must be getting pretty old and filled with nostalgia. It seems to me that older people could make a great contribution to the young people through a community history program of some kind. I have always felt that just the history I know of my town makes the day more meaningful and fuller, when you are in town, and I would think young people might well, in good numbers, like to hear from older people what the town used to be like.

Mrs. ROSENBERRY. I think that is very valuable.

Senator WILLIAMS. Is that pretty conservative and old-time thinking?

Mrs. ROSENBERRY. Not at all. We have had several such programs in our club, and the older people have brought in photographs, showing what our community used to look like when it was called Pleasant Valley, and have given us little stories about what they remember. and it has gone over very well.

Senator WILLIAMS. And this could be a contribution to the younger people in the community, this kind of experience?

Mrs. ROSENBERRY. I think it very well could be; yes.

Senator WILLIAMS. My kids don't believe it, but I tell them that milk used to be delivered by horse and wagon, and also ice, and plows were pulled by horses. Then they know I am old.

We are very grateful to you, Mrs. Rosenberry, and certainly to you, too, Mayor Regan.

Well, it is high time we got into controversy, around here. This has been a quiet and productive morning. I have a feeling that our next witnesses probably will give us the benefit of a clash of views, which will stimulate us now.

In lieu of adding a little sugar to our blood, we are going to start with Dr. Louis Wegryn, who comes to us from the Medical Society of New Jersey.

I know you are a forceful advocate, Doctor. I didn't go back over the files, but I think I have scores, maybe hundreds, of letters from you, over 7 or 8 years in public life. You have always stimulated my thinking, even though we didn't always agree with each other.

Dr. Wegryn, I might say, is one of the most prominent doctors in one of our finest cities, the city of Elizabeth.

STATEMENT OF DR. LOUIS S. WEGRYN, PRESIDENT-ELECT, THE MEDICAL SOCIETY OF NEW JERSEY

Dr. WEGRYN. Thank you, Senator.

Senators Williams, members of the subcommittee, I appear here today as the spokesman for the approximately 6,500 physician-members of the society who supply for the people of New Jersey—old and young—their medical and surgical care.

No group of people has a closer relationship to, or a truer interest in, the health and welfare of our older citizens than the members of the medical profession. The very existence of so many people who have passed the age of 65 is a matter of joy and pride to the physicians of this Nation. We do not regard senior citizens as problems. They are living testimonials of the affection and care—familial and professional—which through their lives they have enjoyed.

We want them, in dignity and propriety, to enjoy their added years. To insure that they do so, as physicians and as citizens, we feel called upon to assay the problems that confront them and to suggest just and adequate means of solution.

It is desirable at the outset to indicate precisely our position.

The members of the Medical Society of New Jersey, in common not only with other members of the medical and health professions, but also with all who are dedicated to the preservation of a sound character in our people and in our Nation, and to the maintenance of a sound and well balanced national economy, are for the following:

(1) The provision of adequate necessary medical care for all citizens, buttressed by our pledge that necessary professional medical care shall not be denied to anyone because of his inability to pay.

(2) The retention by the individual citizen—and of that citizen's family—of the basic, natural responsibility for selecting, arranging, and paying for his own necessary health care.

(3) The intervention of government to assist only those citizens who need health care and who cannot themselves—or through their families—pay the costs thereof. For this reason we support the principle of the Kerr-Mills law, and urge its implementation in New Jersey so that financial help to meet health-care costs will be available to those citizens who lack the means to pay those costs.

(4) The limitation and reduction of tax burdens upon individual citizens and their families, so as to leave to them the financial means of meeting their own responsibilities.

(5) The development and widespread utilization of adequate and economical private voluntary health insurance coverages as the best means of enabling individual citizens to make provision for the costs of their own health care.

(6) The maintenance at a minimum of Federal Government intervention and control. We hold that the assignment of responsibility for financing necessary health care should be in the following order: the individual citizen; the family; local voluntary agencies; local, county, State, and Federal government—each to take over only when the prior agent of responsibility cannot meet the need.

In consequence of what it is "for," the Medical Society of New Jersey is necessarily "against":

(1) Any policy or program that would relieve or wrest from the individual and the family the right and responsibility to be independent, self-sustaining, self-reliant, and free.

(2) Any policy or program that would so multiply burdensome taxes upon the individual citizen and his family as to deprive them of the financial means to retain and exercise those four fundamental rights and responsibilities.

(3) Any policy or program that would encourage government by means of an additional tax program at any level, to eliminate or supplant voluntary, free-enterprise systems of insurance coverage, or of any other fundamental business or service operation.

(4) Any policy or program that would deceive the citizens of this country into accepting the social security tax program—which the Supreme Court has so designated—as a traditional and sound insurance program.

(5) Any policy or program that would enlarge for government at any level entrance into and influence over the lives, rights, and duties of individual citizens—in short, any policy or program that would give to government the control and direction of the lives of citizens instead of reserving to citizens the control and direction of their government.

In consequence of the foregoing, the Medical Society of New Jersey disapproves and opposed H.R. 4222 or any other measure embodying its aims or principles because:

(1) H.R. 4222 would supply the health services embraced to all persons over 65 years of age, whether those persons are themselves financially able to provide and pay for such services or not.

This, we hold, is unjust and undesirable. It is our contention that individuals of any age who can provide for their own needs should be required and encouraged to do so, and should not be permitted to meet such needs at the expense of fellow citizens who, in many instances, are more financially straitened than those for whom the benefits are being supplied.

Any program which unjustly burdens one group of citizens with financial obligations in order to indulge undeservedly another more favored group of citizens is demoralizing to both groups of citizens and is hostile to the spirit and the economy of the Nation.

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(2) H.R. 4222 would change the fundamental character of social security benefits by substituting services for the dollar benefits that have prevailed from the beginning of the social security program until now. If adopted, therefore, H.R. 4222 would establish a precedent that could lead to the discontinuance of all dollar benefits to social security recipients, and to the provision of food, shelter, fuel, clothing, and varied services instead. All this would involve a violation of the fundamental original agreement, in accordance with which the covered citizen, by paying into the program, could look forward to receiving dollar payments, after his retirement, to enable him to defray the expenses of his daily living.

Under this new concept, the social security beneficiary would be denied the freedom of selecting and paying for commodities and services of his own choosing and, like a witness incompetent, would be expected to take whatever it was decided he needed and should receive.

(3) H.R. 4222 (or any other measure embodying its aims or principles) is discriminatory legislation because:

(*a*) It discriminates in favor of those citizens having social security entitlement—and, as we have shown, with unjust indifference as to their really needing help or not. At the same time, unlike the Kerr-Mills law, it discriminates against those citizens whose lives were such as never to permit them to earn entitlement, but whose distress is such as to place them in dire need of help.

(*b*) It discriminates against wage-earning individuals—married and unmarried—who are called upon through increased social security taxes to supply each year, by their compulsory contribution, the revenues necessary to meet the constantly increasing disbursements for benefits of all kinds.

As such, H.R. 4222 is a soak-the-poor tax proposal, which—since no exemptions can be claimed, no matter how many dependents a man may have—will levy on every working man or woman's earnings in order to raise the moneys necessary to meet annual expenditures. Viewed in this light, the social security program will prove to be a tax monster, devouring and crushing the average wage earner as income tax never has or should.

(4) H.R. 4222 is an inadequate and misleading measure because its benefits would still involve serious out-of-pocket expenditures for those recipients who really need to be helped. Under it, every hospitalized patient would be required to pay $10 a day toward hospital charges for the first 9 days. This poses for the recipient a total potential liability of $90—a formidable amount to the needy beneficiaries who deserve to be helped, but an amount of relative inconsequence to the well-to-do recipients who, in justice, should pay their own way.

It is the position of the members of the Medical Society of New Jersey—speaking as citizens who love their country and as physicians whose lives are dedicated to the welfare of their fellow citizens—that H.R. 4222 or any other measure embodying its aims or principles is unsound and unacceptable legislation because it ineffectually and inadequately prescribes for the condition it is seeking to ameliorate.

We believe that citizens of the United States should want to develop and should be encouraged to develop their own strengths and to make their own security; and we believe that it is the duty of government

to maintain a social, political, and moral climate that will enable and induce them to do just that. We believe that it is the task and duty of the Federal Government to keep taxes down and to prevent inflation to achieve this salutary climate.

We believe that no one should be denied necessary medical services because of inability to pay.

We believe that it is properly the responsibility of society and government to help those citizens who are in need to attain the necessities which they cannot themselves provide.

We believe that only those in need should be thus helped, and then only to the true measure of their need.

We believe that any policy or program which would encourage in citizens an attitude of dependence where independence should exist, and would impart to government responsibilities and powers of determination and action which should be reserved to the citizens, is subversive of the character and true good of both our citizens and our country.

That is why we oppose H.R. 4222 and the principles for which it stands.

That is why we support and urge instead the implementation and utilization in New Jersey, and throughout the Nation, of the principles embodied in the Kerr-Mills law.

I thank you.

Senator WILLIAMS. Well, Doctor, I can assure you there is one freedom we are not going to tax away, and that is the freedom to disagree.

I wonder, before I inquire specifically of you, would you care to sit there while Joel Jacobson testifies? I read in the advances in the paper that he is going to deal with this queston, too.

Dr. WEGRYN. I will be glad to.

Senator WILLIAMS, Do you want to stay there?

Dr. WEGRYN. Yes; I will stay.

Senator WILLIAMS. I didn't give your pedigree, Joel. You are executive vice president of a new creature in this State, the New Jersey AFL–CIO. How old are you now? A month old? Three weeks old?

STATEMENT OF JOEL R. JACOBSON, EXECUTIVE VICE PRESIDENT, NEW JERSEY AFL–CIO

Mr. JACOBSON. Three weeks and a day and a half.

Senator WILLIAMS. You are looking in very good health.

Mr. JACOBSON. Thank you very much.

Senator WILLIAMS. The baby is prospering.

Mr. JACOBSON. I think it is appropriate perhaps that you asked me to sit at the same table with Dr. Wegryn.

Senator WILLIAMS. He is probably your doctor but not your political advisor.

Mr. JACOBSON. The position is appropriate, since I have the left microphone, speaking politically, of course.

The subject under consideration is a vast subject, and as you know has already been subjected to vast studies.

Out of concern for your ears, I will try to avoid repeating a good deal of the material that I know you know, as it has already been presented to you.

Within the context of the subject at hand, the labor movement is concerned primarily, Senator, with many problems, but directly, for today's discussion, with problems of income maintenance and its direct relationship to health.

I think the labor movement has demonstrated this concern on many occasions previously, certainly by vigorous and enthusiastic support of social security legislation when it was first enacted; a support that was given then freely, not like so many organizations who opposed it then and only reluctantly accept it now.

And secondly, we have manifested our concern through our collective bargaining process, as we have tried to institute pensions to supplement social security.

And I may say that the history of the labor movement in this State and in this Nation has shown that concessions came—like teeth that were extracted—from employers many times after long and bitter strikes. Nonetheless, this indicates our concern for this problem.

I am afraid that even as vigorously as we have acted in this field, as it cuts across the community of all of the aging, it was hopelessly inadequate. Our statistics indicate that the number of aging people who are covered by union-negotiated pension programs amounts to 3 percent in this State. I think this plight becomes rather evident when one can understand some statistics that have been presented to me by the city of Newark.

Of all the aged in the entire State, three-fourths receive an income of $75 a month. Within the city of Newark, 25 percent of the married couples over 65 have an income of under $125 per month. And within the respective category of aged widows an even larger amount receive less than $50 a month, hardly enough to finance lavish trips to Florida, as you can well see.

Fortunately, the aging are not ghettoized. If they were to be ghettoized, we would be able to see at one fell swoop a center of appalling poverty, hardly consistent with the affluent society of which we are all so proud.

And so, with regard to income maintenance, our solution is simple, and you have recognized it. We would urge continuing increases in the benefit structure of the social security program.

Now, the problems of poverty that are sustained by the aging are compounded manifold when you discuss them in relationship to the health problem. One-third of the income of our elderly individuals is used for medical expenses. This morning's New York Times contained a report by the New York State Department of Public Welfare, which indicates that in New York City 24 percent of the total welfare payments were for medical expenses. For the State, excluding the city, 36 percent of the total welfare benefits were for medical expenses. And they point out the disparity, attributing the difference to the fact that the city of New York has many clinics which the aging can visit.

I don't think New Jersey has much to offer in this respect.

When you analyze the plight of the aging with regard to their health problems, it is the increasing costs of medical care that causes such a heavy burden.

I have a few statistics here to substantiate that position.

Using the years of 1947 and 1948 as a base—these are statistics from the Bureau of Labor Statistics—with the base as 100, we notice the following increases. In all prices for the index, the index is now 128, as against 100 in 1947–48. For medical expenses, the index is 161. For hospital insurance, the index is now 185. And for hospital room rates, the index is now 234.

In addition to this, the question of hospital insurance becomes important. The support of the medical society for the private voluntary hospital insurance plans has been emphasized. Obviously, we think as many people as can participate in these programs should do so. But I think an appalling lack of coverage is demonstrated when I tell you that, of the people over 65 who are currently at work, 93 percent have no coverage under the voluntary hospital plans. And those who are covered find that only one-sixth of their actual costs are covered.

And so I am afraid that, nice as it sounds, the voluntary plans do not do the job that must be done for our aging citizens.

Just in our own State, something was highlighted in the press yesterday, where New Jersey permits a company which offers a health insurance policy to refuse to renew this policy; the sole option is exercised by the company itself.

In New York, they have the Metcalf Act that forbids the dropping of such insurance after a 2-year period. And I think that our State should investigate the possibilities of putting a similar ban on the unilateral option to be exercised by an insurance company.

Now, we have heard a good deal about Kerr-Mills. I know you, Senator, are personally very knowledgeable on the specifics of it, and I am not going to get involved in the specifics, but rather will take a general approach.

Kerr-Mills, stripped of all the fancy verbiage, is nothing more than direct relief. Direct relief—nothing more than that. And its impact in New Jersey, even if we somehow should get it through the State senate—a process that I have been unable to determine as to how you do this—it would not solve the problem. As a matter of fact, even the consideration of the Kerr-Mills bill in the Congress has had its distressing adverse effect upon the State of New Jersey, because we already had in the State a commission appointed by the Governor which studied for 3 years and recommended State legislation to set up a program of care for the medically indigent. This was sidetracked because of the fact that Congress was then considering some sort of bill, and nobody knew what it was going to be, and the hope was that something could be done for New Jersey. Obviously, what came through was this relief program, and New Jersey, as a result, has suffered because of it.

Now, it is perfectly obvious, as you have already indicated, that we are vigorously and enthusiastically in opposition to the medical society's position on the question of medical care through the processes of social security.

We are vigorously and enthusiastically in support of such a program, for many reasons, not the least of which is that if the current trend of the inadequate coverage of health needs for the aged continues, our entire social security program becomes meaningless. The

theory under which it was set up originally was to provide economic independence for the aging citizens. As a matter of fact, this is not so primarily because of the health needs of the aging citizens.

Now, Senator, I am fully aware of the fact that we need no "hard sell" upon you for support of H.R. 4222. We know your vote. I would, however, if I may, for just a few moments, like to analyze the opposition and the tenor of the opposition in perspective of history; because far too often we try to isolate ourselves in the present time alone. And I think the opposition of the medical society to medical care through social security must be viewed in the context of its total opposition to the very principle of social security.

I would like to read to you just four statements that were made by responsible, respectable agencies and individuals in the mid-1930's, when the social security principle was being discussed in the Congress of the United States, and ask you if these statements, applying to the principle of social security alone, do not sound highly reminiscent of things we heard here within the last 10 minutes.

A quotation from the National Association of Manufacturers, with reference to the social security bill being considered in Congress in 1935: "It will facilitate ultimate socialistic control of life in industry."

One of the great benefactors of American industry, Mr. Alfred Sloan, at that time president of General Motors: "Industry has every reason to be alarmed at the social, economic, and financial implications. The dangers are manifest. It will undermine our national life by destroying initiative, discouraging thrift, and stifling individual responsibilites." So says Mr. Sloan.

A recent colleague of yours, Congressman John Taber, of New York: "Never in the history of the world has any measure been brought in here so insidiously designed as to prevent business recovery (and) to enslave workers."

Congressman James Wadsworth, of New York: "This bill opens the door and invites the entrance into the political field of a power so vast, so powerful, as to threaten the integrity of our institutions and to pull the pillars of the temple down upon the heads of our descendants."

As you can obviously see, every one of these dire threats came true.

I would like, also, to indicate the nature of this opposition, and—to make this as apolitical as possible—quote you from the platform of one of the great political parties of our Nation in the year 1936. In reviewing the social security legislation, in 1936, this political party had this to say: "Real security will be possible only when our productive capacity is sufficient to furnish a decent standard of living for all American families and to provide a surplus for future needs and contingencies. For the attainment of that ultimate objective, we look to the energy, self-reliance, and character of our people for our system of free enterprise."

I take the time to burden you with these particular quotations to indicate to you that this is the same type of opposition to medical care for social security that we are hearing today; and that the individual himself, regardless of his particular circumstances, must find the way to take care of himself.

I would like to be so bold, Dr. Wegryn, as to add a footnote to your talk, and obviously you would disagree with this. I think I would, if I were presenting your remarks, at the conclusion say the

following: "In short, let us return to the law of the jungle," because in my opinion this is precisely what the Medical Society and the American Medical Association are recommending.

Now, I understand—I speak not especially of you, Doctor, but of the organization—I understand the desire to uphold a high moral climate. And we support this as a general goal; but I have to enter a rather vigorous dissent: to compel the aged people to continue to have the conditions imposed upon them in the future that have been imposed upon them now is not moral. It is immoral. And of course the medical profession makes the point that a person who requires medical care will not get that medical care because of his economic condition. I must say that this implies, and from it I infer, that the medical profession thereby uses the Robin Hood system of collecting fees. You take from the rich to pay for the poor. And I must say that this is not particularly moral, either.

Now, the opposition to medical care through social security, coming from the organized medical profession, contains some smear attacks that I think are rather childish, sophomoric, and immature. The lebel "socialized medicine," of course, is hurled quite frequently, and I lose patience with the inability to argue without impugning one's patriotism. But it is true that the medical profession has opposed this particular plan. It opposed social security when it was first presented to the Nation. And I am afraid that within the State of New Jersey the Medical Society of New Jersey itself has done a number of things on which we have a great deal of difference with them.

I don't know whether I should burden your time, Senator, but there is another situation here that I think indicates the general nature of the Medical Society of New Jersey in its opposition to organizations that are desirous of providing better health care for citizens.

I want to differentiate, now, between medical care and economics. If there was something wrong with me, Dr. Wegryn, I would be delighted to put my life in your hands as a medical man. Whatever pill you told me to take, I would take, because I trust you in the sphere of medicine. However, I must say I have found on the record your judgment in economics leaves much to be desired. And on this score, I would dissent with you rather vigorously.

In the State, if I may, just for another instance of the opposition of the medical society, the labor movement was anxious to meet one of the problems that has been faced by our members in the field of medical-surgical benefits. Invariably, in far too many cases, when a person came out of the hospital he would find that in addition to the bill that was alleged to be paid by medical-surgical, by Blue Shield, he would get an additional cost to be paid to the doctor. And this became a rather alarming trend. And we decided to do something about it. And so we investigated the possibilities of setting up, under the State's nonprofit law, a competing organization for Blue Shield. And we found an alarming trend of activity on behalf of the medical society, because we found that before any agency could set up such a competing plan to Blue Shield, we had to have our board of trustees and the plan itself subjected to scrutiny by and approval of a medical society having 2,000 members and having been in existence at least 10 years.

And I scratched my stupid head to try to find out: What is the reason for these 2 figures, of at least 2,000 members and being in existence over 10 years. And it came to me one bright morning by the purest quirk of circumstances that the only medical agency in the State that had 2,000 members and had been in existence at least 10 years happened to be the Medical Society of New Jersey.

And so we were in the position of wanting to set up a competing organization to Blue Shield, which as you know is owned by the medical society, and we had to go to them for approval.

That is like Macy's going to Gimbel's, saying, "Can I go into business in competition with you?"

If by some miracle this approval should have been granted, it could be withdrawn on 24 hours notice. So any agency setting up such competition, and having contracted to accept premiums and to pay benefits, would be required to pay all those benefits, even though, therefore, they could no longer accept any premiums, because the medical society had withdrawn its approval.

Now, one final word, with regard to the medical-surgical question—and by the way, this cuts across, of course, the problem of aging. And we are talking now about the coverage, the inadequate coverage, provided by the voluntary plans. We have another cute system in the State. And the medical society will go before the commissioner of banking insurance, or rather the Blue Shield—I am sorry; Freudian slip; the medical society and Blue Shield are both the same—before the banking commissioner of insurance, and ask for an increase in the rates to be charged for medical-surgical insurance.

Now, the commissioner has no authority to do anything but listen, and, based upon the information presented to him, set the rates. He has no corresponding ability to control the fees being set by the Blue Shield. And so what happens is a very simple process. The fees are increased by the doctors themselves, of course, and as the fund is thereby depleted because of the higher fees, they must go before the commissioner of banking insurance and ask for higher rates. There is no question that the fund is being depleted, because it is being paid out in such fees.

We have objected to this rather vigorously. We made the point that if you are going to have a sane and sound system, perhaps the best thing to do is to give the commissioner of banking insurance an opportunity to set the fees as well as the rates.

I make these points, Senator, again with no personal reference to Dr. Wegryn, because we are actually concerned with the opposition from the medical society, to what we consider to be their Neanderthal attitude toward this particular problem. And I don't know who said it, but it certainly strikes in my mind as an appropriate characterization, that it seems to me that we must drag the medical society into the 20th century no matter how they scream or kick.

I would like to close with just two quick references to two other problems. And these are the need for homes for nursing care, about which you have heard a great deal, and finally, the question of discrimination by employers against aging workers.

The definition of aging is becoming more and more expansive by the employers. We all welcome—I know many of us welcome—the advent

of a new administration from the generation born in the 1900's, and those of us who still consider ourselves slightly young appreciate this accent on youth.

I would like to point out, however, that if President Kennedy should find the need for looking for a job in New Jersey, he would run into problems; because industry is not hiring people over 40 years of age. And this reminds me of the slogan one of our great leaders of labor has used many times, that you find yourself "too old to work and too young to die."

We were asked at the administration's inaugural not to ask what the country could do for us, but what we could do for our country. I would suggest, Senator, that we have something in this State, that could be applied to 46 other States—3 others already have it—and that is our system of temporary disability insurance. I take no great pride in pointing out that this system of TDI in New Jersey, also California, New York, and Rhode Island, was in effect in Germany in 1880, under the regime of the Iron Chancellor, Bismarck, certainly no agent of the Kremlin. It appears to me that our Nation could certainly consider a program of national temporary disability insurance.

Our last statement is: You will shortly be hearing from Mr. Edward Gray, a representative of the United Automobile Workers Committee on Aging Citizens, and I would commend to your attention the excellent work being done by this council and particularly by Mr. Gray.

Senator WILLIAMS. We thank you, Joel Jacobson, and Dr. Louis WeGryn. I had a feeling that there would be some disagreement, and I am glad that Dr. Wegryn could be here to hear the other side.

Do you have any comments, Doctor?

Dr. WEGRYN. Well, I have a few comments to make.

I didn't expect this arrogant approach against the doctors, but in view of the fact that we are back in the "jungle days," that means that we have to take the Constitution of the United States and the Bill of Rights and scrap them.

We no longer have a free enterprise system. This country is in debt for over $300 billion; or at least $290 billion, to be exact, and is going in debt for more.

About direct relief payment, under the Kerr-Mills bill * * * the social security tax program is called by many an insurance. The Supreme Court ruled, back in May 24, 1937, that social security is a tax and not an insurance. Then, in 1960, on June the 20th, in *Nester* v. *Flemming*, the Supreme Court again ruled that social security is not an insurance but a tax.

The money in social security goes into the U.S. Treasury and is not covered by any real reserve. A commercial insurance company such as the Prudential Insurance Co. of America, Inc., in New Jersey would have to have at this time, by law, at least $360 billion in reserve.

The Government has only $22 billion in Government bonds, paying interest on those. Furthermore, for a few years the Government was paying out more in social security than it was taking in.

Now, with reference to the medical-surgical plan, and with reference, after all, to the fact that doctors give services, I think we are entitled to have our own organization. I, as a doctor, and as a representative of the State society, will never meddle into the problems of the labor union. Say it is a bricklayer's union. I am not going to

try and have the bricklayers lay more bricks in 24 hours or 8 hours than they do. It is none of my business. I feel the same way about our business; it is our responsibility.

After all, we have a problem. We are giving people good medical care, and no one can deny it. I can take you any place, and I have done a lot of charity work, myself, and I am willing to do it; but I am not willing to participate in a Government plan.

Senator WILLIAMS. Well, we could have a very fruitful discussion here for a long time. Of course, we have time problems, and we have two other witnesses scheduled for this morning. I hope we can get to them.

I think there are just two things I would like to raise with you gentlemen.

First, doctor, your statement implied, throughout your statement, and specifically in some areas, a concern about the tax, and a tax increase, if this social security program is expanded to cover medical costs. Now, we have a representative of most of labor here, most of organized labor in the State. I guess that is a correct statement. Or at least a sizable group. Now, the working people will be part of the community that would pay the increased tax. And I will call it a tax.

And I wonder if you would address yourself to the attitude of the working people that you speak for, Mr. Jacobson, and their attitude on paying an increased tax of a quarter of 1 percent, I believe it is, for this kind of program.

Mr. JACOBSON. We disagree with the interpretation placed upon the Supreme Court by Dr. Wegryn, in that as far as we are concerned, this is an insurance program. We are anxious to participate in the insurance program as to the payment of the premium, the tax on our wages. And it is the soundest, simplest, principle of insurance, that when you are well and working, you contribute to a fund. When you are sick, unproductive, and there is any other reason why you can't be productive, you draw from that fund.

I see nothing wrong with this principle of insurance.

Senator WILLIAMS. How about the bulk of the workers you speak for? What is their attitude?

Mr. JACOBSON. Their attitude is to support social security and its current method of financing.

Senator WILLIAMS. That is the impression I get from people that come to me, that working people are particularly anxious to have this program and are willing to pay the tax.

Dr. WEGRYN. Until the young population realize they have to pay taxes and their children will have to pay taxes until we get a complete paternalistic state.

Senator WILLIAMS. Another thing, on your page 2:

> The development and widespread utilization of adequate and economical private voluntary health insurance coverages as the best means of enabling individual citizens to make provision for the costs of their own health care.

We have heard this for years, a decade or so, that this is the best way. We have heard this from not only the medical societies but other groups, too. But on the record we know this isn't happening. We are not, through voluntary private economical health insurance, meeting the coverage of medical care for older people.

Dr. WEGRYN. I agree, if you accept Mr. Jacobson's figures. The insurance council has different figures. I practice medicine, and believe it or not, the old people are doing better in paying their hospital bills than the younger people. And I refer you to a survey made at the Alexian Brothers Hospital in Elizabeth, N.J. Old people even give money to the younger people, because they are mortgaged to the hilt and have everything on credit. They are "financed," and are paying for all these "benefits," and soon they will have too much to pay. Certainly, if we have confiscatory taxation, we shall lose our freedoms, whether freedom of speech or religion or anything else.

Senator WILLIAMS. I hate to stop on that awfully pessimistic note.

Mr. JACOBSON. Perhaps I can change it to say I disagree with every comma, every dotted "i" and crossed "t."

Senator WILLIAMS. Thank you, gentlemen. You have been most cooperative.

We have a tour that must be underway at 12:30. We have two scheduled witnesses, one from the chamber of commerce.

Is Mr. Dikovics here?

Mr. DIKOVICS. Yes.

Senator WILLIAM. Then we have Mr. Gray. Are you going to be here this afternoon?

Mr. GRAY. I will stay if you can't get me on this morning, yes.

Senator WILLIAM. How about you, Mr. Dikovics?

Mr. DIKOVICS. I am available.

Senator WILLIAMS. All right, then, if you wouldn't mind, because we have people that we have to see. They are waiting for us, on this field trip.

Can you take care of it now, in 5 minutes?

STATEMENT OF EDWARD GRAY, INTERNATIONAL REPRESENTATIVE, REGION 9, UNITED AUTO WORKERS

Mr. GRAY. I don't think it will take me much more than that.

Senator WILLIAMS. All right. Fine.

Mr. Edward Gray, international representative, region 9, United Auto Workers.

Mr. GRAY. Senator Williams, we are particularly pleased to have this chance to appear before this committee and discuss this subject with you, because we have been very much concerned for several years now at the status of our senior citizens in the State of New Jersey.

I think I might begin by saying that we are now well into the second decade of the operation of UAW's pension and retirement program. The first major breakthrough with the large automobile companies in our industry establishing the UAW's program was in 1949. And since that time, the early program, as I am sure you appreciate, has been improved and enlarged in many ways.

There are currently more than 100,000 UAW members drawing pension benefits under UAW-negotiated plans. What you may not understand is that a very large percentage of that number have retired from plants in the State of New Jersey, and most continue to reside in the State.

As our retiring members left the plants and were absorbed full time in the communities in which they lived, we came to learn a great deal more about the problems of older people who are their friends and neighbors in the community.

We learned, for example, that older citizens in New Jersey are poorly housed, poorly maintained, and poorly tended during periods of sickness and ill health. They are frequently neglected and ignored in a nation whose very wealth and opulence is sometimes a major national problem.

Social security benefits have been increased several times within recent years. They remain, however, woefully inadequate. The minimum social security benefit of $40 per month, or less than $10 a week, is not really enough to sustain life in this day and age.

The average social security benefit paid in the State of New Jersey amounts only to $72 a month, or less than $17 a week. And a retired industrial worker is slightly better off. The average for retired industrial workers is $81 a month.

The wife of such a worker, on the average, draws $44 a month for a combined income of $125 a month, or a total of $1,500 a year.

Now, the inadequacy of a $1,500 yearly income is illustrated by the budget recently published by the Bureau of Labor Statistics for a retired couple. That budget, providing for a "modest but adequate" level of living, required more than $3,000 a year, or almost exactly double the social security income of the average couple in this State.

The modesty of this budget, the fact that it is really a modest budget, is pointed up by the fact that the wife must do all of the cooking, all of the cleaning. That is, there is no money available to eat out or to have anyone else do any cleaning; and only $7.86 a year is provided for reading materials, radio, TV, movies, and all other entertainment of that character. Likewise, no provision is made in the budget for payment of life insurance premiums.

Within the State of New Jersey, the UAW has established a council on aging and retirement. Membership in the council consists of delegates who are officers of UAW local unions in the State.

I would like to pause, if I may, Senator, just to introduce some of the officers of the council who are with me this morning, and who are very vitally concerned with this problem.

The first is Rocco Palmero, who is the president of the council, and also president of the Trenton local of the United Automobile Workers.

Along with Rocco is Jack Pollison, Fred DeMino, Fred Judge, and I think one other, Ray Donnelly, is here with us this morning.

In any event, the purpose of this council is to work with UAW members as they retire and to help them become integrated in the community life.

We fully recognize that the needs of our members in the fields of housing, health, income maintenance, and social and cultural development during retirement, cannot be met except as they are met for all retired members of the community.

Working with our members as a part of the total community has impressed all of us with the enormous needs that exist among our senior citizens in every phase of their life.

Our experiences and findings concerning our senior citizens have been confirmed by every serious study made of these problems within the State.

Look at the results of the survey made in Paterson, N.J., under the direction of the New Jersey Division on Aging. More than 1,300 persons, aged 65 and over, were interviewed on a random sample basis, designed to show how older people in that community live.

The Paterson survey showed that a majority of retired persons in that community rely exclusively on social security for their income. The current level of social security payments, of $17.20 a week—this was the average, with many of them receiving far less. The survey also showed that some 14 percent of the older persons relied solely upon their children or upon welfare for their income. They had no social security or other resources.

It further showed that 10 percent live in cold-water flats, and that 17 percent had no one to care for them in cases of illness.

One of the most disturbing statistics of all showed that almost 20 percent were just plain lonely, and had no opportunity to meet people of their own age. It is impossible to meet with any large group of old people in any community in this State without hearing heart-rending details of difficulties caused by lack of housing and lack of medical care.

Similar problems may exist for other groups in our society. The need becomes especially acute, however, for older people, because, as the figures quickly show, incomes are drastically reduced during this period of life. Moreover, a good, warm home becomes even more meaningful to you physically and psychologically as you get older; and of course we all recognize —at least I think we all recognize— that our need for health care increases with our age.

This is the way, though, that our older people live. The pity is, as we see it, that we can easily do so much better, and have not. The remedy, in most cases, that is needed, is obvious. Better housing, higher social security minimums, including provision for health care, as a part of social security, have already been discussed. These are really the economic problems of old age.

And I would like to take just a moment of the committee's time today to discuss with you the possibility of some leadership in the field of human relationships for the aging.

I want to suggest to you a program of Federal sponsorship of activity centers for older people. Activity center programs not only help senior citizens to overcome problems of loneliness, but can provide for educational and cultural development of a person during retirement. Some counseling services are generally available through such centers.

The value of these services to a person who is entering into an entirely different way of life during a period of retirement can hardly be overestimated.

I think I ought to say that our experiences with our own members, who are I think probably as well informed or possibly even better informed than the average person who is retired, do underscore this fact.

I am sure you appreciate that life in the shop, or a community of life, develops inside an industrial plant, where the people take their

problems and discuss them with their stewards or their union officers and committeemen, or at times possibly the foremen, or maybe on occasion even the personnel director of the company.

In any event, upon leaving the shop, they enter into an entirely different relationship with the community, and there is in most cases no place for them to go, or at least the customary avenues for discussions of their personal problems are closed to them. They are cut off from them. And this is the reason why we think it is so extremely important that we develop in some organized fashion a new method of their living with their problems in the community life after retirement.

I had the pleasure of hearing Mr. Sidney Spector, who as you know is Dr. Weaver's director in charge of housing for the elderly, on two occasions during the last 2 weeks, including his appearance before this committee a week ago today. On both occasions, Mr. Spector delivered a very learned address, in which he called for the provision of facilities for activity centers in every housing program. He made the point that it is entirely possible for older people to be lonely and badly adjusted to life, in new housing as well as in old housing, and certainly our experience would underscore the wisdom of his remarks.

It is necessary, however, that we recognize that more than a conference or a meeting room, complete with chairs and card tables, including even, as he suggested, room for kibitzers—more than that is required.

Our experience has shown that activity centers are truly meaningful only if they are planned and supervised and given leadership by competent professional staff. Given decent facilities and good leadership, activity center programs can make for a much more meaningful life for older citizens.

A wealth of experience concerning the possibilities of such programs may now be seen in such places as neighboring New York. New York has had a program of State leadership and assistance to local communities and voluntary groups in the development of activity centers. The State offers assistance on a matching fund basis of 25 cents per senior citizen aged 60 and above in each community. Although the total sums of money expended on this program have not been great, proportionately, that is, this limited assistance has been sufficient to galvanize many communities and voluntary groups into developing organized programs for older citizens.

I think I should also note that the concept of the New York State program visualizes that the State assistance will gradually decline, and as the centers are developed and as communities and community groups become able to assume leadership and responsibility for making them go, the amount of State assistance it is anticipated will decline proportionately.

Unfortunately, the activities of the various States in the Nation in giving leadership in this field vary widely. Many States offer no help at all, and no leadership in the establishment of activity centers for older persons.

Miss Jean Maxwell of the National Council on the Aging in New York City will soon release a comprehensive survey on activity centers and group programs in the Nation. Her survey shows that such centers vary from small, barely organized groups meeting in such

places as a converted comfort station to large-scale, organized programs involving many thousands of dollars of State and local funds, and in which tens of thousands of people participate regularly.

Miss Maxwell's study also illustrates the many services which can and should be rendered to our aging population through properly developed activity center programs.

Her study and our experience cause us to urgently request that you consider the sponsorship of a Federal program that will give leadership and help in this area. Your sponsorship of such a program will encourage States, local communities, and voluntary groups to develop activity centers, to help to fully integrate older people in the community, and to be a major contribution toward meeting what we regard as a great national need.

Now, then, I have not dwelled at any length upon the matter of medical care for the aging under social security. Our position, as Mr. Jacobson has described it for you, and as I am sure you have had others speak to you about, is, I am sure, pretty well known.

On the subject of housing, however, New Jersey's position with respect to providing housing for the aging, your remarks earlier this morning are correct. Per capita, New Jersey does stand in the forefront of the Nation.

I would suggest, however, that this does not really show how well off we are, but really how badly off the Nation is as a whole.

It is our experience, as Mr. Lumley, Jack Lumley, whom you may remember from the meeting of last week, said, that the demand for such housing in the State greatly outruns the amount of the housing available. He told, as you recall, of how in Asbury Park, in this beautiful housing development they have now, they have on file a thousand applications for a hundred units that are available. This is, as we have known it, the story all over the State.

One final word, on the matter of the provision of the activity centers.

I listened with some interest to the remarks about the problems of mental health of older people. And I am firmly convinced, as I have heard others testify from time to time, that there is nothing we can do that will be more meaningful in preserving and maintaining and improving the mental health of older people than to develop this kind of organized program where they could enjoy themselves throughout this period of their lives.

Thank you very much, Senator.

Senator WILLIAMS. We thank you, Mr. Gray, and your organization, which certainly is pioneering some promising new programs for older people. We will certainly review the record that you have made, here, and we will see how we can follow up some of your ideas.

Mr. GRAY. Thank you.

Senator WILLIAMS. We will recess now until 2:15.

(Whereupon, at 12:45 p.m., the hearing was recessed, to reconvene at 2:15 p.m., the same day.)

AFTERNOON SESSION

Senator WILLIAMS. Mr. William L. Lauderdale, representing the New Jersey Farm Bureau.

You have been very patient through the morning. You are the leadoff man this afternoon.

STATEMENT OF WILLIAM L. LAUDERDALE, REPRESENTING THE NEW JERSEY FARM BUREAU

Mr. LAUDERDALE. Senator, I have here a statement prepared by the New Jersey Farm Bureau. I wonder if it might not expedite matters a little if we simply presented the statement to you, without reading it.

Senator WILLIAMS. All right.

Mr. LAUDERDALE. And then I could take a few minutes to present some of my personal views.

Senator WILLIAMS. This represents the attitude of the New Jersey State Farm Bureau. That will go for the record.

(The statement referred to follows:)

PREPARED STATEMENT OF THE NEW JERSEY FARM BUREAU

My name is William L. Lauderdale of Lambertville, N.J. I am here to present a statement on behalf of the New Jersey Farm Bureau, which is a private organization of 6,000 farm families in 20 counties of New Jersey.

I wish to state first of all that I have been an active farmer for the most of my 75 years. I have been a member of farm bureau for nearly 40 years, and have been active in many ways in many farm groups and agencies. I am still actively engaged in operating my own farm of 140 acres near Lambertville.

As I am sure you know, we farmers are often criticized for our insistence on a maximum of independence in our personal and business lives. Most of us still believe that our great country was built on the ideal of maximum responsibility in the individual citizen to manage his own affairs and to earn a living for himself and his family. We still believe this ideal is valid. We believe the principle of the "least government is the best government" is valid and is just as right today as it was in the days of Jefferson and Franklin.

In general, we believe that it is primarily the responsibility of the individual and his family to plan for and take care of the many problems that come with advancing age. We are not in favor of any program that lessens this primary responsibility.

However, we do recognize that government, at its various levels, does have some important roles to play in the whole gamut of problems that face our retired people and older citizens. When the time arrives that a family finds it impossible to cope with some of these problems, the next responsibility lies with his own local government, working in close cooperation with the many private charitable groups that also have a vital role to play. In some instances, assistance of State government is necessary; but we believe that the Federal Government should be brought into the picture only as a last resort.

This hearing today is concerned mainly with Federal and State programs dealing with problems of the aged. We would like to present our views on some of the programs already underway and some that have been proposed.

In general, we are concerned about the growing tendency to dump our problems in the lap of the Federal Government. We believe our Federal Government had already grown too large, already is involved in too many programs, already has more power and control over the daily lives of individual citizens than is healthy for the continuation of our form of government. We believe that the growing trend toward a welfare state is dangerous if we want to preserve our traditional American ideal of the dignity and worth and responsibility of the individual.

Take housing for example. Why do we now consider it the role of the Government to provide housing for people? Are we headed for a system where our old people will be salted away in old-age housing centers, where they will associate only with old people? For myself, and for most of the older people I am acquainted with in the farm areas of New Jersey, nothing could be more horrible. We recognize there are people who seem to want this type of program; but we still are not in favor of such housing being provided through Government programs of any kind. If this is a need, we feel it can be met through normal channels of private enterprise.

In the field of medical care, we believe that enormous strides have been made to cover over-65 people in the private, nonprofit hospitalization and medical care plans. Here in New Jersey, as a direct result of efforts within farm bureau, more

than half of the 6,000 member families of farm bureau have subscribed to a voluntary, prepaid group hospitalization and medical care plan. Many more are covered by plane of their own choice. A high percentage of our over-65 farm people are already covered by these voluntary plans; and there will be an increasing percentage in years to come.

The great majority of farm people are opposed to any compulsory medical care or hospitalization service plan as a part of the social security program. We definitely fear that it would be the first giant step toward overall socialization of medical care in the United States.

If the Federal Government wants to be of real assistance to solving the problems of adequate medical care for people over 65 years of age, it might develop some sort of plan to assist and encourage the private, nonprofit plans in the form of reinsurance, or in some other way. It is true that these private plans have been slow to provide full coverage for people over 65 years of age. Naturally, they have to consider the best interests of all the subscribers to their service.

For a number of years, we have been supporting legislation in the U.S. Congress to provide better incentives for self-employed people to invest their savings to better plan for their own retirement. Such a program is provided for in H.R. 10 (Keogh bill), which has passed the House of Representatives at least twice; but has always been held up in the Senate. This bill would make it possible for self-employed people, like farmers, to set aside a certain part of their annual earnings, invest it is annuities of various kinds, and not pay income taxes on such income until the annuities mature. This is a good example of legislation that would encourage people to plan for their own old-age security, and not be as dependent upon Government. It should be passed without further delay.

In the past, retired people, and old people living on fixed incomes have suffered the worst from the cruel tax of inflation, which has almost constantly eaten away at the purchasing power of the dollar, until our dollars will not buy very much. The most constructive thing Government could do is to provide better management of fiscal affairs so that the value of the dollar can be stabilized. This means an end to deficit financing, and a lessening of the constant pressure for ever-increasing Government expenditures.

We believe that the State and Federal Governments should interest themselves mainly with providing adequate medical care for the indigent. The Congress has already provided a significant step forward in this regard with the passage of the Kerr-Mills law. Unfortunately, the New Jersey Legislature has not passed the needed legislation in this State so that we can participate in this new program; but we feel sure that such legislation will be passed in the near future.

The New Jersey Legislature has taken a most significant step in relieving the property tax burden on property owned by people over 65 years of age. In our way of thinking, this type of legislation is far superior to raising more taxes to provide more governmental services for more people. The New Jersey old-age tax program aims at making it possible for more old people to provide for their own needs through their own retirement incomes.

We realize that the easy thing to do is to pressure the Government to do more and more things for us. We must always keep in mind that Government services must be paid for from taxes paid mostly by ordinary citizens. The more we ask of Government, the higher our taxes will be.

We appreciate the opportunity of presenting this statement on behalf of our Farm Bureau members in New Jersey.

Senator WILLIAMS. You are going to offer your separate views, now?

Mr. LAUDERDALE. Well, my separate views will coincide pretty well.

Senator WILLIAMS. Probably a little more liberal, though, in tone.

Mr. LAUDERDALE. I thought that would expedite the hearings somewhat for you.

Senator WILLIAMS. All right. That is fine.

Mr. LAUDERDALE. I am just an ordinary farmer.

Senator WILLIAMS. Where do you live?

Mr. LAUDERDALE. I live at Hunterdon County, Lambertville, on a dairy and poultry farm of 140 acres, where I was born some 75 years or so ago. I am still living there.

Senator WILLIAMS. Fine.

Mr. LAUDERDALE. I have been a member of the New Jersey Farm Bureau ever since it has been in existence, and have held offices in the Farm Bureau, and most agricultural organizations of the State, and many other places.

I might say also that I am municipal clerk of my home township, and have been interested in government in that wise and have been there for 50 years. That is a long time.

We generally, and farmers generally, like to remain independent, and so on, as you probably know. And we believe that we should do things for ourselves at home and through our home government, just as much as possible; that we should not move out of our home unit into our county, State, and Nation except as we meet up with problems that cannot be handled by us.

In my lifetime there was very little opportunity to do what we can do today to build up programs that take care of sickness, accident, and so on. With our hospitalization program, both Blue Cross and many other kinds of programs, we believe it is possible for most folks to build up an acceptable program and take care of themselves. With social security, we believe that helps some, and there are a couple of things about social security that I personally believe ought to be changed.

When we get to be 72, which I am, and past, we may get social security without any consideration as to our income otherwise, and we believe that might apply to 65 as well as to 72.

We are opposed, as farmers, to socialization of medicine. We feel we should be able to take care of that ourselves.

Also, in the State of New Jersey, as you probably know, from a taxation standpoint, among our older folks, the legislature and the Governor were good enough to initiate a program which gives our folks over the age of 65 an exemption of $800 of their property from taxation. We believe that is a real help, and it only applies, of course, to residents of the State with incomes of $5,000 or less, but we believe that is a real help, and we think that Federal help along that line for income tax purposes would give us more than our double exemption from income tax, which would be another point that would help the elderly people of our State.

We also are rather opposed—although I was very much pleased this morning to hear somebody make reference to the New Brunswick situation with their home for the aging over there, where it was put in, in relation to where other folks live; because I know farmers wouldn't like to be put in a ghetto by themselves.

Senator WILLIAMS. I notice in your statement that this observation is made: Are we headed for a system where our old people will be salted away in old-age housing centers, where they will associate only with old people?

Mr. LAUDERDALE. That is what I am saying.

We feel that is something well worthwhile.

One other thing, and this may not be true from a national standpoint. I don't know. It is quite prevalent in New Jersey, where, with our planning and zoning, we are setting up regulations which require a $25,000 house being built on an acre of land or more, and I feel personally that there ought to be a place where these folks could

build a house that cost maybe $8,000 or $10,000, where these old folks could live out in the country comfortably.

Senator WILLIAMS. In other words, reduce the lot size requirement?

Mr. LAUDERDALE. And the house size, also.

Senator WILLIAMS. I am in foursquare agreement on that with you. We are trying to encourage higher density living in that connection.

Mr. LAUDERDALE. There are many more things, Senator, that I might have in my mind; but we believe that the Federal Government should only concern itself with things that we cannot do on a local level. Thank you.

Senator WILLIAMS. Well, I also want to observe that in your statement you say, "In the past, retired people and old people living on fixed incomes have suffered the worst from the cruel tax of inflation." Now, some dramatic statistics were given us this morning, that probably the area of greatest inflation is in the area of medical costs.

Mr. LAUDERDALE. Well, that is possible, you know. However, maybe we have to expand insurance programs on that.

I might say, if you don't mind a personal word from me—I don't like to bring personal things in—I spent some time in our local hospital with what they said was a little heart affliction, you know, last winter, and I stayed there until my Blue Cross and Blue Shield ran out, and then I said, "Now, you had better send me home." So I have got to stay out of the hospital for the rest of this year, or else it is going to cost me hospitalization.

Senator WILLIAMS. Well, the best way for you to stay out of the hospital is to play tennis, and if you broaden the racquet, probably the Governor would like to have you two fellows over for tennis this afternoon.

Mr. LAUDERDALE. That may be so, although I probably have to be a little careful.

Those are just a few observations from a fellow who has studied these things all his life.

Senator WILLIAMS. Well, we are always glad to have the Farm Bureau's ideas, and particularly glad to have your own personal observations.

Now we will go back to the list. We got the cooperation of Leslie Dikovics of the chamber of commerce, this morning, and now we will hear from him.

STATEMENT OF LESLIE J. DIKOVICS, CHAIRMAN, SOCIAL SECURITY COMMITTEE, NEW JERSEY CHAMBER OF COMMERCE

Mr. DIKOVICS. Thank you, Senator.

Senator WILLIAMS. We appreciate your cooperation.

Mr. DIKOVICS. Senator Williams, my name is Leslie Dikovics. I am assistant controller of Walter Kidde & Co. of Belleville, N.J. I am also chairman of the Social Security Committee of the New Jersey State Chamber of Commerce, and I appear before you today in behalf of that organization.

In accordance with the desires of this committee, as expressed in your invitation for me to appear today, I shall summarize the content of our prepared statement and request that the chamber's full statement be entered into the record of this hearing.

Senator WILLIAMS. We will be happy to receive your full statement.

(The statement referred to follows:)

PREPARED STATEMENT OF THE NEW JERSEY STATE CHAMBER OF COMMERCE

This statement is respectfully submitted to the Senate Special Committee on Aging on behalf of the New Jersey State Chamber of Commerce. Oral testimony, based upon this statement, will be presented by Mr. Leslie J. Dikovics, assistant controller, Walter Kidde & Co., Inc., of Belleville, N.J., and chairman of the Social Security Committee of the New Jersey State Chamber of Commerce.

The announcement of this hearing indicated that the subject matter which will be discussed is Federal and State programs and relations in respect to the aging. This statement will dwell primarily on one aspect of that subject: the provision of medical care for the aged.

The New Jersey State Chamber of Commerce believes that adequate medical care should be available to all the aged. This is a sound and desirable goal which, we believe, is accepted by everyone. Thus, it seems to us, the differences in viewpoint revolve about the best method or methods of attaining that generally accepted goal.

In 1960, the Congress provided what we believe is the best public means to supplement private efforts toward that end when it enacted the Kerr-Mills bill, H.R. 12580. On the other hand, the creation of a new federally-controlled program for health care benefits in conjunction with the OASDI program, or any similar proposals for old-age health care where control is vested in the Federal Government, is a move we vigorously oppose. It is our firm belief that such a drastic modification of the social security system is neither necessary nor desirable to assure reasonable health care protection for aged persons.

The American system of voluntary health insurance has accomplished a great deal toward reducing the health-care cost problem for millions of the Nation's aged citizens. According to reliable estimates, about half of the Nation's 16.6 million aged are now covered by private hospitalization insurance. And such coverage will continue to grow.

Other forces are also at work. Current health-care protection is extended nationally to 2.3 million aged persons under State old-age assistance programs. About 1.5 million aged persons are entitled to health care protection under other programs, or do not want health-care protection. In this category are included veterans, medical practitioners, members of religious groups, the well to do, etc. And much commendable activity is taking place to cover with protection the great majority of the remaining aged population under the Federal-State assistance program for the medically indigent aged—the Kerr-Mills program.

There are several other factors at work which should tend to bring about even more favorable results, and thus reduce the problem of health care costs even further. Expanded social security coverage means more individuals will be eligible for benefits and the higher benefits being paid means a better ability to finance health care. The higher earnings during recent years means future beneficiaries will have accumulated greater savings than did those retiring in the past. Private pension plans have grown markedly in scope and in benefit amounts.[1] More employers are helping their employees to pay for medical care after retirement. Insurance companies, Blue Cross and Blue Shield, and the medical profession are sharply intensifying their efforts to provide more health care protection for the aged on terms more in keeping with the requirements of the aged. Thus, it would be a mistake, in our judgment, for the Congress to enact a permanent Federal program of health care benefits to meet what is admittedly, a temporary problem.

For these reasons, we believe it is unnecessary to sharply alter the philosophy underlying the social security program by adding the provision of health care benefits. Furthermore, we believe this would be most inadvisable for it could produce results that in our opinion would be highly undesirable.

It would constitute the first provision for services, as distinguished from cash benefits under the Social Security Act. This is a sharp change in philosophy. In effect, Congress would be deciding how a part of each social security beneficiary's monthly benefit should be spent.

A federally controlled program under social security would violate and alter the basic concept of OASDI. OASDI covers three risks—old age, death, and total and permanent disability—that occur only once, are easily identified, and

[1] Details of a study of private employer benefit programs in New Jersey are included in a supplement at the end of this statement.

involve substantial but fixed liabilities. The need for medical care can recur innumerable times, cannot be easily determined, and the liability therefor is almost without limit. Therefore, it is patently untrue and unsound to say that OASDI provides a tried and true precedent for the socialization and federalization of medical care. It is significant that other recurring risks such as workmen's and unemployment compensation, temporary disability insurance, and medical care under categorical assistance programs are provided under State programs rather than a federally controlled program. Also, in connection with recurring risks of medical care there is a vast range of individual preference as to desirable coverage and the way it is obtained. A federally controlled program would stifle such individual preferences.

Any provision for hospital or nursing home care is not a simple matter, and the characteristic that makes this kind of program so impractical for the Federal Government is the nature of the risk involved. In hospital and nursing home care, there is no objective test of when such care is needed. Almost anyone beyond 65 with any infirmity could be given better care in a hospital or nursing home. In retirement or survivorship, the eligibility conditions are largely beyond the control of the claimant, whereas hospital or nursing home care depends to a substantial degree upon the volition of the claimant and the decision of the attending physician with control or regulation of the latter specifically disclaimed in recent legislation. Once eligibility to retirement or survivorship benefits is established, the cost of benefits is specified in dollar amounts in the statute. In hospital and nursing home care, the cost of benefits would depend upon charges and the decisions made by medical personnel, again, with a disclaimer of control or regulation.

The administration of the program and the attendant control of costs by a Federal agency would inevitably lead to efforts to regulate hospitals, nursing homes, and the attending physicians who certify their patients for such care and result in intrusion by a Federal agency into the personal medical problems of the individual aged.

Such a program, we believe, would lead to massive Federal intrusion into all phases of medical care. It would affect adversely three important personal and private relationships: the doctor-patient, the hospital-patient, and the doctor-hospital relationships. Standards and controls for both medical administration and medical services which would be centrally promulgated and administered by nonmedical and nonprofessional individuals could only lead to serious deterioration in the quality of medical care made available. Such a program with a single standard for medical administration and medical services would disregard geographical or regional differences in costs. This could led to excessive benefit costs, excessive administration costs, and to the overutilization of free medical services.

A federally controlled program has been advocated on the ground that the cost of health services contemplated are modest, predictable, and controllable. The initial benefits suggested in legislation this year are modest—understandably so—because the immediate objective is to establish such a program. However, in our opinion, the current cost estimates of the initial program are understated. Moreover, irresistible pressures for greater benefits and services and for the expansion of such coverage to the working population under age 65 and to those over age 65 who are not eligible for OASDI benefits would make the future extension of the program unavoidable and even more costly.

The foregoing reasons demonstrate that a federally administered and controlled program is not the best approach in solving the problem of old-age medical care.

We believe that the States and local communities are better judges of the needs of their citizens and how these needs should be met. We therefore support the Kerr-Mills approach as the appropriate and superior solution to the problem. It covers those who need protection and it permits greater and fuller medical care coverage. It goes beyond the basic needs of the destitute and recognizes the problems of the medically indigent aged persons. It does not provide a single system of benefits with attendant controls and standards. It provides for local judgment as to need and as to protection afforded—it permits a State program to be tailored to fit the needs and resources of the individuals, the community, and the State. It provides the stimulus for continued expansion of private insurance coverage. It provides the opportunity for greater economy and the prevention of abuses. It is the best possible solution in avoiding disadvantages pointed out above.

We believe that Congress was wise in selecting this course of action last year and we are greatly impressed with the quick action taken by the States to implement this program. We know of no other Federal-State grant-in-aid program which has had such speedy approval in such a limited period of time.

In just 1 year since the Kerr-Mills approach was adopted, 23 States have passed acceptable implementing legislation to establish a program of assistance for their medically indigent aged. There are five additional States where no legislation is required. Together, these 28 States have over 10 million aged persons, or 62 percent of the Nation's aged population. Similar legislation is pending in a number of other States, including our own New Jersey. We foresee a potential coverage of 75 to 80 percent of the Nation's total aged population this year under the Kerr-Mills approach.

We believe that the States are measuring up to their responsibilities, and that the problem of old age medical care will be satisfactorily solved through the operation of existing law. And the country can gain experience in the solution of medical care problems without irreversible legislation embodying past mistakes such as encouraging hospitalization in order to establish eligibility for benefits.

In conclusion, we would like to emphasize that we are not here in opposition to health care for the aged. However, we do oppose the provision of health care benefits under the OASDI program. We support the Kerr-Mills program as an adequate and appropriate solution to the problem of medical care for the aged. With its diversity as between States, it permits accommodation of regional differences. With its case-by-case administration, it permits consideration of individual needs and greater control over costs. Also it permits a greater control in respect to overutilization of medical personnel and facilities. More adequate individual care can be provided at lower total cost because of the smaller number involved. Private insurance and prepayment programs will not be curtailed or supplanted.

SUPPLEMENT

SUMMARY OF 1960 SURVEY OF PRIVATE EMPLOYER BENEFIT PROGRAMS IN NEW JERSEY

As a part of its contribution to the overall effort on behalf of the aging and aged in New Jersey, the New Jersey State Chamber of Commerce in 1960 conducted a survey of private employer benefit programs and plans. This project was undertaken because little information was available on a statewide basis regarding privately financed benefit programs and plans for employees after retirement. The survey was completed in August 1960.

PROCEDURE

A questionnaire designed to develop basic facts about private employer benefit programs in New Jersey was sent to 1,475 member companies in the State requesting information on their employee benefit programs. Replies were received from 36.5 percent (538) of the companies, a response considered to be good for a questionnaire of this kind. The responding companies currently employ more than 406,000 New Jersey workers. In addition, 32,993 former employees of these companies are retired and currently receiving pension benefits.

SUMMARY OF FINDINGS

The replies show that the large majority of persons currently employed by the responding companies will have the benefit of pension, hospitalization insurance, medical-surgical insurance and group life insurance available to them on

GROWTH OF BENEFIT PLANS

Most significant is the tremendous growth which the survey reveals has taken place in the availability of benefit plans among the reporting companies.

Today, for example, 70.8 percent of these companies have a pension plan for regular full-time employees but in 1950 only 43.9 percent had a pension plan. and in 1940, this figure was only 13.5 percent. In other words, availability of pension programs among the responding companies increased more than threefold in the decade 1940-50, and nearly doubled again in the last decade.

Insofar as the respondents' employees are concerned, 94.4 percent today will have pension benefits available to them upon retirement whereas, in 1950 only 79.8 percent were covered by a pension plan and in 1940 the figure was only 42.4 percent.

Similarly, with respect to hospitalization insurance coverage, 94.9 percent of today's employees will have hospitalization insurance available to them after retirement. In 1950, only 42.6 percent had such an advantage and in 1940 it applied to only 17.5 percent. Today, 75.5 percent of the companies have hospitalization insurance coverage available to retired persons. In 1950 it was available through only 27.3 percent of the companies; in 1940, through only 5.1 percent.

In the field of medical-surgical insurance, 93.4 percent of the respondent's present employees will have medical and/or surgical insurance coverage available to them after retirement. In 1950, only 32.1 percent had such coverage while in 1940 only 3.3 percent had this advantage. Presently 72.9 percent of these companies have medical and/or surgical coverage available for retired employees. In 1950 this figure was 19.9 percent; in 1940, only 2.6 percent.

The oldest of these benefit programs is, of course, group life insurance. Today 97 percent of the respondent's employees will have group life insurance available upon retirement. In 1950 and 1940 the figure was 76.5 percent and 63.3 percent, respectively. Of the responding companies, 84.2 percent have group life insurance available to their employees upon retirement. In 1950 and 1940 this figure was 62.1 percent and 34.6 percent, respectively.

PENSION BENEFITS

When pension benefits are combined with the primary benefit under the Federal social security program, current experience shows that 50 percent or more of the employee's final wage is replaced in 19.3 percent of the companies having such plans; 33⅓ percent to 50 percent of the final wage is replaced in 47.6 percent of the companies; and 33⅓ percent or less is replaced in 17 percent. Of the companies with pension programs 16.2 percent did not respond to this question. If it is assumed that the distribution of wage replacement in the companies failing to respond would correspond to that in the responding companies, the distribution of final wage replacement would be as follows:

Pension benefits combined with primary benefits under the Federal social security program replace 50 percent or more of the employee's final wage in 23 percent of the companies; 33⅓ percent to 50 percent in 56.8 percent of the companies; and 33⅓ percent or less in 20.2 percent.

Based on current experience, companies with long-established pension programs generally provide a higher percentage replacement of the employee's final wage while companies with newly established pension programs generally provide a lower wage percentage replacement. As these newer pension programs mature, i.e., when employees covered accumulate longer service credits and thereby qualify for larger benefits, the percentage of final wage replacement in future years will automatically increase. Thus, without any change in the pension programs of these companies, the percentage of final wage replacement in future years will tend to increase beyond the 50 percent level for more individuals and fall away from the level below 33⅓ percent.

HOSPITALIZATION AND MEDICAL-SURGICAL INSURANCE

Group hospitalization insurance may be continued for former employees after retirement through a group continuation plan, through a conversion privilege or through some combination of both methods. Of the companies which make coverage available to retired persons, 46.8 percent provide hospitalization insurance coverage through a group continuation plan, 47.8 percent through a conversion privilege and 5.4 percent through both methods.

Of those companies that continue hospitalization insurance coverage for retired employees, 87.7 percent also have such coverage available for the retired employee's dependents.

Similarly, for medical-surgical insurance coverage, of the companies which make coverage available to retired persons, 47.4 percent provide medical-surgical insurance coverage through a group continuation plan, 47.4 percent through a conversion privilege and 5.4 percent through both methods.

Of those companies that continue medical-surgical insurance coverage for retired employees, 87.5 percent also have such coverage available for the retired employees' dependents.

Regarding the cost of these benefits to retired employees, 38.6 percent of the companies pay at least part of the cost of their hospitalization-medical-surgical coverage.

GROUP LIFE INSURANCE

Group life insurance also may be continued after retirement. Of the companies which make such coverage available to retired persons, 40.8 percent provide group life insurance through a group continuation plan, 46.6 percent through a conversion privilege and 11.5 percent through both methods.

CONCLUSIONS

The remarkable growth of private employee benefit programs clearly indicates that the position New Jersey employees find themselves in upon retirement is constantly improving. More and more individuals each year, after retirement, have available in varying degrees the hospitalization, medical-surgical and life insurance protection that they had as active members of the labor force. In addition, a constantly increasing number will receive pension benefits upon retirement and the amount of these benefits will increase as the newer pension programs mature. Therefore, it follows that some of the problems confronting the present aged in New Jersey may not be problems for the future aged in our State. This should be a basic consideration to any long-range planning to meet the needs of New Jersey's senior citizens. Moreover, it would seem incumbent upon those who are now seeking remedies for problems of the present aged to take cognizance of the basic tenet that long-range, permanent governmental programs should not be established to meet short-run needs.

The State chamber survey reveals the tremendous progress being made through private initiative to improve the economic security of retired persons. Therefore, we urge that governmental legislative and administrative action at the Federal, State or local levels should encourage private, voluntary efforts and be directed away from compulsory, unsound and uneconomic measures.

Mr. DIKOVICS. The announcement of this hearing indicated that the subject matter which will be discussed is Federal and State activities in the field of problems of the aging. My testimony will dwell primarily on one aspect of this subject—the provision of medical care for the aged.

At the outset let me emphasize that the New Jersey State Chamber of Commerce believes that adequate medical care should be available to all the aged. This is a sound and desirable goal which, we believe, is accepted by everyone. Thus, it seems to us, the differences in viewpoint revolve about the best method or methods of attaining that generally accepted goal.

In 1960, the Congress provided what we believe is the best public means to supplement private efforts toward that end when it enacted the Kerr-Mills bill, H.R. 12580. On the other hand, the creation of any new federally controlled program for health care benefits in conjunction with the OASDI program, or any similar proposals for old age health care where control is vested in the Federal Government, is a move we vigorously oppose. It is our firm belief that such a drastic modification of the good purposes of the social security system is neither necessary nor desirable to assure reasonable health care protection for aged persons.

The American system of voluntary health insurance has accomplished a great deal toward reducing the health care cost problem for millions of the Nation's aged citizens. According to reliable estimates, about half of the Nation's 16.6 million aged are now covered by private hospitalization insurance. And such coverage will continue to grow.

Other forces are also at work. Current health care protection is extended nationally to 2.3 million aged under State old age assistance programs; another 1.5 million aged persons are entitled to health

care protection under other programs, or do not want such protection. Expanded social security coverage and benefits, the growth of private pension plans and higher individual earnings during recent years have provided greater individual ability to finance health care.

Last year the State chamber surveyed private employer benefit plans in New Jersey. Our survey covered over 500 companies employing more than 400,000 employees. We found that the large majority of persons employed by the responding companies will have the benefit of pension, hospitalization insurance, and medical-surgical insurance available to them on retirement.

Our survey also revealed:

That over 70 percent of the companies had a pension plan; and that 94 percent of the employees covered in the survey will have pension benefits available to them on retirement.

That over 75 percent of the companies made hospitalization insurance available to their retired persons, and such insurance could be continued by 95 percent of the employees after their retirement.

Similarly, with respect to medical-surgical insurance, about 73 percent of the companies make this coverage available to employees upon retirement, and over 93 percent of the employees could enjoy such protection.

All of these facts lead us to the conclusion that it would be a mistake for the Congress to enact a permanent Federal program of health care benefits to meet what is, admittedly, a relatively short-term problem.

Furthermore, we believe that sharply altering the philosophy underlying the social security program by adding the provision of health care benefits would produce results that in our opinion would be highly undesirable.

For example:

It would constitute the first provision for services, as distinguished from cash benefits under the Social Security Act. This is a sharp change in philosophy.

In effect Congress would be deciding how a part of each social security beneficiary's monthly benefit should be spent.

A federally controlled program under social security would violate and alter the basic concept of OASDI.

Irresistible pressure for greater benefits and services and for expansion of such coverage to the working population under age 65, and to those over 65 who are not eligible for OASDI benefits, would inevitably result.

Such a program would lead to massive Federal intrusion into all phases of medical care.

We believe that the States and local communities are better judges of the needs of their citizens and of how these needs should be met. This is why we support the Kerr-Mills approach. We consider it to be the appropriate and superior solution to the problem.

The Kerr-Mills approach provides help for those who need protection. It permits greater and fuller medical care coverage. It recognizes the problems of the medically indigent aged persons, thus going beyond the basic needs of the destitute.

It is not confined within a single system of benefits with attendant controls and standards. It allows for local judgment as to need, and

as to protection afforded. It permits a State program to be tailored to fit the needs and resources of the individuals, the community, and the State.

It provides the stimulus for continued expansion of private insurance coverage. And it provides the opportunity for greater economy and the prevention of abuses.

In just 1 year since the Kerr-Mills approach was adopted, 23 States have passed acceptable implementing legislation to establish a program of assistance for their medically indigent aged. There are five additional States where no legislation is required. Together, these 28 States have over 10 million aged persons, or 62 percent of the Nation's aged population. Similar legislation is pending in a number of other States, including our own New Jersey. We foresee a potential coverage of 75 to 80 percent of the Nation's total aged population this year under the Kerr-Mills approach.

We believe that the States are measuring up to their responsibilities and that the problem of old age medical care will be satisfactorily solved through the operation of existing law.

In conclusion, let me again emphasize that the State chamber is not here to express opposition to health care for the aged. We consider the Kerr-Mills program and expansion of private insurance coverage as an adequate and appropriate solution to this important problem, and our opposition is directed solely to the provision of health care benefits under the OASDI program.

Those are my comments, Senator, on the statement as we have submitted it, here. And if you have any questions, I would certainly be glad, if I can, to answer them.

Senator WILLIAMS. Well, on the question of the extended coverage through private insurance of medical costs for older people, it was described to me at lunch today that the cost of that coverage is going up and the coverage is being reduced. The days of hospitalization, for example, are being cut back. Do you have any information on this trend?

Mr. DIKOVICS. I have no specific information on that, other than that it reflects the normal increase in hospitalization costs. The hospitals have to meet that cost. The insurance programs have to be tailored to provide funds, again, for this purpose.

Senator WILLIAMS. But it works against the problem of meeting the cost of medical treatment for older people. I believe it is true that the need for hospital care, for example, is greater among older people. It must be, when, in our older years, the major illnesses occur. So as the need is increasing, the private insurance coverage is going down, decreasing.

Now, you see, this is just working against the need. It is not meeting the need. It is defeating.

Mr. DIKOVICS. I don't have any statistics, Senator, to show that, but I have some doubts that the quality of coverage or extension of coverage is decreasing. I think that there is a great deal of improvement in private insurance plans. I see it in various companies in New Jersey. There is I think to a great degree an extension of coverage, as to time and types of coverage.

I agree costs have gone up, and costs in many cases are the result of improved hospitalization and medical treatment; not necessarily the

quantitative value of those treatments. I think we are all enjoying a far greater degree of better medical care than we enjoyed before.

Senator WILLIAMS. Well, Mrs. Harger told me that. I hope she doesn't mind if I mention that. She will be speaking at the end of this meeting, and maybe she will address herself to that problem, that is one that is extremely bothersome to us.

Mr. DIKOVICS. Senator, if the costs increase—and I think perhaps they may increase, because of the improved value and quality of medical and hospitalization coverage—I think that cost would increase regardless of the type of coverage that is provided to pay for it; whether the coverage be under the Kerr-Mills and private insurance, or whether it would be under the Federal social security program. I don't think either program necessarily controls the cost of medical care.

We do feel, however, that the medical care program, under the Kerr-Mills approach, is the most effective for administrative purposes and cost purposes, and in that way we feel it is more efficient and less costly than it would be under the Federal social security program.

Senator WILLIAMS. The Kerr-Mills approach, of course, is a welfare approach, a requirement of demonstration of indigency before there is any coverage under it.

Mr. DIKOVICS. That is correct. It is a demonstration of need; which to me I don't think is objectionable. We find many aged people who are willing to contribute to their share of medical care. These State programs under Kerr-Mills can be tailored to suit the requirements of the individual States. The States have made a great deal of progress in respect to that. The point at which they set the financial resources or assets of any individual is, again, a matter of State choice. We think it should remain there.

Senator WILLIAMS. There is just one other thought on this that I think has some validity. We know the illnesses in our later years are more costly for a variety of reasons than illnesses in our earlier years. Now, it seems to me that this would suggest to me that if medical care could be put on its own insurance program, this, taking the high-risk, high-cost illnesses out, away from the private companies, would allow private companies to insure more illnesses of more people in their earlier years, probably at less cost, if you take the high-cost older age illnesses and put them under a separate program.

Mr. DIKOVICS. I don't quite agree with you, Senator.

Senator WILLIAMS. I don't see how you could demonstrate that it wouldn't. If you take from the private insurance companies those risks where they have to spend most of their money, won't they be able to do a better job with the others?

Mr. DIKOVICS. That is true; but the overall cost I think to the entire population would certainly be no different. By segregating one element of coverage and paying for that separately, I can't see that it would necessarily reduce the cost.

Senator WILLIAMS. Well, now, on the contrary, under the Anderson-King approach, or under the social security approach, I think we would have some very significant savings. We know that older people frequently are hospitalized when they could be just as easily treated at home or where, with diagnostic services available to them,

their illness would be caught early, or maybe preventive medicine could prevent illnesses, and they wouldn't be going to hospitals.

But there is no insurance program for these, and so we wait and wait. It is a hospitalizing illness, you see. We know that is far more costly than with the doctor who is preventing through diagnosis or caring for the individual at home.

I think you will find—and I wish the chamber would look into this. It is a field where we wonder why the chamber of commerce is trying to make for better industry and is in this field, but you are in it, so I would suggest you go into it and go into it deep, and see how we can save money on unnecessary hospital bills.

There is something here. I am convinced of it. It didn't occur to me. I have gotten it from far wiser, more knowledgeable people. And let's search a little further together. And we will make available to you the findings of our committee. And let's just think this thing through. OK?

Mr. DIKOVICS. Right.

Senator WILLIAMS. Thank you very much.

Mr. DIKOVICS. Thank you, Senator.

Senator WILLIAMS. We will now hear from Mr. Lang, Mr. Coyle, and Mr. Goldstein, in that order.

Mr. Lang, you are vice president of the American Hospital Development Corp.?

STATEMENT OF GERARD J. LANG, VICE PRESIDENT, AMERICAN HOSPITAL DEVELOPMENT CORP., MOONACHIE, N.J.

Mr. LANG. That is correct, sir.

Senator WILLIAMS. You live and work in Moonachie?

Mr. LANG. I live in Rutherford, N.J., 96 Wheaton Place. I work in Moonachie.

Senator, I have no prepared statement to give, here. I do have notes, and I hope you will bear with me, while I refer to same.

I sat through this morning's session and was quite impressed and pleased with what has been going on, both with what is being done presently and with what is anticipated in the future. However, I don't enter into that category at all. I represent private investors. We originally have incorporated and have done research and development for the past 18 months to 24 months for the purpose of looking into the field and organizing and building hospitals, nursing homes, and other related institutions.

Before going any further, I will say that with regard to hospitals, we have come in contact with many private groups, particularly represented by doctors, who are anxious to put up their own private hospitals. Unfortunately, the means of financing was not available to them. This I just add as a point of information.

Through the wonderful cooperation of FHA, it is available for nursing homes.

More recently, it was brought up to the 90 percent level, which is quite an inducement to ourselves and other private agencies.

If you will recall, Senator, when we started our program, we contacted a Mr. Hoffman, who is now commissioner of elections in Bergen County, who in turn introduced us to your good office, and you in turn

gave us everything available on the Hill-Burton Act and survey and also introduced us to Mrs. Helen Holt, who is the special assistant to the FHA on nursing homes.

Well, we likewise had available to us the Hamilton report, as prepared for the commissioners of Bergen County, on the need for hospitals, that is, additional beds and also nursing home beds.

On contact with your office, we were shown and given a copy of the Hill-Burton survey, which we therefore accepted as our bible.

We got no end of cooperation, and we were full of big ideas. We wished to go on into a program of nursing homes, having dropped the hospital program, because of the lack of funds, but getting into the nursing home field we anticipated that in view of the fact that there were high costs associated with the nursing home field, it would be advisable to develop a string of them under a central management; thus, in our minds, reducing the overall cost of operation.

We were going beautifully, and we hit back into our own home town in Bergen County, and went so far as to get the investors and select a beautiful site that we thought would be the start of a venture having benefit both to the public and to ourselves.

In selection of the site in Secaucus, N.J., we chose 10 acres of ground. To us and our complete staff, composed of administrators, doctors, architects, builders, lawyers, attorneys, and an accountant and myself, it was agreed on that this was the ideal site, and we went ahead and drew up preliminary plans for a 250-bed nursing home.

Realizing from the information gleaned before, it becomes necessary to submit your plans to the various agencies and likewise procure a certificate of need, we submitted our plans and our purpose; which required then site approval. The State level went into our program, thought very highly of it, and stated that there was a need in Hudson County and Bergen County for the beds. They said our selection of site was ideal. However at a later date we were turned down on the selection of site.

Incidentally an interesting sidelight to that is a recent article in the Hudson Dispatch, in which a 700-bed elderly and geriatrics home has been approved by the Government to be located in Secaucus, N.J., at a cost of $10 million. Our project of 250 beds would have been $2½ million. That would have been a private investment.

During our campaign, we looked into the existing nursing homes. We had quite a few talks with present operators of nursing homes, who advised against going into our project.

Incidentally another interesting thought there: A lot of these people that advised us are now putting up additional homes.

We were informed that the Hill-Burton survey is overstated, and that New Jersey is in the process of downgrading these figures to about two per thousand, two beds per thousand; and an actual survey would be carried out by the State of New Jersey in about 1 year's time.

We were further advised that competition is not advisable in the nursing home field. It would downgrade and lower the standards of nursing homes.

I believe there are State laws governing all of these nursing homes that are licensed.

Further, based on the Hill-Burton survey, we made a deposit on land in Passaic County. We were told there was no need for homes or

beds in Bergen County. In fact, I believe we were told there was an overage of 319 in Passaic County.

An individual survey made of Passaic County directly in contact with the nursing homes revealed a vacancy of only 15 beds. That is, out of 717.

Further, these operators that we contacted, when asked the question as to why there were so few beds available—and mind you, this is in seeking room for prospective patients—we were told that there is such a need in the county; that there are none available.

I might just add this, Senator. In going around and looking at the present facilities available, our FHA has a wonderful statement in there "to provide a home away from home." And unfortunately, in my contacts with the present facilities, we, in our own organization, see none of these facilities that we talked about.

That, briefly, is what we have in mind. We have been in operation for the past 18 months. We have accomplished the structure of no nursing homes. It seems to me that it is broken down on a county level. That appears to be fine, when we are talking of welfare agencies or welfare funds; but when you have private investors, I don't believe you can put them into counties where you would like them.

The State itself has a need: If the investors are willing to risk their money and put up the services and facilities that we are looking for, I believe it should be on a broader basis.

It is true, I have heard, that the people of north Jersey are perhaps going to south Jersey for accommodations. But again, I believe that is the choice of the people; particularly if we are told that Passaic County has an overage of 318 beds, yet south Jersey is full.

I believe that is all I have at the moment, Senator, and I certainly thank you for this opportunity of appearing here before the committee.

Senator WILLIAMS. Well, we are glad to have you here and have the benefit of your experience.

Mr. LANG. Thank you.

Senator WILLIAMS. Mr. Leonard Coyle, executive director of the Licensed Nursing Home Association.

Mr. Coyle, if you want to submit your statement and summarize it, you are welcome to do it that way.

STATEMENT OF LEONARD COYLE, EXECUTIVE DIRECTOR, LICENSED NURSING HOME ASSOCIATION OF NEW JERSEY

Mr. COYLE. Senator Williams, we are particularly happy to appear here today, especially since there has been so much interest expressed in nursing homes and their place in our community and the job that they are doing here in New Jersey.

I am Leonard Coyle, executive director of the Licensed Nursing Home Association of New Jersey.

In submitting this statement, it is our desire to bring about a greater awareness of the important role played by nursing homes in meeting the health needs of our aged and convalescent citizens, and the manner in which Federal-State programs have affected them.

There are approximately 175 nursing homes licensed in New Jersey. Of these, approximately 120 are members of our association.

Today, nursing homes in New Jersey offer more than 6,000 beds daily for the care of the convalescent, the chronically ill, and the aged, requiring medical and nursing care.

During the last decade, the number of private nursing homes in New Jersey increased from 101 licensed facilities to the present 175, while during the same period the number of beds tripled. This increase and startling growth has been typified not only by new construction of modern facilities but of renovations and additions to existing facilities.

Our attention has been focused on the recent criticisms of the McNamara committee on conditions in nursing homes as found on a national level. In this respect, I would like to point out that New Jersey's nursing homes have long operated with the highest standards of professional, medical, and nursing care. This is evidenced by a constant raising of standards recognizing advances in our professions which have come about through greater interest and research in the care of the geriatric patient.

We invite members of the committee as well as the general public to visit nursing homes in New Jersey and to inspect them personally.

While it is to the credit of the private nursing home administrator who has cooperated in the formulation of higher standards of care, we also acknowledge the cooperation and assistance of our standard-setting State agency, the bureau of community institutions of the department of institutions and agencies.

Of the more than 4,000 recipients of old-age assistance in New Jersey, more than half are cared for in privately licensed nursing homes at a cost far less to the taxpayer than that which is obtained in most county and municipality-run institutions. We stress these points to emphasize the valuable contribution given to the public by the private nursing homes of New Jersey. Presently all patients receiving public assistance in nursing homes are recipients of old-age assistance or disability assistance.

The amount paid for the care of such patients is established by the State bureau of assistance in the department of institutions and agencies. It is now $180 a month, or $190 a month, an inclusive rate for all services—room and board, laundry, medical services, medications, nursing services, and all other services normally available in a private nursing home. Needless to say, there is always a great demand of our facilities for the indigent aged patient, and seldom enough beds to provide for their care. More funds can and should be made available directly to the recipient of old-age assistance to purchase his health care needs. Greater economic motivation must be given to the privately licensed nursing home to build additional new facilities.

I would like to add that we have been successful in getting the Federal Housing Administration to recognize the need for additional facilities for aged citizens in nursing homes and the handicaps we have had in the past in obtaining sufficient financing to construct these facilities.

Today, nursing homes have been recognized and are included in the Federal Housing Administration program under guaranteed loans up to 90 percent of the value of capital construction. This has added a great impetus in the construction of new nursing homes; and, as previously mentioned today, four commitments have already been made in New Jersey for FHA loans.

We expect that there will be a far greater stress on building new facilities to create additional beds wherever they are needed in New Jersey.

It is indeed unfortunate that many of our substantial citizens, upon the advent of a long, lingering, chronic illness, must be reduced to the point of giving a pauper's oath before becoming eligible for assistance. Not only must all the assets of an individual be encumbered for reimbursement agreements to the State, but responsible relatives must contribute to the maximum of their ability. Even friends and nonresponsible relatives are prohibited from aiding the aged person requiring medical and nursing care by purchasing services over and above that provided by our assistance programs.

We do not feel that as a requirement for financial aid, our citizens must first give the equivalent of a pauper's oath. Nor do we feel that Government is utilizing all of the human resources available in providing health services to our aged when they ignore and prohibit others from contributing supplemental payments to provide higher quality of care and more abundant facilities. When a person passes the peak of his earning years and is reduced to pauperism through prolonged serious illness, upon receipt of old-age assistance for medical and nursing care he loses all aspects of the economically independent person. If capable of physical restoration, he carries the burden of looking forward to a future of economic bankruptcy. In other words, even if restored to physical well-being, he cannot be restored economically, and his fate depends upon the beneficence of our State welfare programs.

In this respect, I would like to add that some consideration should be given by the Congress to allowing our aged citizens to retain a measure of independence economically, whereby, when they require medical care, they will be allowed to have as a deductable item at least a minimum income of $50 a month to themselves, which would not be used in computing their eligibility of need when determining their income. I believe that leaving this amount of minimum money to an individual would give them some independence in choosing the type of services that they would want and where they would like to go.

It has been said that the Kerr-Mills legislation when adopted will do much to alleviate this situation. However, in our opinion this legislation, though providing more money to the State through greater Federal participation, it does not provide additional funds to the individual, nor will it increase his purchasing power for better facilities or additional services. It will increase the number of people receiving assistance by reducing eligibility requirements, but it does not provide economic motivation to increase the building of facilities, nor will it increase the availability of existing facilities for the medically indigent. Rather, it puts greater strain on present facilities to care for more people without increasing the actual rate paid for their care.

If it is not now possible to provide sufficient nursing home beds for present assistance patients, who will build the facilities needed for the additional people to be covered under this program?

At the present time each State determines in its own way the services it desires and the amount it is willing to pay. New Jersey pays the picayune rate of $6 per day per patient for 24-hour nursing home care.

Who will deny this amount barely covers the costs of present day subsistence, much less the actual cost of medical and nursing care services?

We propose that the cost of good health care for our aged citizens be recognized through a formula devised by Congress and made mandatory on the States for reimbursing health care facilities for the actual cost of rendering needed health services.

In 1948 we witnessed the creation by Congress of the Medical Facilities Act, more commonly referred to as the Hill-Burton program for the construction of hospitals, nursing homes, and other related facilities. This program provides grants by the Federal Government to nonprofit organizations, corporations, and various municipal governments upon application for the construction of such facilities. A review of the program after 12 operating years reveals the inability of Government to provide adequate facilities for our needy aged. Let us look at the results.

(1) Construction standards for nursing homes developed by the Department of Health, Education, and Welfare, though admirable, are so unrealistic as to prohibit the construction of nursing homes for people of moderate incomes, to say nothing of our indigent aged.

(2) There is no requirement that these facilities when built must give care, or even priority of admission to our aged citizens who cannot afford to pay their own way in private institutions.

(3) Many such institutions built under this program and supported in full by taxpayer funds, have adopted a policy of admitting only private patients, while refusing admittance to our aged needy citizens. It is our belief that a full reappraisal of the Hill-Burton plan should be undertaken. The standards for the construction of such facilities preclude meeting those needs intended by the Congress. We believe the intent of Congress in this program was to provide facilities adequate to meet the needs of people who cannot afford to pay for their own care. Experience here in New Jersey indicates this result is not being achieved.

In closing we would like to say much can be done to improve the health care of our aged by greater recognition of private facilities and those organizations which are concerned with rendering day-to-day services to our aged citizens. While liaison to some degree has been effected between the Federal Government and its respective State governments, many shortcomings have resulted in our welfare programs through failure to affect liaison with professional associations whose members daily provide health care services. In this respect much can be done. Recognizing this need the Federal Housing Administration has recently appointed an advisory committee of prominent nursing home administrators to assist them in their nursing home program. Recently the Department of Health, Education, and Welfare recommended the creation of a nursing home advisory board composed of nursing home administrators to assist State governments in their progams. While this recommendation has not yet been adopted by New Jersey, it does represent a promise of better liaison which will ultimately benefit our aged citizens.

We take this opportunity of thanking the committee for allowing us to present this statement, and I will be most happy to answer any questions which might come up as a result of the statement which I

have given you or any previous statements that have been made relative to nursing homes in New Jersey.

Senator WILLIAMS. Can you express your view on the need for additional nursing home beds and facilities right in New Jersey?

Mr. COYLE. Yes, sir. There is a need for additional nursing home beds in the State of New Jersey. We have cooperated and worked with the Bureau of Community Institutions and particularly with the Hospital Advisory Board, and Mr. F. Spencer Smith, Chief of the Bureau of Community Institutions, on this particular program.

As mentioned previously by Mr. Lang, we did have a program here in New Jersey which was based on the Federal formula of five beds per thousand; four nursing home beds per thousand of population and one bed for hospital chronic disease facilities.

In reviewing this program, we sat with the various state officials, and concluded an agreement with them that the total picture, as shown, using the suggested Federal formula, was unrealistic and resulted in showing a need for an additional 24,000 more beds in the State of New Jersey.

We had made studies on this particular subject, and our studies had shown that using all existing nursing home beds in New Jersey during the calendar year of 1960, there were available every calendar day of the year 1,234 nursing home beds.

It was evident that some adjustment should be made in the old plan, showing need for nursing home beds; and after a study had been made we had concluded that a figure of two beds per thousand might be more realistic. This has not yet been acted upon officially, nor has it been endorsed as yet, to my knowledge.

Beds have been distributed on a county basis, and certain counties have shown, based on the two beds per thousand, that there is a surplusage of beds in those counties.

Senator WILLIAMS. That is 2,000 ——

Mr. COYLE. Two beds per thousand of population.

Senator WILLIAMS. Not older people, not retired people?

Mr. COYLE. We have weighted these figures also for each county, based on the number of aged people 65 years and over in each county; so that we have given adequate weight to those counties which bear the greater proportion of our aged citizens.

Senator WILLIAMS. All right. Thank you very much, Mr. Coyle.

Mr. Jack Goldstein, president of the Council for Older Adults of the Newark YM–YWHA.

Glad to have you come down from Newark to be with us, Mr. Goldstein. Why didn't you catch us while we were in Newark?

STATEMENT OF JACK GOLDSTEIN, PRESIDENT, COUNCIL FOR OLDER ADULTS OF NEWARK, YM–YWHA

Mr. GOLDSTEIN. I was there, too. In fact, one of our members, the chairman of our board, spoke about housing.

Senator WILLIAMS. You know, I promised the group I would carry that message to Dallas to the transit people about reduced fares for older people on nonpeak hours on transit. I fulfilled my promise and made it a part of my speech down there.

Mr. GOLDSTEIN. Let me take a minute or two to tell you something about our own club, the one I am president of.

This morning I heard the statement from the director of the club at Edgewater that she had been organized since 1957, and what she has done. But the one thing I didn't like that she said was that she was one of the oldest of that kind. We are organized since September of 1947, and I just wanted to give you a brief résumé of the activities that we have to this day.

Our membership is about between 450 and 500. New members come in and others fail.

First of all, she spoke about counseling. We have had counseling for all of those years. We have a staff, a director, a supervisor, for counseling for our members.

Then we have lectures once a week, on Wednesday, all different topics. We have discussion groups, roundtable discussions, and other discussions. We have cultural meetings. We have volunteers coming in with discussions on readings.

We have monthly birthdays the last Thursday of the month, when we celebrate the birthdays of all our members during that month. It is quite an achievement. Our members look forward to these, and we always have guests.

Then we have entertainment every Thursday. We have a choral group of about 25 to 30. We have a dramatic group of about 20. We put on plays and concerts.

We have arts and crafts. We have a painting group. We have painting for beginners and painting for advanced. In fact last year we put on quite an exhibit at Kresge's Department Store in Newark, and we won ribbons.

We have English classes for those who want to brush up; some even for beginners. We have a history class.

Senator WILLIAMS. What was that?

Mr. GOLDSTEIN. History; such as Jewish history, American history, and history of the world, all different topics.

We have a sewing group of about 15 to 20 women who come in every Monday. They make children's dresses. We send them to the children of Israel, the children of North Africa, mostly where it is needed. They are very cute little dresses.

We have a group of 20 to 30 women who come on Tuesdays, and they make cancer pads for the American Cancer Society. That is quite a project. They turn out 3,000 and over a year.

We have a canteen. We get volunteers to serve our members, sometimes guests, too, at a very nominal fee. You can have a hearty meal, whatever everyone wishes, for a very nominal fee, such as 15 cents or 20 cents, with a quarter as tops. You can have a hearty meal at lunch time.

Senator WILLIAMS. Can you take guests in for those meals?

Mr. GOLDSTEIN. Well, guests come in just once or twice; yes.

Senator WILLIAMS. Where is your Y, by the way?

Mr. GOLDSTEIN. On Chancellor Avenue; 255 Chancellor Avenue.

We have one of the volunteers who comes and teaches our women millinery.

We have plenty of other activities we didn't start yet this year. We had them last year, but this year they haven't started yet.

Most of our members are very satisfied. In other words, they are not too unhappy. We are fortunate that we are in that position to

help others, because I am also president of the Newark Senior Citizens Council, which organized last year, and there we come in contact with other clubs that are not so fortunate.

Of course, anybody that comes to us for guidance gets it, even before the senior citizens council was formed.

I am also chairman of the Essex County Council of Older Adults.

I am telling you this to show that I am in contact with different people. I see when they are happy, and I see when they are unhappy.

The most unhappiness, naturally, is that some of them get very little social security. Very few are apt to get State assistance or welfare assistance. But most of them, the middle ones, have trouble. There are some that can afford anything they want. But there are very few of those. Most live off a limited income ranging from $60 to $70 social security to about $110, and so forth. Most of them are $80 or $90. That is about the middle.

Well, some of them try to get along on that; and they do. In order not to apply for any city assistance, they will try their best to get along.

I am talking about single people, naturally. We also have couples. For instance, myself. I have $142.50, together with my wife. But we try our best not to come for any assistance.

The only problem is when it comes to illness. Younger people get sick, but older people more often. Some have very little coverage of hospitalization. We have the 65-plus. Some of our members, very few. I am one of them that carries 65-plus. There is very little coverage on that.

Senator WILLIAMS. I missed that. On what?

Mr. GOLDSTEIN. That is the Mutual Continental.

Senator WILLIAMS. Mutual of Omaha?

Mr. GOLDSTEIN. No; Continental Casualty Co. We pay $6.50 a month each. But the coverage we get is not too much.

Senator WILLIAMS. How many days of complete hospital coverage a year do you have under your hospital program?

Mr. GOLDSTEIN. We get 30 days a year, but they only pay $10 a day.

Senator WILLIAMS. I was in a hospital yesterday, where my father is, and the daily rate for the room is about $30.

Mr. GOLDSTEIN. $30 and more. It is all according to the cases. So 10 days would be $100 of coverage, and the bill could be, just for the room, $300. It could be more. Certainly. And you can imagine what we get.

But we try not to get sick. That is the only thing we can do. But people do get sick.

Senator WILLIAMS. We heard a lot today to the effect that private plans and these insurance programs that we now have can do the job. Now, are they doing the job?

Mr. GOLDSTEIN. Private plans? This is a private plan, the Continental Casualty Co. They give you $10 a day.

Senator WILLIAMS. Now, tell me. You know your folks very well in your center?

Mr. GOLDSTEIN. That is right.

Senator WILLIAMS. You have 450 to 500 members. How many of your members would you estimate have that kind of coverage?

Mr. GOLDSTEIN. Not very many. I don't think there are more than about 10 or 12.

Senator WILLIAMS. Percent, or people?

Mr. GOLDSTEIN. No, no; people.

Senator WILLIAMS. What coverage do the others have?

Mr. GOLDSTEIN. Well, a lot of them have no coverage at all, but some have coverage. Some have Blue Cross, without Blue Shield. I don't think there is 1 percent that have the Blue Cross and the Blue Shield. Just those that can afford to pay.

Senator WILLIAMS. Would you say 10 percent of your members have some kind of coverage for hospital costs?

Mr. GOLDSTEIN. I wouldn't say definitely.

Senator WILLIAMS. Would you find out? Would you make a little study of your group?

Mr. GOLDSTEIN. Yes.

Senator WILLIAMS. Would you write me on that?

Mr. GOLDSTEIN. All right. I sure will.

Senator WILLIAMS. We are going to have a town meeting here very shortly; so if anybody can help us with some actual backhome information on this question, that would be fine.

There shouldn't be any mystery about this. We want to get the facts. And when we have statements that people are well taken care of presently, and others say they are not, we want to find out.

Mr. GOLDSTEIN. That is why I came here. I am not a professional speaker, as you can well see.

Senator WILLIAMS. Listen, I will have you testify for me any time.

Mr. GOLDSTEIN. I don't know whether you recall, but about 4 or 5 years ago you were in Elizabeth when we had the Trenton group over. I was a member there then, too. In fact, now I come there once in a while when we have something. And I spoke to you about housing at that time for elderly people.

You remember? You spoke about different things, and you omitted this subject, and I asked for the floor, and you called me over to the mike that I should repeat the question on the mike, and I understood at that time you had just omitted it; but you were for it. And I know you are for our trouble now, too.

Senator WILLIAMS. In politics I will take 1 person over 65 to 10 under 65 to work for me.

Mr. GOLDSTEIN. That is good. So that is why I came here today. Our director didn't even ask me before did I want to speak, but Friday morning she told me, "I sent in a letter and asked Senator Williams to call on you to speak about medical care."

I said, "Me?"

She said, "Yes."

As I said before, I am not a professional, but I say what I know.

Senator WILLIAMS. How long have you been retired?

Mr. GOLDSTEIN. Seven years.

Senator WILLIAMS. You have been in this club for the entire 7 years?

Mr GOLDSTEIN. That is right. As soon as I retired, I went into the club and became active right away.

Senator WILLIAMS. Do you have a pension program beyond your social security?

Mr GOLDSTEIN. No. No pension at all.

Senator WILLIAMS. Were you employed by a company? Or self-employed?

Mr. GOLDSTEIN. Well, I was mostly self-employed. And at that time there was no coverage for the self-employer.

But let me tell you. The reason why I don't have money put away like some of the others—I was sick for 16 years straight, and with doctors, hospitals, and nurses, I came out clean. But after that, I came a little bit to myself, and I started to get jobs. One job was too much. I quit that and got another one. And little by little I worked myself in. And there was a small center, and I was director of the Jewish Center. And that didn't last too long, because the people in that neighborhood didn't respond, and I got myself a job with an engineering manufacturing company, Stewart Engineering of Newark. They are out of business, now. I worked there about 3½ years. And I came to myself a little bit, but naturally you can imagine how it is.

So we do the best we can to get along, because when I was sick I went through the clinic. Coming into a clinic for medical treatment—I believe you heard many times, but didn't know it yourself, that every patient who comes into a clinic, for free treatment, goes through the third degree. And that is what hurts the most. And now I appeal to you to work for it. I know you would. But with your courage to work for it through the Congress and the Senate, none of us should have to go through a third degree again, like the bill they are introducing in the senate of this State, a pauper's bill, that you have to go through a third degree before they give you anything, and they take the life out of you.

That is in plain everyday language. They take the life out of you by the third degree. That is why I strongly appeal. I heard a doctor talk here, and then another one, about those bills. And believe me: Many of our older people would rather die than go through a third degree like on those bills that are pending now.

Senator WILLIAMS. How many of your members have a pension above and beyond their social security?

Mr. GOLDSTEIN. I really don't know. I have here the chairman of the board, who only spoke last Monday. Maybe he knows more about it.

Senator WILLIAMS. All right. Maybe later you can.

What kind of recreation do you have? You have dancing, for example?

Mr. GOLDSTEIN. Yes, we have dancing. We have singing, chorus, individual singing, and choral group singing. We have dramatics. We put on plays. As far as the center is concerned, we are a 5-day center.

Senator WILLIAMS. Five day?

Mr. GOLDSTEIN. Yes, practically all week. And sometimes on a Sunday, also, if it is a special program, we do it on a Sunday.

Senator WILLIAMS. What time do you open in the morning and close at night?

Mr. GOLDSTEIN. We open at 9 o'clock. Some come even at 9 and at 9:30 and stay until 4:30. You can stay until 5.

Senator WILLIAMS. At 5 your part closes?

Mr. GOLDSTEIN. Yes.

Senator WILLIAMS. This is your chairman of the Board, who was here last week?

STATEMENT OF ADOLPH RUBENSTEIN, NEWARK, N.J.

Mr. RUBENSTEIN. It would be hard to estimate how many people have outside incomes, outside of social security. As a matter of fact, there are some who are not even covered with social security. But somehow they manage.

But here I have to divulge my age. I am 82 years of age. The worst fear, the late President Roosevelt said, the only fear we have is fear itself. But the worst fear is when you get to this advanced age. It is shelter and medical care. You don't even think about food. You are afraid that you might get sick.

Personally, I am covered. I had to work for many years with a company. I am covered with medical care in all respects.

Senator WILLIAMS. How many hospital days a year, under your plan?

Mr. RUBENSTEIN. The company that covers me? Unlimited.

Senator WILLIAMS. You have an unlimited hospital coverage plan?

Mr. RUBENSTEIN. Unlimited. I had two major operations and every cent was covered by a company I have been working for. I have been retired now for 17 years.

Senator WILLIAMS. Well, that is a good plan. What company?

Mr. RUBENSTEIN. Metropolitan Life.

Senator WILLIAMS. You work for the Metropolitan Life?

Mr. RUBENSTEIN. Yes. I am fully covered, as far as I am concerned. I am pension covered; all my sickness. So if I do say anything about medical care for the elderly, I do not talk for myself, because I am fully covered. Now I am covered 75 percent of costs, whatever costs it might be. And my wife is covered at 50 percent.

Senator WILLIAMS. We would like to see everybody covered like that.

Mr. RUBENSTEIN. And while my social security income is limited and my pensions are not any too liberal, it is not enough to get along. But thank God I have a little besides which I saved up in my years. And as I said to my wife, if we live another 50 years, we still have enough to live on as far as that is concerned.

Senator WILLIAMS. Well, as Moses said, "Let's hope you live to be 120."

For the record will you give your name, too, sir.

Mr. RUBENSTEIN. Surely. Adolph Rubenstein, 148 Chancellor Avenue, Newark. I have been living there for 30 years, in that same house.

Senator WILLIAMS. The taxes have gone up a little in those 30 years?

Mr. RUBENSTEIN. Well, even rents are going up. Rents have gone up 2½ times since the time I have been living there. But as I say, I believe that the greatest burden to be taken off the aged is by covering them with medical care the same as they are covered with social security.

You know, there is one thing. There are no ifs or buts. There is no going out there and investigating with detectives watching that maybe

you have another doctor, checking up on your income, your assets, hospital money you have in the bank. If you have $200 in the bank, you are disqualified. You are not eligible for medical care.

If that burden would be taken off from the old man and woman, they would be happier. I met a man in the club last week who came over and complained to me he was sick. So I said, "Did you go to a doctor?"

He says, "How can I go to a doctor? I have to pay $10."

Evidently he didn't have $10. I said, "Why don't you go into the clinic?"

He says, "I have been in the clinic. You have to wait 2 or 3 hours, and when you get to the doctor he rushes you through, and when you get through it doesn't mean anything."

I said, "What are you going to do?"

He says, "Struggle along as it is."

So that is not preventive medicine.

My system was, from my company: At least once a year to be examined whether I am sick or not.

Senator WILLIAMS. And then if you get it in time, you can perhaps prevent hospitalization.

Mr. RUBENSTEIN. And in the last 16 years that I worked I lost 1 week from sickness in 16 years. And that was due to an accident. I stepped out of a car and sprained my back, and I was out for 1 week.

Senator WILLIAMS. Maybe on your record that is why you got that big coverage, you see. They knew you wouldn't get sick on them.

Mr. RUBENSTEIN. And in the 17 years that I have been retired, as I said, I had two major operations, which is natural—it comes with age—fully covered. So I have no worry about that.

But I do know that a big burden would be taken off the old man and woman, the senior citizen, if he would know in case he gets sick he would have something to fall back on, without going through a third degree, as Mr. Goldstein mentioned.

I really believe that the Social Security Administration is doing the best job of any administration that I know of.

There is no question there that you are entitled to that much and that is it. It is a settled thing.

Senator WILLIAMS. One more question to both of you gentlemen.

I have before me an editorial that appeared in one of our leading papers in the State, and the theme developed in this editorial is that older people, most of them, at least, don't like age labels. They don't like to be called senior citizens. They don't want to be segregated as problem people. Now, we are talking about retired people.

Is this true? Do you not like us to sit up here and say, "senior citizens," or "our older population"? Do you folks feel we shouldn't be talking about older people and their problems?

Mr. RUBENSTEIN. Personally, I don't feel that way. But we had experience with some of the women folks that come into our club. About 60 percent of our members are women, and 40 percent are men. And they don't like the idea—when the club was first organized, in 1947, it was called Council Club for the Elderly. They didn't like that "the elderly." So now we have it "for older adults." That may sound a little better.

Senator WILLIAMS. Well, give us the pitfalls, here, because we don't want to make people feel badly as we do our work.

Mr. GOLDSTEIN. There are people who resent being called golden agers or old folks or anything like that. Those are the people that don't belong to any clubs at all. They are skeptical about coming in. "Well, what would I do there among all the old folks?"

They don't consider themselves old. But once one talks it into them and they come into one of those clubs, if they come into any of those clubs they will change their minds. They are willing to be called golden agers or anything like that.

And the other question, as far as living isolated: I don't think anyone wants it. I do know of one. And I always argue with that person. She doesn't like kids, doesn't like noise or anything like that. I said, "What do you want to be, isolated?" She says, "Yes."

But all the others I come in contact with don't want to be isolated.

Some say, "I moved down there in Newark especially. Why do I move down there to be isolated?" They resent that. They want to be among us.

Mr. RUBENSTEIN. Another thing we experienced at the beginning: When we first organized this club, the Council of Jewish Women furnished free lunch every day between 12 and 1. All the lunches were free to everybody. And a group of us resented it, and we started to beg them to make a charge, and it took about 3 years until we convinced them. Now they charge 5 cents an item. But for 15 cents or 20 cents you can have a very good lunch.

They run a little short by the end of the year. A lot of people resented it. I didn't feel well when I had to go there and have a lunch for nothing. I would rather go outside and have a sandwich than have something for nothing.

We don't want to have any welfare. Whatever little the cost may be, whether it is only 5 cents or 10 cents, as long as we pay for it, we are satisfied. We don't want any welfare. We don't want anything for nothing.

Senator WILLIAMS. Well, that same spirit underlies the thinking of people who want to pay now under social security for an insurance program later: independence and self-reliance.

Mr. RUBENSTEIN. That is right. We don't want to feel we are getting charity. That is one word we don't want, charity. Whatever we get, we like to pay for.

Senator WILLIAMS. That is why representatives of the union here today say the American working men and women want to pay for the coverage. I think that should be stressed, because the opponents feel there is welfare in this. This is not welfare. This is pay as you go, and the people want to pay.

Mr. GOLDSTEIN. It is easier for them to pay a little more tax, if we call it a tax.

Senator WILLIAMS. Call it a tax. I don't care.

Mr. GOLDSTEIN. Better to pay a little tax than to help upkeep their father and mother. It is much easier like that.

Senator WILLIAMS. If you people will persuade your doctors, maybe we will see it sooner. I persuaded my doctor. He is not with the AMA.

Mr. RUBENSTEIN. The majority of doctors are private enterprise, you know, profitmaking organizations. If we can pay a little bit out of it, it is the same as buying life insurance, which I have sold for

many years. You buy income insurance for the future. That is why social security and medical care—you pay for it and get it later.

Senator WILLIAMS. Gentlemen, we are very grateful to you.

We have Mrs. Eone Harger with us, and she is the director of the division on aging. We are also going to have a town meeting. Mrs. Harger, you can have your statement now or at the end.

STATEMENT OF EONE HARGER, DIRECTOR, DIVISION ON AGING

Mrs. HARGER. Senator Williams, I am, as you know, Eone Harger, director of the division on aging.

I don't come here with a prepared statement; but I do feel, since you wanted to know what is going on in New Jersey, and since this division has been mentioned in testimony of several other people, it may be important to put into the record the kind of work which we are doing.

My division is a central source of information on all the programs which you have heard discussed today by other people. We keep a finger on the pulse of health care and hospital care and nursing homes and recreation programs, and we are able to give out information to voluntary organizations as well as governmental agencies.

In order to save time, I shall not try to blueprint our operation, but I would try to call to your attention that we have described the kind of operation that has evolved in New Jersey, in a report which we have called a triennial report, inasmuch as it summarizes the work of 3 years.

We were an experimental agency to start with, and still are, since there has been no other agency of this kind in this country. This report shows the numerous directions in which such a governmental agency can move, in order to change the atmosphere in relation to programs for older people, and to initiate and extend action of already existing organizations.

In fact, this has been one of our chief aims, and we have done this by giving grants of money to other agencies to do programs. We initiated a restorative nursing program in the nursing homes, which now is operated by the health department. We are moving to establish a recreation program to follow up on the restorative nursing. We have experimented with employment programs.

We are trying to broaden interest by bringing together a great many groups around a single subject. For example, the subject of housing has received a great deal of attention. We have tried to stimulate interest throughout the State and share responsibility for some of the widespread activity that goes on.

However, we have been handicapped by diffusion on the Federal level. There has been activity in many fields of housing by the Federal Government but it hasn't been brought together in a single spot. For example, here in New Jersey, for public housing we turn to the New York office. When we want to get information on FHA, we go to Camden or Newark. When we want to know about urban renewal, we turn to Philadelphia. For direct loans for housing for the elderly, we have gone to Washington.

It has been almost impossible for us to draw this together into a single answer for a person asking "What we do to start housing for the elderly?"

I am very happy to say that we have had wonderful response to solving this problem from the administration in Washington. They have now gathered together an agency on housing for the elderly that will cut across all these many areas and, under Mr. Sidney Spector, we are going to get this pulled together. This will help us to stimulate housing activity.

There are areas that have a great deal of interest where we haven't been able to gather enough information to be an adequate witness, but I might point out some of the areas that we are exploring.

One is the matter of women under social security. Here in New Jersey we have more older single women than any other State in the Union in proportion to our population, and many of these women are in financial distress. We know that a wife cannot have the full amount of her husband's social security when he dies, and yet we are sure she needs as much money as any other single individual to live on.

We also know that many married women work, contribute to social security, but they are not able to get the benefit of this unless they have as many benefits as their husband. They either have to take a wife's share or the other share, whichever is the larger.

This is one thing under the social security system that we would like to explore and might point out to you as an area of interest that you might like to look into.

Another area where we have thought there is something worthy of looking into is the matter of using our surplus foods in a program to help centers for older people with meals for their participants. Most people want to pay for their meals, but they want them inexpensive. In our schools, we have a school lunch program. Something of the same type might be worked out for older people. This idea hasn't been fully developed, but is another area that we think deserves some investigation.

Somebody raised the question about cost of insurance—and the amount of coverage. We know that older people need about two and a half times the amount of hospital care if they do become ill as younger people do. We haven't read all the policies for older people, but we do know in many cases the hospital allowance for a person, when he reaches the age of 65, is cut to 30 days, whereas when he was younger he had up to 90 days under the same policies.

This is the sort of discrimination that makes it difficult for many older people. Some people who retire from industry have the privilege of carrying on their insurance programs, not at the group rates, but at the private individual rates. This, too, is difficult for people who have retired. So while many have some health insurance coverage, we know that many others want to have the privilege of having insurance but are not able to afford it.

Senator WILLIAMS. Thank you very much.

We are most encouraged by the program that has been created here in New Jersey under Mrs. Harger, and appreciative, too, of the Governor and others who have made it possible.

Thank you.

We have no further scheduled witnesses. I will keep the record open for a statement from Dr. Joseph Still, public health officer of the city of Camden.

When we first decided on these hearings, we thought it would be wise to get the benefit of the thinking of two important men in this State. One of them won't make it, but one will be the next Governor. Judge Hughes testified in Newark a week ago today, and I just had submitted to me now a statement from Mr. Mitchell, and a statement from Judge Hughes on the subject of today's hearing. These will be put in the record at this point.

(The statements refered to follow:)

PREPARED STATEMENT BY JAMES P. MITCHELL, LITTLE SILVER, N.J.

As a report of this committee once put it, the story of the 16 million persons over 65 we call aging, their children, and close relatives is, in short, the story of all America.

Their problems, too, are the problems of America. After we increase employment opportunties for older people, after we help provide them with a livable retirement income, after, with the help of family, insurance programs, and governmental, too, we provide health care for the aging, we are still left with perhaps the most difficult of all problems.

How do we help those who are growing old to more useful, productive, satisfying lives for their own sake and for the sake of their communities which badly need the human resources available at their retirement?

According to the 1960 census there are in New Jersey 560,000 men and women over the age of 65—just over 9 percent of our population. It is interesting to note that the percentage is higher in resort areas and slightly higher in old, established communities, and much lower in areas of recent fast growth. For instance, Cape May County has about 17 percent over 65, Atlantic County 14 percent, rural counties, such as Hunterdon and Sussex have 19½ percent and 11 percent, respectively, while fast-growing Middlesex has only 6.6 percent, Burlington 6.4 percent.

In our large counties, Essex has 10.2 percent, Hudson 10 percent, Passaic 9.8 percent, and Bergen 8.2 percent.

Of New Jersey's aging population those between the ages of 65 and 75 amount to 385,000, while those who are over 75 number 174,000.

In the past 10 years there has been nearly a 50-percent increase in those over 70 and a distinct drop in the percentage of nonwhite after the age of 70. In the latter case, better living conditions for all should alleviate this situation in future years.

It is particularly important to note that, nationwide, of those between the ages of 65 and 75, only 20 percent have health problems which interfere with their being employed in their normal jobs if employers will hire them. Most of those in that age group—both mentally and physically—are able to render useful services to the community.

I am not a stranger to these questions. As Secretary of Labor, I was a member of the Federal Council on Aging. The Council's job was to mobilize Federal activities and resources in dealing with the problems of older people in our society.

More than $16 billion is administered by the Federal Government alone in programs and services for older people.

Under my administration, the general objective of the Department of Labor's older worker program was to help make it possible for older persons who desire and are able to work to continue their productive lives through suitable gainful employment.

Approximately 38 percent of the labor force of the United States is 45 years of age and over. A rise to nearly 40 percent is expected during the next decade. There is conclusive evidence that many individuals are barred from suitable employment opportunities because of arbitrary age restrictions.

Experience in public employment offices also showed that once a worker 45 or over loses his job, he has greater difficulty finding another one and he remains on the unemployment compensation rolls considerably longer than younger workers.

To meet these problems, beginning in fiscal year 1957 the Department initiated an expanded program of specialized services which sought to:

Increase employment opportunities for middle-aged and older men and women by providing services, such as job counseling, designed to enhance their employability and by stepping up efforts to find jobs for them through the facilities of the affiliated State employment security agencies.

Carry out factfinding activities in the field of employment of middle-aged and older men and women by collecting, analyzing, and publishing the basic facts regarding their capabilities, work performance, and contribution to the economy.

Promote public understanding of the employment problems of middle-aged and older men and women. This was done by conducting sustained informational and educational activities designed to emphasize that in reality there is no fixed age at which a person becomes too old to work and that each worker should be considered for employment on the basis of his individual qualifications as these measure up to the basic requirement of the job.

Clearly the Federal Government plays a major role—through its public health, housing, and old-age public assistance programs—in contributing to the well-being of the elderly.

At some future time, it may be that both Federal and State Governments will be able to withdraw from the public assistance field, as public and private social insurance programs gradually extend coverage to all Americans, a desirable objective in itself.

But the assistance which the Federal Government extends to the elderly is here to stay, and we need not make any bones about it. In such areas as health care for the aging, the role of the Federal Government has not, in my judgment, reached its full potential.

As Governor, I would implement the Kerr-Mills law passed by the last Congress. As far as it goes, this is necessary legislation. Its purpose is to help the needy and the indigent, who cannot pay their medical and hospital bills, through a Federal-State program of financial assistance.

Though this program in New Jersey would narrow this gap, it certainly is inadequate in meeting the health needs of a broad segment of Americans past age 65 who, as a group, have difficulty in obtaining adequate health protection at rates they can afford to pay.

I hope that, next year, Congress will enact a broad program of health care for the aging. The mobility of our population makes the health problem national in scope. Congress should enact a program of health benefits for all those over 65, financed, in the future, during the period of their actual employment, by those who will benefit by the programs and by their employers.

Your subcommittee is interested chiefly in Federal-State relations as they affect the problems of the aging. As Governor of New Jersey, I would implement a program for the aging covering a variety of important points. Lest I unduly take the time of this subcommittee, I am appending these recommendations to this testimony. I prefer to devote the remainder of my statement to a point wholly relevant to the issues before you.

The Federal Government is best equipped, I believe, to deal with the massive problems of public assistance, public health, housing and other programs which affect the aging. Working cooperatively with the States, with private research organizations and with universities, Federal programs are essential to solving the problems of the elderly.

At the State level, I place great emphasis on expanding vocational training programs to fit for useful occupations those in the age range, 65 to 75. I would stress, particularly, occupations in short supply, such as practical nurses training for older women.

Beyond that, I would urge a State program of technical and, if necessary, financial assistance to communities and to private welfare organizations in an effort to provide a trained army of older volunteers for community work.

A great gap exists between the volunteer work which needs to be done in the life of a community and the manpower and womanpower now serving in these tasks.

The United Auto Workers Union, for one, has a program of special service projects for its retired workers. The Red Cross retrains retired persons as visitors to the sick, to hospital cases and to shut-ins generally.

A vigorous program, sparked by the initiative of the State government, would broaden this area of private action. The ingenuity of each community, and of each private welfare organization within each community, would be sparked

to retrain the retired worker who wants to make his or her life count for something more.

Ours is not only a task of training the retired for specific occupations. We can train them for useful avocations as well.

We need to identify on an orderly, community-by-community basis, all the volunteer assistance which each community requires. Then older people should be trained to fill these gaps. I believe the cost will be small in dollars, but great in results.

Important as it may be to promote the beneficial work of arts and crafts for the pleasure of those who have retired, I connot help but feel that the dignity and sense of usefulness which are characteristic of the elderly can be served in ways which will better all man and bring to the individual retiree a sense of fulfillment never before realized.

Following are other recommendations which I have made for State action on the problems of the aging:

(1) Enactment of legislation prohibiting discrimination in employment because of age.

(2) Vigorous leadership to encourage expansion of private pension plans by industry; and for modifications permitting workers to retain partial pension rights for substantial past service, when changing jobs before retirement.

(3) The establishment of top-level State standards in facilities, medical attention and treatment, and in safety for nursing homes.

(4) Enactment of legislation to implement in New Jersey the Mills-Kerr Act, which provides a State-Federal matching medical aid program for elderly men and women unable to pay for adequate medical service.

(5) A moderate relaxation of the present 1-year residence requirement for old-age assistance.

(6) Institution of periodic statewide conferences to analyze and coordinate research, and solve problems of the aging.

PREPARED STATEMENT OF RICHARD J. HUGHES, DEMOCRATIC CANDIDATE FOR GOVERNOR OF NEW JERSEY

Mr. Chairman, last week I appeared before you to sketch briefly what New Jersey is doing to take care of its large and growing population of senior citizens. I pointed out that 560,00 residents of our State are 65 or older, amounting to 9 percent of the total. New Jersey has pioneered in setting up a division on aging to give special attention to senior citizens; it has by vote of the people approved a tax exemption of $800 on the property of older citizens who meet certain income qualifications; it is the No. 1 State in the Nation in the field of low-rent housing for the aged. Today I should like to supplement my remarks both as to housing for the aged and medical care.

Under various Federal financing programs, we are going to see immense progress in housing for the aged, under both public and private initiative. We are going to see American ingenuity at work in the construction of houses suited to the needs of older persons. In this connection, I was struck by the remarks of a North Cape May builder, whose testimony was quoted in hearings before a Senate committee 2 years ago. He said:

"The older people who came to us wanted homes they could move around in with ease and clean and maintain with a minimum of effort. At North Cape May we build only one-story houses; older people are very step conscious and, of course, this eliminates stairs and ramps.

"We build on flat land wherever possible and have leveled many sloping sites to make sure that even a few steps in front of the home would not be needed. All of the appliances—stoves, refrigerators, water heaters, and washing machines—are carefully selected for safety as well as efficiency (our newer homes have eye-level ovens to save bending, which is difficult for many older people); yet we never stress safety features—older people resent any insinuation that they need special accommodations. Some builders refer to such advantages as 'living' rather than 'safety' features."

We can see here inventiveness at work and tactfulness as well. Yet we must take care that housing for the aged does not result in creating vast colonies in which the aged are cut off from the mainstreams of life. I think we should pay careful attention to the words of Robert C. Weaver, Administrator of HHFA,

when he defines the major objective of housing for older persons. "It is," he says, "the encouragement of an environment and an opportunity to join with others in productive activity—important enough for a man to replace his job and for a woman to replace gainful employment or the raising of a family. This means that an essential element of housing for senior citizens is a multipurpose senior center which can become a means of reentry into community activity. Senior centers too often are conceived of as places for bingo, card games, or entertainment. Recreation is essential to men and women at any age, but the budding science of gerontology gives evidence that he who pursues recreation exclusively feels unimportant—and frustrated."

Let us not fall into the error of supposing that the later years of a man's or a woman's life are to be spent, so to speak, in pasture. If we look around us, we see many older persons doing useful, valuable, even brilliant work. The world would be far poorer if Michelangelo, Titian, Verdi, and many other great artists had not turned out masterpieces while in their eighties and nineties. Our own Grandma Moses has been an inspiration to thousands of persons. In more commonplace spheres, retired persons should be encouraged to do volunteer work in hospitals, to play a role in civic leadership, to take adult education courses, to employ their wisdom and experience in numerous ways.

But there are two prerequisites for useful activities of the aged: one is for housing and the second is for adequate medical care. In my statement of last week, I pointed out that 88 percent of New Jerseyans over 65 live in urban areas. The time is long past when several generations of one family lived together in large farmhouses. Some pertinent remarks on this subject were made some time ago by J. J. Seaman, chief of New Jersey's Bureau of Housing. Mr. Seaman said:

"The number of farm families has dropped to the lowest level since the 1880's, while the number of persons living in urban areas is climbing higher and higher.

"There has been a corresponding change from the close family relationship of the rural areas to the desires of the elderly in urban areas to have the freedom of independent households.

"Until fairly recently, most of the elderly were unable to accomplish this and even though they did not want to, they found it necessary to move in with their children. They simply could not afford any other living arrangement.

"Lately, this situation has shown some change. With social security benefits and improved pension programs, more and more of our older citizens find themselves reaching retirement with some income. True, it is a modest amount in most cases, but it has an important influence on their demand for suitable accommodations in which they may live independently instead of being obliged to live with their friends and children."

In passing the 1961 Housing Act, with its many devices for the promotion of public and private housing for the aged, Congress has faced up fully to its responsibilities. I wish I could pay the same tribute to Congress in the field of medical care. Unfortunately, I cannot. The Kerr-Mills Act is only a half-hearted effort to meet the need of older persons, who spend twice as much time in hospitals as those under 65, and also are admitted more often. It should not be necessary for American citizens to take a means test, or swear to a pauper's oath, to get the treatment they need.

The medical care of the aged should be financed as a part of the social security system, as proposed by President Kennedy. For years, this proposal has been before Congress in one form or another, but its passage has been blocked by shortsighted persons who raise specious arguments against it. In my opinion, it cannot be blocked forever any more than King Canute could sweep back the ocean waves. Let me quote the words of a distinguished Iowa medical authority, Dr. Harold J. Peggs:

"Why don't we have the courage to admit what we all know? The Forand bill, or something like it, is sure to be voted into law. Sooner or later, there will be Government health coverage for all elderly recipients of social security."

I urge this committee, and Congress as a whole, to accept the inevitable. It has done a fine job on housing for the elderly. Now let us have an equally fine job in the field of medical care.

PREPARED STATEMENT BY JOSEPH W. STILL, M.D., M.P.H., DIRECTOR, DEPARTMENT OF HEALTH, RECREATION, AND WELFARE, CAMDEN, N.J.

My name is Joseph W. Still, a physician whose specialties are public health administration and research. I have been a student of the aging problem for 15 years and have published a number of articles that relate to physiological as well as social and economic aspects of the aging problem. (A biographical summary is attached.) At present I am the director of health, recreation, and welfare in Camden, N.J., but this statement is entirely a personal one.

I wish to place before the Senate committee two papers which I believe are especially pertinent to its deliberations. The overriding facts and conclusions that I believe should constitute the basis for a solution of the problem of providing medical care to our older citizens are these:

Fact No. 1: Today, too many Americans are reaching age 65 with too small a monthly income from their savings (social security, pensions, etc.) to be able to maintain a good standard of living, let alone to be able to pay a catastrophic medical bill.

Suggestions: Four major things can be done to improve this generally unsatisfactory situation:

(a) Stop further inflation or possibly put an automatic escalator arrangement into all our social security and pension plans.

(b) Increase social security savings to provide larger future benefits.

(c) Increase pension accumulations by establishing the principle of vesting all pension rights in the individual—thus increasing the total pension benefits accumulated by the average individual.

(d) Permit oldsters to work (if they wish to do so) without penalizing them by withdrawing social security or pension benefits.

Fact No. 2: Few of our older people are today able to individually afford the costs of catastrophic illness. Complete medical and hospital insurance is very expensive for older people and few (if any) insurance policies give complete coverage against these risks.

Suggestion: The only way ordinary individuals can meet catastrophic financial losses of any kind is through the use of the insurance principle. Hence the only question is: What insurance plan will best provide the top quality medical service to older people?

My study has led me to believe that the best system would be one which would involve the Federal Government's subsidizing the excess costs to insurance companies of insuring older people at standard rates (as suggested in the attached papers) and establishing controls over the terms of all policies sold on an interstate basis. Such a system could very quickly bring most older people in the United States under the protection of health insurance with little or no disturbance of the existing system of distributing medical care. At the same time it would raise the quality of insurance being sold.

If this opinion is correct I believe this approach to a solution of this medical-insurance problem is far preferable to those solutions which would involve making the social security system the agency for distributing payments to the physicians providing medical service to insured people.

Of course the social security system might collect at least part of the taxes needed to subsidize the excess costs of insuring over-65 people. But the wholesale payment for the excess costs incurred by private insurance companies would be a relatively simple nonbureaucratic procedure as compared with making direct payments to physicians at the retail level as would be required by most other bills offered to date.

Since the Government would be subsidizing the excess costs of insuring older people it would be in a position to assure that minimum standards, which would adequately protect the quantity and quality of care to which the insured would be entitled, were met by all participating companies.

Fact No. 3: For many people work has therapeutic value. For such people, enforced retirement hastens the occurrence of the mental and physical diseases of aging and shortens their lives. These statements are accepted by most physicians who treat older people. If true it means that our present social security policies are aggravating this medical-economic problem.

Suggesting: I believe it is shameful for a government to maintain a fiscal policy such as the social security restriction on working, which is harmful to the health and welfare of substantial numbers of people. I therefore urge that this limitation on earnings be entirely removed from the requirements for receiving social security benefits.

Fact No. 4: With advancing years there is an average statistical decline in the mental and physical vigor of people. But the rate of decline is extremely variable as between different individuals. Also for many people this decline is accompanied by an increase in knowledge and wisdom that in many jobs can more than compensate for the above-mentioned physiological decline.

Suggestion, in a predominately automated industrialized economy, such as ours is fast becoming, it seems absurd to continue to hold attitudes and policies toward retriement which made sense when we had a mixed agricultural and industrial system both routinely requiring heavy hand labor, but which make little or no sense in the pushbutton economy such as ours is fast becoming.

Furthermore, antiquated retirement policies and attitudes are even being applied to teachers, and scientists, engineers, physicians and other technicians. These are people who are today in very short supply. For individuals in these kinds of work, a policy of arbitrary retirement at age 65 never made any sense.

On the other hand, I do advocate a policy (described in the attached papers) of arbitrarily removing people at relatively early ages from jobs which carry special potential for harming others. At the same time such people should move into jobs where their wisdom and knowledge will continue to be used. By transferring them to teaching, research, writing and consulting work we would strengthen our educational and scientific efforts and make full use of these valuable people.

I suggest that this committee investigate the feasibility of tying in a national pension system with the Social Security system so that all accrued pension savings which an individual might acquire would be vested in him and be placed in his account. (The detailed arguments favoring such a policy are covered in the attached paper.)

SUMMARY

The suggestions advocated above are designed to quickly relieve the problem of providing good medical care to all our present older people. But over a longer period of time these policies will act to achieve these additional benefits:

(1) To increase the average amount of guaranteed income (from social security, pensions, etc.) of future older people. They will be able then to afford a relatively higher standard of living than today's oldsters and the amount of the Government subsidy of their health insurance could then decline.

(2) Increasing the amount of money available to buy medical care, as these policies would do, would tend to increase the number of physicians and ancillary medical personnel in this country.

(3) We would be acting in a way that would have real preventive medical value for older people. As a result we would be diminishing the rate of disability among our older citizens and we would be adding years of happy life to their lives. (In this connection the committee is invited to compare the average length of life of American men and women with that of advanced European countries whose policies are very much in harmony with those advocated here.)

LET'S USE COMMONSENSE ABOUT THE AGED—NO PRESENT PLAN FOR GIVING OUR SENIOR CITIZENS ADEQUATE MEDICAL CARE TO THE HEART OF THE TROUBLE: THEIR UNPRODUCTIVE IDLENESS. HENCE THIS DOCTOR'S PROPOSALS FOR A FAR-REACHING PROGRAM TO SOLVE THE PROBLEM

(By Joseph W. Still, M.D.)

Like teenagers, Americans over 65 have become a group apart. Mostly retired or involuntarily unemployed, they compose an increasingly distinct social unit—and an important political one. Thus, they're played up to by the politicians. They're surveyed, studied, and examined by medical scientists and sociologists, by economists and statisticians. And the endless tabulations about our senior citizens reveal some frightening things. For example:

Nearly 16 million Americans are now past 65. Ten years from now, the figure will have reached 20 million.

Three-fifths of these older people have annual incomes of less than $1,000, according to one estimate.

The aged are hospitalized about three times as much as the population in general. And three-fifths of those over 65 are chronically ill.

The conclusion is as painful as it is obvious: Most over-65 Americans need medical attention they can't afford. And this situation is sure to worsen in the years ahead. The money for their medical care will have to come from some source. The big question is, Which one?

"From the taxpayer," suggests Representative Aime Forand, Democrat, of Rhode Island. He has sponsored a controversial bill to provide free hospitalization, nursing-home care, and surgery for social security beneficiaries.

"From the doctor, at least in part," suggests the AMA. Its equally controversial proposal calls for doctors to treat low-income oldsters at less than normal fees through lower Blue Shield rates.

Many medical men—perhaps most—seem convinced that neither of these plans would work. And they probably wouldn't. But the arguments used against both proposals are the wrong arguments. They fail to recognize that if our aged are ever to be cared for properly, substantial changes in the very fabric of our society must first be made.

Take the argument that's most often voiced against the Forand bill: that any such program would cost the taxpayers too much money. Of course, the bill would be fantastically expensive. Even its supporters admit it might cost the Government an additional $1.1 billion a year. But that's beside the point.

Or take the objections to the AMA's reduced-fee proposal. Generally, they go this way: "What's the good of doctors cutting their fees when rents, food prices, health-insurance premiums, and other costs continue to rise? Physicians can't solve this thing alone." True—but that's also beside the point.

THE BASIC PROBLEM

The real trouble with both the Forand bill and the AMA proposal is this: They take it for granted that nothing will ever change. They assume that few Americans over 65 will ever be able to pay for their own medical care.

It's true that as things stand, many an oldster can't meet his bills. But the tragedy is that too often he's forced into idleness, poverty, and even illness by the very programs that have supposedly been designed as old-age security measures.

Let's look at one such elderly American. I'll call him Freeman. At 65, Mr. Freeman is in good health and anxious to support himself. But he can't. Industry made him idle by retiring him at 65. Government keeps him idle by withholding his social security payments if he gets a part-time job that pays him more than a pittance. Mr. Freeman and his wife have been able to save only a small amount.

So he's forced into idleness, unproductivity, and poverty just at the time when his medical bills are likely to go up. They'd probably rise anyway. But they're almost sure to do so sooner and faster simply because he doesn't have anything to do. A city dweller, he doesn't even have a garden to provide him with exercise and diversion.

The major force that has turned Mr. Freeman the producer into Mr. Freeman the ward patient is the Social Security Act. This act was geared to an era of economic depression. Its objective—to cut back our onetime army of unemployed workers—is no longer valid. Today, it simply robs the elderly worker of all initiative. It does this by denying social security payments to Americans who stay on the job beyond 65.

Thus, a program intended to aid older people has actually become a scourage to many of them.

That's why I believe that neither the Forand nor A.M.A. proposal makes much sense. Neither gets to the roots of the problem.

Actually, both might make it worse by encouraging still more idleness and boredom, and so causing older people to need more medical care than they would if they were busy members of society.

For the point isn't: Who's going to foot the medical bills for the millions of Mr. and Mrs. Freemans? Rather, it's this: Can't we do something to help them out of the wards in the first place?

As citizens, we must. As doctors, I think we can.

We can't do the job alone. But it's logical that the medical community should take the lead in tackling the basic problem of the aged. Older people must be granted a place and purpose in present-day society. Then they'll be able to take care of at least a larger share of their own normal medical bills.

We'll have to fight for an overhaul of the social security structure and of industrial retirement policies and pension plans. So it's a formidable task. But by working together, I'm convinced that our local medical societies can help do it.

HIS RECOMMENDATIONS

As I see it, there are four parts to the problem. Here they are, together with my recommendations for a solution:

(1) Nowadays, older people are often forced to retire before they're eligible for pension benefits or able to collect social security. There's no provision in the law and no precedent in industrial practices for those who prefer to gradually cut their income and worktime as they advance in years.

Recommendation: That we fight for the removal of such restrictions in social security and pension plans, so that older people can withdraw from full employment on a little-at-a-time basis.

(2) When an employe changes jobs, he usually loses his pension rights. On the other hand, the prospect of a pension sometimes anchors a man to a job he doesn't belong in.

Recommendation: That we back an educative and legislative program to vest pension rights in the individual, not the employer. If this were done, the worker who finally retired would be able to rely on 30 or 40 years of social security benefits plus 30 or 40 years of pension-fund accumulations, no matter how many times he may have changed jobs.

(3) Too few people over 65 have much incentive to keep on working, even when they're well qualified and permitted to do so.

Recommendation: That we advocate a conversion of social security to a straight insurance-type annuity program. Contributors might be allowed to receive their benefits any time after they reached 60. But the longer they waited for their payments to start, the larger the amounts would be.

(4) Far too many aging men and women can't afford the health-insurance protection they need.

Recommendation: That we recognize the necessity for limited Government help, and that we support a program to make standard and major medical coverage available to older people at under-65 rates. Such a plan would provide for Government coverage of any deficits incurred by the carriers that participate.

Does this sound like just another let-the-Government-do-it scheme? Perhaps. But there's an important difference between this proposal and most similar ones: Under my plan, the Government wouldn't be a permanent partner.

For as the program was put into effect, the rates for younger people would be raised gradually, over 20 years or so. Thus, the deficit produced by insuring those over 65 would be systematically diminished and the income of older people would begin to rise. In time, a universal no-age-limit policy could be sold and the Federal subsidy could be greatly reduced or entirely eliminated.

Right now, we're forcing nearly 16 million people to spend years in wasteful, unproductive idleness. No wonder they can't pay their medical bills. Is it unreasonable to ask that Federal funds be used to halt this tragic situation? I think most will agree that it's merely commonsense, particularly since the Government could be out of the picture within a single generation.

CAN WE AFFORD AN AGED POPULATION?

(By Joseph W. Still, M.D.)

Ten or so years from now we may face a strange and devastating new kind of rebellion—the rebellion of youth against oldsters. Youth may be forced to rise up in self-defense because of the massive debts and burdens it will be forced to shoulder. Particularly, it may come to resent the burden of supporting an alarming increase in the number of oldsters. If this should occur it will be the result of our failure to make some commonsense policy changes now before the situation gets completely out of hand.

Ironically this social threat actually arises indirectly from the speed of our scientific progress. Medical science has stopped us from dying young of acute infectious diseases. So many of us now live long enough to develop the expensive chronic degenerative diseases that we are forced to reconsider some of our social attitudes and policies. I refer to our attitudes and belief about aging

and retirement, matters which have not been of great concern to us until quite recently.

Let's consider some of the medical factors involved in the present predicament. Until fairly recent times it was accepted that, aside from a pitiful handful, 70 years was an upper age limit that few people would exceed. Probably this consideration entered into the selection of age 65 as a standard retirement age. Even if everyone who reached age 65 retired, there still were very few retirees living at any one time, because most of them died in 3 or 4 years. So there simply were never enough of them to constitute an economic or social problem. Their individual problems concerned only themselves, their relatives, and a few close friends.

When most people were dying before they reached 70, it was also true that few people over 65 were in sufficiently good health to be useful in the kinds of hard physically demanding jobs of the 19th and early 20th century. But today, not only are more people living longer than ever before, but on the whole they are a more vigorous lot than 50 or so years ago. Not only that, but because of changes in our working and living patterns the sheer physical demands of many of today's jobs are less fatiguing than in earlier times. Consequently a great many of today's over-65's are capable of performing useful work and quite a few of them are doing so despite many discouragements and unnecessary handicaps placed in their way.

What about hiring discriminations against men and women in the middle years? Are there medical facts which justify hiring policies which discriminate against men over 45 or even 40 and women even at 35? Perhaps in an earlier time when people wore out younger and when the physical demands of many jobs were very great, there could have been some sense in such policies. But today there are relatively few jobs that require great physical work. With the improved health and vigor of middle-aged people in the United States such discrimination cannot be justified on any medical or psychological grounds, that I know of. In fact, most of the studies of this problem indicate that the healthy over-40 worker is very often a superior worker for the reason that he is less accident prone and has fewer absences on the average than younger ones.

We have heard so much about the economics of the growing number of oldsters that it is only necessary to mention the key statistics involved. The over-65 group constituted less than percent of our total population in 1830 and is expected to exceed 9 percent by 1975. There will then be 25 million over 65. Those who recall the problem created by 15 or 20 million unemployed of the depression years, will wonder how we can support 25 million who not only are unemployed but many of whom will be afflicted with the chronic diseases of later life.

When we look at this problem from the standpoint of the producers, largely age 25 to 65, we see that they are a group which is tending to grow ever smaller in our population while their burden grows ever larger. This is because there not only is an increasing percentage of oldsters to be supported, but because the length of schooling is increasing. Consequently our youngsters must now be supported to a greater age before they go to work.

The great majority of children over 15 years old were working in the 19th century. The 15- to 24-year-old age group then were largely producers. But by 1975, if present trends continue, most of those under 25 will probably still be in school. Thus a large part of the 15–24 age group will have shifted from producers to nonproducers. Until the 1960's this imbalance will be rendered even worse by the fact that the annual addition to the producer ranks will be small. For the small "baby crop" of the depression years, 1930 to 1940, are now the 18- to 28-year-olds from whom new additions to the producer ranks must come.

Also we must remember that in the last century a great many of the over-65's were living on farms or in small villages where they were at least part-time producers. But if present attitudes and policies continue very few of the over 65's of 1975 will be allowed to work and since few people will have room to raise their own food and fuel there will be little opportunity for them to produce anything. If employers are still refusing to hire people over 40 and 45, the problem would be even worse.

The effect of all this is that an ever-declining percentage of producers are having to support an ever-increasing percentage of nonproducers. It is being widely overlooked that saving dollars for retirement is not the equivalent of saving food, clothing, heat, shelter, and services. Generally speaking these commodities are perishable. Pension dollars are only valuable if they can be used to purchase these perishables. If the ratio of nonproducers to producers

gets too great there will eventually be a real shortage of goods and services. When too many dollars get to chasing too few commodities and services, inflation always occurs. Therefore, all policies which encourage people not to work tend to be inflationary. Who knows how great a role this factor is already playing in our creeping inflation? Certainly the continuance of these policies, in the face of the great increase in oldsters to be expected, appears to be a formula which can only have one end result—wild runaway inflation.

We should also consider the fact that by 1975 the number of voters over 45 will be as large—or larger—than the voters from 21 to 45. The Townsend plan failed in the 1930's because there were not enough older voters. By 1975 there will be enough. If hard times were to recur a future Townsend movement might have little difficulty voting in a monthly pension of $200 or $300 or even $400 or more a month for everyone over say 45 or 50. The fact that this would only add to the inflation would not trouble them then.

In the face of such facts, we continue to penalize people so severely for producing after 65 (62 for women) that relatively few of them do any work. The present social security regulations require anyone who earns over $100 in a month to forfeit his social security for that month. The effect of this policy is to confiscate the first $100 that a person entitled to social security might earn in any given month. That's a pretty strong deterrent to people whose earning power is perhaps already tending to decline somewhat. For those who simply can't live without working this policy means they get no help toward equalizing the disabilities of advancing years. Instead of receiving the social security payments which they are entitled to so they could work a little less hard, they are forced to forego them and maintain the same pace of work as younger people.

Social security was not enacted purely in the interests of the over-65's. To a considerable degree it was a job security policy for the under-65's. Remember social security had its inception over 20 years ago and grew out of the depths of the depression when there seemed to be not only too many hogs and too much corn, but also too many workers for two few jobs. Social security was then looked on by many as a humane way of "plowing" a few oldsters out of the labor market.

When we add to this forced idleness of the over-65's, that resulting from discrimination against hiring of those over 45 or even 40 and the many years our children must go to school, we get a very large number of nonproductive years of life. Thus government social security and private employment policy as well as the educational needs of our society are all operating to increase the ratio of nonproducers to producers.

In criticizing our present social security and many private hiring policies, I do not mean to suggest that we abandon the whole concept of retirement. But we must develop retirement policies which fit the medical, economic, and social facts of life today. Will producers eventually rebel and let the oldsters starve? No society has ever faced the problem of getting rid of 25 million oldsters. Can the United States afford to waste the wisdom and skill of so many able-bodied oldsters? Are we not in danger of supporting idle oldsters at the expense of having poorly educated youngsters? Can we really afford either the economic or social cost of maintaining millions of oldsters in idleness? When we consider that many of our wisest statesmen, scientists, and artists have made some of their greatest contributions after 65, is it sound policy to force our teachers, our scientists, our business leaders into full retirement? And why should any workmen or artisans be forced into unwanted retirement either? It is interesting that judges and legislators have avoided this trap for themselves.

There are a great many jobs today that require the wisdom which only years can bring and many of them are being poorly filled or not filled at all. In many jobs—in teaching, research, and consultation—the individual is probably at or near his peak of effectiveness at 65. But in too many cases, such people are now being either forced out of work or forced to spend much of their energy fighting rigid administrative rules which are working toward retiring them. When the average 65-year-old man will live 12½ and the average woman 14½ years longer. it is absurd to force nonproductivity on those who are both able and eager to work. Since today three-fourths of those over 65 have annual incomes of less than $1,000 it isn't that most of them can't use some more income.

There is a medical fallacy which has been getting in the way of our solving this problem. This fallacious idea comes from a group who oppose arbitrary

retirement ages. They want to base retirement on physiological age rather than on chronological age. Their argument is not with our present concept of retirement, but simply with our way of choosing the precise time to retire. These people want doctors to decide when we are finally ready for the scrap heap. Their arguments ignore the fact that aging results in a gradual decline in physical vigor, starting at least as early as the 20's. The physical decline is slow and fairly steady until true senility sets in. The decline is primarily in endurance, and not so much in ability to perform short term feats of strength or even feats of agility. Hence as we grow older we need to gradually reduce the total physical demands on our bodies and to have gradually more leisure time to recover from the fatigue of work and living.

Fortunately our mental capacities need not decline with age as our bodies tend to do. Consequently a major aim of all people should be to develop their mental powers so that as their physical powers wane they have a reserve with which to make compensations. No similar change occurs in mental capacities of people who use their minds.

Now, obviously it would be very dangerous to let airplane pilots, railroad engineers, or bus drivers work right up to the time they begin to show signs of senility, even if we had perfect tests for senility which we haven't and never will have. Commercial airplane pilots, bus drivers, railroad engineers, and others whose sudden death or disability would endanger the lives of other people should not be allowed to continue these kinds of work into the years when these risks become great. I doubt if there ever will be a way to really predict vascular accidents in individual cases. There is certainly no reliable test for them at present. Until a reliable predictive test is found we should transfer such people to jobs which do not carry such potential dangers for other people.

Because there are less dramatic but no less important risks in allowing older executives to exercise great power over other people's lives and fortunes, we should consider them in essentially the same category as those whose sudden death or disability would endanger people's lives. The catastrophe of gradual executive deterioration has often seriously harmed, sometimes wrecked, good businesses as well as the lives of others. The subtle psychic effects of loss of full vigor or of endocrine imbalances are far too delicate for present-day medical instruments to measure. I see no reason why businesses should not also identify key executive jobs in their organization where such deterioration would have unusually serious effects, and rule that these sensitive jobs could not be held by men or women over some specific age. The exact age chosen will depend on balancing the potential damage that might occur against the probabilities of an executive decline going unnoticed for a time.

On reaching these ages, people in either type jobs would be shifted into research work, or consulting or some area of the company's work where the individual's skill could still be used effectively but where he no longer would have so much operational or executive power under his direct control.

At the same time we change our retirement policies we should also end our present all-or-none approach to retiring. We would encourage working people to retire gradually as housewives or farmers generally do.

In her 40's the average housewife's work begins to decline as her children grow up and begin to leave home, first for summer camps, then to college and later to take distant jobs and to establish homes of their own. Fortunately for most women the decrease of work and increase of leisure is usually rather gradual. As a rule, if there are 2 or 3 children, they all do not leave home at once. And, of course, in most homes there still will be a husband to keep house for. Consequently, there is no sudden overwhelming quantity of leisure time to be dealt with.

But consider what now occurs to most men and women in business at age 65. Most of them have relatively little leisure except on weekends or in vacation time, until they retire. Then one day they suddenly have 12 or 13 hours a day of full-time leisure to cope with. Such a sudden change in a lifetime pattern can be, and often is, a morale shattering experience. I have discussed this problem with a number of doctors who care for older people. Without exception they have been of the opinion that this kind of sudden retirement actually kills many who, being unprepared to use so much leisure time, simply die of what is basically a severe case of boredom.

To sum up, my study of this problem leads me to these conclusions:

We should oppose arbitrary retirement policies wherever they exist. People should be forced to retire completely only when they are truly unable to do useful work or when their continued work is dangerous to others. By this,

of course, I do not mean that people should not be forced, as indicated above, to relinquish certain physically dangerous or highly sensitive executive jobs in favor of less dangerous or less sensitive ones.

We also must change our present Social Security policy so it does not penalize those over 65 (62 for women) who want to or need to work. Social Security payments should be placed on a straight annuity basis payable at the stated age regardless of whether the individual works or not. This would lead to an increase in our total production which cannot fail to benefit our economy even if social security costs do increase somewhat. It will also enable older people to gradually reduce their work without too greatly reducing income.

We must change our attitudes about people over 40 as potential employees. Our attitudes must be brought into harmony with the realities of our society. Unless industry is willing and able to support millions of people over 40 with unemployment benefits (raised by taxing industry), then industry must find jobs for these people. Actually, of course, studies have shown that, in general, age is not a handicap, often even an asset, in most job situations. Such facts must catch up with and overcome some of these prejudices. The one compelling argument is, that in the United States today, over 9 out of 10 jobs are in private industry or business. Either jobs must be made available to those who want to work, or industry and business will be required to pay enough Social Security taxes to support these people on unemployment rolls. The wisdom of choosing the first alternative seems plain to me.

The decisions we must make are going to be painful, for they will require us to discard some cherished beliefs. Most of us have grown up believing that full-time loafing would be great fun. We (came to) believe America is so rich, so bountiful, and so productive that there is no limit to what we might do, if we only wanted to. Suddenly we have discovered that there are limits in both areas. We face a clear-cut choice. We must either abandon some of our archaic attitudes about work and wealth and retirement or face the real possibility that our children and grandchildren will be forced to abandon us in our old age in order to care for their children. The knowledge that nature is such that survival of the species has always superseded survival of the individual should help us make our choice.

Senator WILLIAMS. And now, as announced, we will open the discussion generally in town meeting fashion to anybody who desires the privilege of the floor to help us with our deliberations, within some little bit of time limitaton, here.

Last week we had a system up in Newark that worked very well. Rather than you folks in the audience seeing the back of the speaker's head, we had the speakers appear at the edge of the platform and speak to us and to the group.

Yes, sir. If you will give your name and address, the reporter will take it, and we will know later who you were.

STATEMENT OF ELMER H. CHRISTIE, SECRETARY, OLD GUARD, POINT PLEASANT, N.J.

Mr. CHRISTIE. Thank you, sir, for the opportunity to appear here.

My name is Elmer H. Christie, and I am 67 years young. I am secretary of the Old Guard of Greater Point Pleasant area at Point Pleasant, N.J.

This is the largest voluntary organization of the Old Guard in the United States of retired and semiretired men. It was organized 5 years ago. It has a membership of 800. They range in age from 44, which is a young age to retire, because of physical disability, to over 90. Our wives also have a large organization in Point Pleasant, which is called the Lady Guards.

Point Pleasant is in the Jersey shore vacation area, famous for salt water bathing, fishing, and boating.

Our principal purpose at this hearing is to point out what senior citizens can do for themselves through an energetic organization and a well-planned program. We think we have the answer to many of the problems that have been discussed here.

The Old Guard keeps its members active, alert, and interested. Members say that they can hardly wait for Thursdays, the year round, that being our meeting day.

We have 30 committees, each with definite assignments. We have a band of 15 musicians, whose average age is 72, and they are famous for high quality talent in their music. They accompany our octet, our soloists, and our community singing.

Our hamburger and hot-dog chefs with the band stage picnics at old folks' homes and hospitals. They feed the patients, and they give them a real glorious time.

We also engage in charitable work, particularly at Christmas time. We keep everybody busy with shuffleboard, bowling, cards, fishing, and other recreation.

Some of our members are widowers, living alone, and our program is vital to them. We help to keep people out of these mental hospitals that we have been talking about today.

Now, upon retiring, members moved into the area from elsewhere in New Jersey and invested their life savings in purchasing one-family homes, since they could not afford to pay rent. Their homes are scattered among homes of younger families, and they do not like to live in developments built exclusively for the elderly. One-family programs.

After considering the debates at the White House Conference on Aging and on TV and in the newspapers and such debates as recorded here today, we believe that adequate medical care can only be solved through social security.

I would like to discuss, off my script, here, the Kerr-Mills bill that has been referred to here. The way that has appeared to me is this: If this room, from floor to ceiling, represented the 570,000 people who are over the age of 65 in the State of New Jersey, and if from there down represented the number of people who can be helped by public assistance under the Kerr-Mills bill, and if from here up to those chandeliers or higher might represent the people who have only a moderate income, people who are living largely on social security, and maybe a small pension besides—they get the shock of a heavy medical expense, and sometimes a repeated expense and hospitalization charges, with $24 and $27 per room a day—then that is the area from here up to those chandeliers that are up against it. And that is the area, we feel, that this medical aid program hits. But the Kerr-Mills bill only hits from there to the floor. That is the way it has occurred to me. I may be a little off on my illustration, but that is about the way I have viewed it.

Now, on another subject: There is a tendency among some insurance companies to cancel automobile insurance, solely because of the attainment of a certain age: although it seems that most companies will deny such discrimination.

There was a survey which was made jointly between the division on aging and the State department of banking and insurance, in which 208 companies stated they do not discriminate. However, several of

our members have received such cancellations, and all of them never had an accident in all the years of driving. We assisted them in obtaining coverage.

Now, denial of automobile insurance would be nothing short of a calamity to most of those who are 65 years of age or older. In our area, you will find them living in outlying areas, where, if they didn't have a car to drive to the supermarket, they would be really up against it. And to be forced to quit driving because you have no insurance protection—you can imagine what it would mean to yourself.

So we think this matter needs watching, and we are going to watch it, and we have been in touch with the State department of banking and insurance in a few cases.

We surveyed some members and came up with some significant facts. Many members have no hospitalization or health insurance. Some of them have hospitalization only, which in many cases would cover only part of the hospital bill. Most of them stated that they could not pay sudden heavy medical expense.

Their total incomes are close to the average reported by the Social Security Administration.

And right there, I might refer to this. In regard to this $800 assessed valuation exemption, the Borough Point Pleasant Beach had over 200 applicants, and those were, under the law, of incomes of $5,000 or less. The average of those 200-odd was $2,542 a year total income. That is a little less than $50 a week; as shown on the applications, which had to be attested to.

And incidentally, I understand from the papers that in Morristown the average was even less than the 25.2 I have just quoted.

Now, our survey of members before retiring: They planned ahead what they would do after they retired. And then we asked them: And are you contented now?

Now, about the same number answered that they had planned what they would do, as those who did not plan. But in all cases, they said they were contented, and they gave this reason: this Old Guard organization.

I will give you just two or three typical answers that they gave. Here is one: Just what the doctor ordered.

Another one: Without them, a lot of us would be lost.

A third said: Best thing that ever happened.

And that is the general consensus. As I said before, they can't wait until they get to meeting day with all the other activities.

Incidentally, our dues are only $2 a year.

Now, such an organization takes a lot of work, but it is really worth it. And of course we would be glad to help any group of retirees.

We have one very acute immediate problem in our own particular organization, and that is the necessity of building a building of our own. With a membership of over 800, we have practically outgrown every place we can meet in. We want to permit anyone who has retired to get the benefit of it.

So now we are wondering, due to shortage of funds, and the limited income, whether there is any place we can go to for some financial assistance, such as foundations; or if the Senate committee can offer any suggestions or advice, or anyone here, we would like to hear about it.

We think we are doing a good job down there, and the people just love it.

Senator WILLIAMS. Thank you very much. That was very helpful. Yes, ma'am?

STATEMENT OF MRS. MINNIE JACOBSON, LADY GUARDS, POINT PLEASANT, N.J.

Mrs. JACOBSON. I am Mrs. Minnie Jacobson, of the same club. I just came here to fulfill a certain purpose, and I wanted to say two words to fulfill it.

The necessity for medicine, social medicine, for the older people is so necessary if they want to go on living, because they would rather die than approach their children to help them when they get sick. And I am one of them. They would suffer all sorts of ailments before we come to our children for aid. And when we do come, it is too late for help.

Social medicine is the greatest thing for us; and our children, to take the burden off their shoulders when their parents get sick.

When a person is operated on for a certain ailment, he has to sign if he is ever sick again under this same ailment to go through surgery. He cannot get any insurance.

Thank you.

Senator WILLIAMS. Thank you, Mrs. Jacobson.

STATEMENT OF THOMAS D. HALEY, RELOCATION DIRECTOR, CITY OF TRENTON

Mr. HALEY. Senator Williams, ladies and gentlemen, I am Thomas D. Haley, relocation director of the city of Trenton.

As you know, Senator, we have a vast redevelopment program going on at the present time in the city of Trenton. I have with me this afternoon two area residents who would like to appear here as witnesses.

I would first like to introduce Mrs. Catherine Cramer, an area resident.

Senator WILLIAMS. Mrs. Cramer, very nice to see you again

Mr. HALEY. Mrs. Cramer, will you tell the Senator and the members of this audience your age and just what your present problem is?

STATEMENT OF MRS. CATHERINE CRAMER

Mrs. CRAMER. Well, I will be 70 years old day after New Year's, and I am still working. And the only thing I want is no steps where I have to move. I can't make them. That is my one problem. If there is no steps, there are no problems where I am moving to, up or down. The only thing I don't want to be—where there are steps.

Senator WILLIAMS. Now, the new housing that we saw in the elderly housing program in Trenton, beautiful housing, is going to be nine floors. Some people last week, in Newark, expressed some anxiety or fear about these higher floors. They probably always lived in a one-family house, and they didn't know how easily they were going to

adjust and adapt to the elevators and the heights. How do you feel about heights?

Mrs. CRAMER. That doesn't mean anything to me. Just climbing the steps.

Senator WILLIAMS. And then elevators don't bother you, either?

Mrs. CRAMER. No, they don't.

Senator WILLIAMS. And how about your friends? What is the general feeling? They will get used to those higher levels of living, won't they?

Mrs. CRAMER. If they don't, they can stay away.

Senator WILLIAMS. That is a good way to put it. I am sure they will adapt to them, all right. That is beautiful housing.

Mrs. CRAMER. Just so I don't have to walk steps.

Senator WILLIAMS. Where do you live now?

Mrs. CRAMER. 163 South Broad.

Senator WILLIAMS. And are you going to move into the project?

Mrs. CRAMER. I guess I will have to. I don't want to move in a private home or an apartment, because I want to move where I am going to stay and be carried out. That is what I expected here on Broad Street about 37 years ago.

Senator WILLIAMS. And is your housing being taken away by one of the programs?

Mrs. CRAMER. Yes.

Senator WILLIAMS. In other words, you are losing your house?

Mrs. CRAMER. I am losing my rooms.

Senator WILLIAMS. Because of the urban renewal?

Mrs. CRAMER. That is right.

Senator WILLIAMS. So you represent one of thousands and thousands of families that find that where they live is being taken for a Federal program or an urban program, and it is necessary to find another place to live?

Mrs. CRAMER. That is right.

Senator WILLIAMS. This is happening where the highways go through, and where urban renewal comes in, and where community facilities take areas. And it is a responsibility, where there is this governmental program, to find you a place to live, and a decent place to live.

Mrs. CRAMER. I hope so.

Senator WILLIAMS. Well, I am sure this man here is chiefly in charge of making sure you find the right place to live.

Mr. HALEY. Will you give us your reaction to this entire program, as to just how you feel you are being treated?

Mrs. CRAMER. Well, I think I have been treated very well, both by the landlords and the city. First Perlstein handled it, and the city took it, and now I guess the city has it again. They have been very nice to me, very wonderful. He saw how when it was cold I got heat put up there, and everything is just wonderful. I think he is a wonderful man to deal with. And he will sit and talk to you and explain things to you.

Senator WILLIAMS. You have been very kind to come over here from your employment over at the Stacy Trent. Thanks very much.

STATEMENT OF JOHN COLAO, DIRECTOR OF ORGANIZATION, NATIONAL COUNCIL OF SENIOR CITIZENS FOR HEALTH CARE THROUGH SOCIAL SECURITY

Mr. COLAO. I would like to make a few remarks on behalf of the social security approach on medical care for the aging.

I am John Colao, director of organization, of the newly formed National Council of Senior Citizens for Health Care Through Social Security.

The well known and respected and beloved Aime J. Forand, author of the Forand bill, is the national chairman of our organization.

Before joining the staff of the National Council, I had the experience of going out into the field and learning at firsthand some of the problems faced by the older people in the State of New Jersey. It was my good fortune and privilege to show the film "Cast Me Not Off" before 55 separate older age groups in the State of New Jersey. The film, as many of you may know, deals with arguments in support of the social security approach for medical care for the older people.

Following the presentation of the film, I went on to explain the inadequacy of the Kerr-Mills law signed by President Eisenhower. Then the question and answer period that followed was the classroom in which I received a liberal education.

Here I had firsthand accounts of a passing parade of human misery. It is this sort of experience that has left an indelible mark on my whole being. And when I hear members of the American Medical Association, members of the chamber of commerce, get up and say, without batting an eye, that the Kerr-Mills program will deal adequately with the medical care problems of the older people, I know deep down inside it is not true; because I have talked with these people, and I know what their problems are.

Just to recite a few, going back to the Elizabeth Day Center, a little old man, dejected and stoop shouldered, came up to me and said, "Mr. Speaker, I want to tell you about an experience that I had." He put his hand in his pocket and pulled out a hospital bill for $1,145, and said, "This is what it cost me to stay in a hospital for 6 weeks."

And we have another case, a heart attack victim, who had $10 a day private insurance coverage, plus up to $80 for incidentals. And even with this inclusion, over and above that, he had to pay $1,400 for an 8-week stay in the hospital. Six months later he had another relapse and had to go back to the hospital for an additional 6 weeks. And it cost him another $1,100, a total of $2,500 for a total period of 14 weeks in the hospital. And who had to pay for it? His savings were wiped out, and his children had to pay for the balance.

Next we have a little woman from the Jewish YWHA, who came up and with tears in her eyes said, "I get $70 a month from social security, and every month I must part with $30 for drugs and visits to the doctor for my condition."

Then we come to the woman from the Columbus Homes Golden Age Club, who said she had a $700 hospital bill and was utterly destitute and had to turn to her children and her relatives in order to have this paid.

Then we have the case of the senior from Bloomfield Center who incurred a hospital bill of $1,000 and did not have the wherewithal to pay for it. And again he, too, became a burden on the rest of his family in order to have this covered.

Now that I am located right in Washington, I am getting letters from all over the country, from people who are testifying through the mail, as to the critical need for medical care for the older people. Just taking excerpts in brief succession, here are a few:

DEAR CONGRESSMAN FORAND:—

This is September the 10th of last month.

On behalf of senior citizens like myself, I hope and pray for you that you will be able to pass the bill which provides for the health care of our Nation's elderly through social security. Many of us are denied this service because of inability to meet the expenses individually.

Most respectfully yours,

FRANK A. CENTRELLA,
North Miami, Fla.

Another letter:

DEAR MR. CHAIRMAN: I am heart and soul for any national movement that will further the cause of health care through social security. That is the only way we will get any place with our problems of medical care.

DEAR MR. FORAND: I am sure, with everyone doing his part, we not only will be successful; we must be. People are sick of the way Blue Cross is going up all the time. I strongly feel that in view of the present low average social security benefits, full and complete needed medical care is the least that can be humanely offered.

C. R. BURRILL,
Central Point, Oreg.

GENTLEMEN: We, my wife and I, only get $114 per month together. I am sending you my card for membership. Hoping things will be different when Congress gets together again early in 1962.

A. H. ASHLEY,
Reading, Pa.

DEAR MR. FORAND: I am myself retired, age 69, interested in the proposal to give some consideration to the older people through social security, and also the Railroad Retirement Board. I cannot for the life of me understand American Medical Association objections or the attitude of Congress, because it does not cost either one of them a thin dime.

Sincerely,

EDWIN H. POWELL,
Rocky Mount, N.C.

DEAR CONGRESSMAN FORAND: I am writing to you in regard to the great problem we old folks have facing us. No health insurance in our old age. Not that we haven't tried to get protection. We have. But we haven't been successful. We do hope, through you, we may be able to get some help. Let us know if we can do anything to help in this great cause.

And the letters go on and on, all testifying to the critical need that we have.

Now, then, just a word on this Kerr-Mills law so that it will be better understood. One of the previous speakers got up here and gave us a rather rough figure of speech, indicating that about this portion (extending his hand about 3 feet above the floor) would have

application of a beneficial nature to the people who really need help, while the remaining portion up to the ceiling would not be helped materially by the Kerr-Mills law. And he is absolutely right.

Just in the way of a specific example, we had a bill in the State of New York earlier this year, and Governor Rockefeller signed it into law, implementing the Kerr-Mills bill in the State of New York. We have, through this legislation, an additional $40 million that are going to be pumped into the mainstream, making it possible for those already on public assistance, those in mental institutions, and now the newly included medically indigent older people, who are going to be entitled to receive benefits after taking the means test. There will be appropriated for them $40 million more now than what existed before.

This will take care of 268,000 people. This includes those who are already covered, and have been covered, under the public assistance program, and those who have been covered as occupants in mental health hospitals.

Now, then, we see that with the $40 million, 268,000 people in the State of New York can stand to be benefited by this sort of legislation.

If we just abstract, if we just present these figures without tying them into an anchor, we are apt to emerge with the concept of the Kerr-Mills law as good. It does help all these people, yes; but in the way of a backdrop for this figure, there are 1,600,000 older people in the State of New York, who are over age 65, and every one of them is a potential applicant for medical care needs and assistance. When we stop to think, with this new legislation in the State of New York, we are potentially able to take care of 268,000 people, but there are 1,600,000 older people over age 65 in the State of New York. Then the picture is clear as to the very limited extent of coverage and benefits available through the Kerr-Mills law.

One more point on Kerr-Mills before relinquishing the floor in favor of others who may wish to speak.

I want to point out that as of the weekly report from the Department of Health, Education, and Welfare, of October the 16th, there were only 19 States, 17 States and 2 territories, the Virgin Islands and Puerto Rico, which had already passed legislation, and action was already in progress to implement the Kerr-Mills law. There were 20 States that bypassed legislation completely. They wanted no part of Kerr-Mills, because of the obnoxious and odious pauper's oath requirement that is part of it.

Now, then, here is another point that is not brought out too often, and I think it should be. When you talk about coverage or benefits under Kerr-Mills, it is directly and proportionately related to the ability of that State to pay for the coverage that is given to the people of that particular State. It stands to reason, regardless of whether the Government puts up the money or whether the State puts up the money, if you are going to purchase medical services, you are going to have to have the money to do it with. And one of the sad, hard, economic facts of life is simply this: There are too many States in the United States that just don't have the revenue in their State treasury in order to finance any really meaningful kind of a program for the medically indigent.

In the State of Kentucky, for example, we have a maximum of 6 days' coverage for those who need help. And the only condition under which they can get it is if they are acutely ill and on the point of emergency treatment.

Of all the 50 States, there are only 2 States that have a really comprehensive program under Kerr-Mills where a fairly adequate supply of services is rendered.

I feel in closing, now, that these points should be highlighted. And as we direct our remarks to Senator Williams, one of the points that we wish to make, Senator Williams, in behalf of the over 300,000 members of the national council, is that we need medical care for the older people, and we, in Washington, are going to carry on the fight in order to get this medical care for the people who need it so much.

Thank you.

STATEMENT OF LOUIS LURIA, FRANKLINVILLE, N.J.

Mr. LURIA. My name is Louis Luria, 38 Hardwick Drive, Franklinville, N.J.

I am 78 years old. I am not under social security, thank God. I am still capable of working. And I wouldn't say I don't need social security, but as the honorable Senator says here, in the editorial: Older people resent to be called old.

I am opposing the Kerr-Mills bill. I am for the Forand bill under social security.

Now, the Kerr-Mills bill is nothing else than a fancy word for charity. I would like to ask our honorable Senator: Why are we spending so much money to pay the Senators to waste time to pass such a bill? We have charities. Why not depend on those charities? We have reports that, if a person comes to apply for medical care: What kind of a medical care does he get? There isn't enough money. There aren't enough institutions. And they do not give the right care and will never give the right care under the Kerr-Mills bill.

Now, we have here a statement from the New Jersey State Chamber of Commerce. Friends, figures can be juggled around. You can take big figures and make them look small. You can take small figures and make them look bad.

I am going to take one figure here to show how ridiculous that figure is. They claim there are 444,000 employees, of which 94 percent are under a pension plan.

Let me tell you, friends: Those people, those 444,000 people, divided by 94, at 6 percent—those people are agents, because in the factories today, when you come in in a factory, if I would have to go into a factory and ask them for a job, I wouldn't get a job. So we find the ages are between 20 and 40 and 45. When you say you are 45 years old, they don't want you any more. Those people have to wait. Let's say they all average 40 years. Those people have to wait 25 years for retirement until they are going to get that plan.

Now, how about those 16 million aged people which are now under social security? Do they have that plan? No.

Let's say if a person made $4,800 a year and was lucky enough to accumulate the full pension, $117 a month. Is that correct, Senator?

Senator WILLIAMS. A little better.

Mr. LURIA. A little better. To get $160 a month.

I am not going to bore you with my operations, but I am going to tell you a story about one of my workers. Last year, I was supposed to go for an operation. I was waiting 2 months for a bed. We haven't got enough beds. One of my workers comes over to me and says, "How much will that operation cost you? I am not trying to be inquisitive, but I'll tell you what happened. My father had an operation, and there is a $1,500 bill, medical bill, doctor bill, and so forth and so on. The doctor charged him $500 for the operation. How much will your doctor charge?"

I says, "I didn't ask him, but I carry Blue Cross and Blue Shield. I will pay, and I will get done with it."

Now, this worker told me that the children have to pay the bill.

Even if he has this Kerr bill, his father is stuck up, or whatever you want to call it. He is not going to go for charity to pay the bill. And I wouldn't, either.

If I would be under social security or any other, and if I would have to go, and they should come and ask me questions about how much I got and how much I spend and what I do, I would refuse. I would refuse.

Now, we heard here of Mr. Goldstein. Five hundred members. If you only carried medical insurance, Blue Cross or any other insurance—Blue Cross and Blue Shield or whatever you call it is the cheapest insurance there is. Still, when anyone carries those insurances and has to go to a hospital, he gets full hospital pay, but a doctor sends him an additional bill besides what he has to pay, $100 a year or $125, or whatever it is. The rates are not for everyone the same.

There is group insurance. There is personal insurance. I do believe, from the average I heard here, people getting social security—the average is between $60 and $100 a month. How can a family of two, man and wife, spare a hundred dollars a year for Blue Cross and Blue Shield? They can't. They are not issued.

So we heard here out of 500 members only 5 or 6 were insured.

I believe that medical care should go under the Forand bill without any strings attached to it. Without any strings attached to it.

And all those who come here to represent all kinds of figures—they represent the medical association, private industry, and so forth and so on, or insurance. That is all they represent. We here have to bring out the truth and the real truth of what is going on and what we need.

And I ask our honorable Senator to work for the Forand bill, to work for homes in any part of the country, not only in New Jersey, but everywhere.

An old couple that go out and look for an apartment of three rooms have to pay between $80 and $100 a month. Social security amounts to $100 a month. How are they going to eat?

Senator WILLIAMS. Thank you. Thank you very much, sir.

STATEMENT OF REINHARDT V. METZGER, NORTH CALDWELL, N.J.

Mr. METZGER. Senator Williams and gentlemen of the committee, before I make the statement that I plan to make, I feel that it is necessary to make a comment or two on some of the statements we have heard this afternoon.

One was the cost going up. I wonder how many of you realize, and particularly you, Senator Williams, that it isn't so much the cost going up as it is the devaluation of the dollar. I hope, Senator, that you will take that into consideration, in considering these points of increasing cost.

The improved medical and surgical care which we are getting today, if related to previous medical-surgical care and the costs of both, together with the shorter time which the improved medical care and treatment is requiring patients to be hospitalized for bedfast or other care, I think you will find that there has not been too great an increase in those costs on that basis.

My name is Reinhardt V. Metzger. I live in North Caldwell in Essex County. Excuse me.

Also, I think the committee should make particular note of the fact that the present elderly folks in our State and our country are under the handicap of not having the good fortune to get the opportunities for insurance, health insurance, either in group or individual cases, as the present generation has had.

In the last 20 years or perhaps less, that situation has changed materially. People who are 70 or more today never had those opportunities under the situations that the present working people have. And I think that that will also make a considerable difference. And I hope that the committee will consider that.

Now, speaking in behalf of the conservative citizens of this State, may I say that we are all acutely aware of the problems of the aging. We are also acutely aware that the severity of these problems is increasing steadily.

Your committee is studying ways and means of easing these problems, and among these possibilities you are considering, I believe, medical care, housing, and so forth, to be paid for, or subsidized by and operated by, the Federal Government.

For the record, may I point out, as I am sure you know, that the Federal Government, according to the Constitution of the United States, is the citizenry of our country, operating through their elected representatives, and that the Government, at any level, has nothing which it does not get from the people. And nowhere in the Constitution or Bill of Rights is the Government given the authority to regulate the lives of its citizens. Therefore, obviously, the funds for medical care, housing, et cetera, will be raised by more and more taxes.

The continued increase of taxes and of deficit financing by all levels of government, but most particularly the Federal Government, has caused such a degree of inflation that the dollar bill that was worth a dollar in 1939 is now worth 46 cents. That is why some of your costs are going up.

This means that compared to 1939, people can now buy less than half as much goods as they could have in those days.

This is certainly a hardship for the aging, particularly for those hard-working, conscientious people who saved some of their money over the years in order that they might be able to care for themselves in their later years.

Many of these people bought their homes and paid off their mortgages, so that they would have their own home; not a regimented home for the aged, or not a regimented institution or a series of small rooms where they would be segregated as a group.

But the Federal Congress has proceeded through various schemes in confiscating many of those homes for such boondoggling socialistic schemes as urban renewal, Federal housing, Green Acres, et cetera; all of which require more and more taxes to operate.

Therefore, gentlemen, we submit that the overwhelming burden of taxation is the real, the basic problem facing the aged, including the aging of our present youth and the yet unborn citizens to come.

If you are sincerely interested in helping the aging—and everyone is aging day by day, you and I both—why not do something to reduce taxes, so that the people will be able to save for their later years, and thus continue to be independent and do the things they want to do in their own way, instead of having to depend on the Federal dole, socialized medicine, and bureaucratic controls to live out their lives?

How much further can you legislate our lives and still say we are a free people? Your so-called permissive or enabling legislation, which many of your bills are, both State and Federal, is a ruse, because it becomes enforced legislation as soon as some bureaucrat decides he wants it done.

For example, inoculation, fluoridation, urban renewal. I can cite these at length, if you care to give me the time, cases specifically where there has been permissive legislation, but it has suddenly become mandatory legislation.

And I speak those terms as a former legislator in the State of New Jersey and member of the assembly.

Taxes can be reduced and reduced rapidly without restricting the authorized functions of government as defined in our Constitution and the Bill of Rights. Get the Federal Government out of the tax-free rent-free tax-supported enterprises in which it is unconstitutionally engaged, and the entire personal income tax, with its tremendous staff of people, including the "snoops," the enforcement people, and the odious reports, can be eliminated.

The figures are in very round figures: The personal income tax last year produced $39 billion. The Government spent $43 billion maintaining business enterprises which the Constitution says it shall not participate in in competition with private industry.

I would be glad to be corrected if I am wrong, Senator.

Senator WILLIAMS. What was that last amount?

Mr. METZGER. The figure I have is $43 billion, against $39 billion social security income, a difference of approximately $4 billion more that it cost the Government to run private tax-free, tax-supported, rent-free, nondividend paying businesses.

Senator WILLIAMS. Are you talking about our defense expenditures?

Mr. METZGER. No, sir. I do not mean anything connected with defense, nor the functions of Government prescribed to the Government by the Constitution.

One example of what I am talking about is the rope factory in New England, which has been in existence for many, many years. They hand-make rope today in our modern machine age. I am sure you are quite familiar with that. Most every rope they make—they make decorative knots which are used in the Navy and for decorative purposes.

Senator WILLIAMS. We have been fighting to get rid of that rope factory for so long. I thought we had got rid of it 6 years ago. The rope work at Charleston.

Mr. METZGER. In New England?

Senator WILLIAMS. At Boston, in the Navy yard.

Mr. METZGER. That was still working this last year. I did check that.

Senator WILLIAMS. I still don't get that figure. I really don't know what that figure is. What did you say?

Mr. METZGER. $43 billion.

Senator WILLIAMS. What about it?

Mr. METZGER. Spent to run industry and commerce, which the Constitution says the Federal Government shall not participate in in competition with private enterprise.

Senator WILLIAMS. What is the total Federal budget?

Mr. METZGER. The total Federal budget? You can tell me that better than I can.

Senator WILLIAMS. It is around $80 billion, isn't it? You are saying $40 billion is running businesses a year?

Mr. METZGER. Yes, sir.

Senator WILLIAMS. Holy smokes. That is impossible.

Mr. METZGER. I don't think that is so.

Senator WILLIAMS. Our defense budget is around $43 or $44 billion. That is not running Lockheed. That is not running these companies. This is the money we are spending to stay free. And we are spending it in private companies.

Mr. METZGER. That I think could develop into quite a discussion in itself, Senator Williams. That is not quite so. It is the same situation as presented to the public, that all the increases in Federal taxes and expenditures are required for maintenance of the Armed Forces and the defense of the Republic.

Senator WILLIAMS. Over half.

Mr. METZGER. I ask you what the increase was last year in nondefense spending over the preceding year?

Senator WILLIAMS. 1960 over 1959?

Mr. METZGER. Yes; that is the latest year, 1960 over 1959.

Senator WILLIAMS. Oh, maybe a billion and a half.

Mr. METZGER. A billion and a half increase?

Senator WILLIAMS. That is enough. That is nondefense spending. Much of that, of course, is in programs, veterans' programs and others, where we have contracts with people, and you have to honor your contracts. You wouldn't have the Government violate a contract it has under a program with veterans, for example, would you?

Mr. METZGER. Well, I believe the Government has on occasion, particularly in aircraft industries, had to, shall we say, change a few programs. Let's put it that way. And of course the Federal Government has the great advantage, in this country, of not having to operate under a balanced budget. They may have the privilege of spending, regardless of whether they have the money available or not, which has put us in the terrific position of having been broke several times in the past few years.

As you are quite well aware, I am sure, our gold reserve at times has been practically nothing. On one occasion I believe we purchased

$3 billion worth of gold to maintain our gold balance, if I am not mistaken, and to pay our obligations in gold.

Senator WILLIAMS. We never ran out, though. Our gold holdings were declining until in January of this year we reversed the gold flow, I am glad to say. But that figure has me stumped.

Mr. METZGER. Well, I will be glad to check into it and discuss it with you at any time.

Senator WILLIAMS. I missed your name.

Mr. METZGER. Reinhardt V. Metzger.

Senator WILLIAMS. Mr. Metzger, are you speaking for a group of people, or are you here individually?

Mr. METZGER. I am speaking for a conservative group, citizens, or party, either way you want it. I didn't want to go into any political aspects of it.

Senator WILLIAMS. You are running for Governor?

Mr. METZGER. That is right.

Senator WILLIAMS. Well, by gracious, you have every right to come here and speak.

Mr. METZGER. Thank you very much. But I came here more as a private citizen.

Senator WILLIAMS. We could have put you on the more formal part of the program. We invited you and Hughes and the other fellow.

Mr. METZGER. I am sorry. I didn't receive any invitation, or I would have been glad to accept.

Senator WILLIAMS. Well, sir, it has been interesting to hear you. You haven't got my vote, but you have your statement in the record.

Mr. METZGER. Thank you, Senator.

I would like to add a few words, here.

Don't forget that in addition to the savings of this cost of running these affairs, the mere fact that you sell these businesses to private enterprise does a number of other things.

It first produces capital money, which could be used to pay off a portion of the Federal debt, which in turn reduces the amount of taxes required to pay the tremendous interest which again, to quote a figure which you will challenge, I am sure—the total interest on the Federal debt this year I believe is somewhat more than the total Federal budget in 1939. You might want to check that figure, Senator.

Senator WILLIAMS. All right. I was just reading your campaign card. This is a credit card, isn't it?

Mr. METZGER. A State credit card, yes.

Senator WILLIAMS. "Admit bearer to merry-go-round, jet to the moon, darn foolishness to nowhere."

I just happen to be supporting all of these programs.

Mr. METZGER. I wouldn't doubt it. I thought you would be interested in that, Senator.

Senator WILLIAMS. You know, I will tell you, though. Take that Tock Island proposition.

Mr. METZGER. That dam on Tock Island could be spelled either way, you know.

Senator WILLIAMS. Your grandkids will be very grateful for our storing up this water. When this State is urbanized, as it will be in 25 years, that water will be life to thousands of people.

Mr. METZGER. Senator, I wonder if you are referring to or have in mind the Tock Island Dam, which we refer to there; not the entire project of the Delaware Valley, but the Tock Island Dam, which, according to the figures that I have received, will produce so little electricity, if a generating station is placed there—and under the Federal program, in order to establish dams for flood control and so forth, the Federal Government requires that a generating plant be utilized with it. That ties in with the Federal program of flood control, water supply, and power supply. And I believe you will find that the figures of the possible electrical current furnished by the Tock Island Dam itself will be insufficient to provide a city of, I think, a couple of hundred inhabitants sufficient electricity to run their freezers and refrigerators.

Senator WILLIAMS. And the water will be useful, too.

Mr. METZGER. That particular dam is only part of a much larger project of the Delaware River Basin, Senator, which you may be more interested in getting some details on.

Senator WILLIAMS. Well, on this jet port to the moon, I go along with you on that. I think it is far more important for us to get our people to work on time at home without going through the waste of traffic jams than to get us all to the moon for a vacation.

Mr. METZGER. I am glad to hear that, Senator. I agree with you.

Senator WILLIAMS. One out of four? That is not bad.

Mr. METZGER. That is a good percentage.

Senator WILLIAMS. OK.

Mr. METZGER. Now, in closing, I would like to say this: Another way the tax load can be reduced is to quit legislating more and more of these boondoggling spending schemes, which are strictly in the guise of welfare, but frankly, as a candidate for Governor, it having been announced by our good Senator, I feel it is strictly a vote-getting scheme and nothing else.

It is going to cost the taxpayers money, and the more money you take out of the taxpayer's pocket, out of the citizen's pocket for taxes. the less money they are going to have to take care of themselves and their families and old age, including medical expenses.

We respectfully suggest that is probably the greatest assistance the Federal Government can lend, not only to the present aged and aging and senior citizens and what have you, but to those who are going to become aging from time to time, and that includes me, you, Senator Williams, and all the rest of your committee.

Thank you very much for the privilege of being here.

Senator WILLIAMS. Well, we thank you, Bob Metzger.

Now, I have had many good reasons prior to today regretting that the gubernatorial candidates for one reason and only one reason didn't get together and debate the issues. Now, I have another one. I would like to have heard you debate.

Mr. METZGER. I would be very happy, as I have already challenged the Democratic gubernatorial candidate, by letter——

Senator WILLIAMS. Why not the other one?

Mr. METZGER. Because he has already, very foolishly, I think, made the mistake of announcing he will not engage with anyone in debate.

Senator WILLIAMS. Well, I'll give you 5 minutes on that proposition.

Mr. METZGER. No doubt.

Senator WILLIAMS. But I am perfectly willing to debate any State issue at any time, including the related State-Federal issue of the government-in-business aspect, of which we spoke a minute ago; and any time that the honorable gentleman would care to do it.

Mr. METZGER. Thank you.

Senator WILLIAMS. All right. Thank you very much.

Could I have a show of hands on how many more town meeting speakers we have? Because we have got to start budgeting our time, you see.

I have learned something about budgeting, here, in the last few minutes. We have to budget our time. We have a lot of people who have to make trains and planes.

Fine. Now, can you all express yourselves in a minute or so? Because I have got to take care of these folks, some of whom have to get to Los Angeles tomorrow for another hearing like this.

STATEMENT OF LOUIS J. PERSICO, FIRST VICE PRESIDENT, AFL–CIO

Mr. PERSICO. My name is Louis J. Persico. I am first vice president of the newly merged AFL–CIO in Mercer County. I am also one of nine community service staff representatives in the State of New Jersey from the AFL–CIO. So I do have some experience as far as the aged and others are concerned.

I was very much interested in hearing some of the previous speakers here this morning, particularly the medical society, the chamber of commerce, and what have you. These are organizations that, if you were to look up their history, you would find that they have been against social security or were against social security, Blue Cross, Blue Shield, unemployment compensation, workmen's compensation, and temporary disability.

Today they are telling us that Blue Cross-Blue Shield is a wonderful thing and social security is a wonderful thing, but they are opposed to the medical bill as far as social security is concerned, because they say it is socialistic. And they say people will receive social security that don't need it.

Well, under social security there are a lot of people who receive it that don't need it. And they take it. They have the option of either taking it or leaving it.

Now, as far as the medical profession is concerned—and don't get me wrong; I have a lot of friends that are medical men, and they are honorable people, but I am talking about the association, not only here in the State of New Jersey and Mercer County, but the country as a whole.

For example, take Blue Cross-Blue Shield. I come from the General Motors plant here, where we pay a little more than someone else on riders to take care of certain things. One of them is physical therapy, up to $50 a year for anyone who needs that service, if it is administered by a medical doctor at his office.

And what do you find? You find that the same medical men, and thank God they are few in number, that will refer them to a physical therapist—these people are charged extra for this service, which they contract to provide. And they circumvent that. It is a matter of

record, because I went to the Blue Cross-Blue Shield office in Newark to protest on this thing.

The same thing if you go to the hospital for an operation. They pay for the operation; but when you make visits to the doctor's office, it is that much more of a tag. Those are things that go on.

And again I have to take off on the medical society, because right here in the city of Trenton not too long ago I attended a meeting where we were trying to establish a blood bank. And I testified that we need a blood bank very, very much in this area. I was told by the representative of the medical components' society here in Mercer County that we had too much blood now.

Still, day in and day out, I get calls for blood. For example, last week a father of a nurse needed blood, there was also another fellow in the same room with him who only had one pint of B-negative blood and needed more. I had to put something on the air through the courtesy of WTTM, to get volunteers to go to the hospital and provide blood. The two doctors attending were fit to be tied, because there was no blood in the hospital.

I told them, "Go before your society and get them to change their policy as far as blood is concerned."

One man testified he waited 2 months. I waited 30 days for a hospital bed. We have any number of these things. But still when we go for these services, we don't get them.

These are the kind of people that come here who, without batting an eyelash, try to tell us we don't need social security, we don't need medical care, and what have you. Let them get out and contact the poor people. I come from a working family.

Then we hear about pensions. I heard the representative of the Chamber of Commerce of the State of New Jersey. Where were these people years ago? My father worked for a company in Trenton for 41 years. They gave him then $51.01 pension.

If it wasn't for unions—and I am not trying to make union talk here—but if it wasn't for organized labor in this country, we would not have workmen's compensation, unemployment compensation, et cetera, we would be back in the dark ages.

But these same enlightened, educated people that come here representing these organizations should read a little history about this country—how these things come about.

With that, honorable Senator—because if I get wound up on these things I could go on all night long—I will just close. Thank you for the opportunity to testify.

Senator WILLIAMS. Thank you.

Now, Miss, you go right ahead. I will have to read later what you have said. I have to go out and make arrangements for another meeting, but you go right to it.

STATEMENT OF MRS. MARIE WILLABOY, ORANGE, N.J.

Mrs. WILLABOY. Senator Williams and ladies and gentlemen, I just heard about the medical care the people are getting. I have heard my physician, Dr. Alvarez, speak about it. No one has had more experience with doctors than I.

My name is Mrs. Willaboy. I have lived in Orange over 50 years.

I was a part-time social service worker. And I resigned only last

week on account of my illness. I was serving up to 50 people every Monday in East Orange and every other Tuesday in Orange. And every other Tuesday in East Orange.

Now, I would like to ask for help. We don't only need medical attention, but we also need legal aid.

I could go on with the situation as to my husband. I can go through my hospital bills to show I had him home before he died. So they can't have me arrested. This is what one psychiatrist says: "She has been to the police, the legal aid, half a dozen lawyers, the Federal Department of Justice, the State labor department, and the prosecutors. My conclusion is that she is psychotic."

Now, I went to all these people to get some help for my husband when he was ill. He worked on his profession 47 years. And 25 years for one firm. And he became ill in 1936. He was paid $13 and a few cents. He was sent to the State labor department.

As I say, I went to all these people, and from the prosecutor's office I was sent to a lawyer to file a petition for compensation. Well, the petition was filed, but when the trial was to come up, on December 20, he was sent to Overbrook, to the insane asylum. He was sent there December 6, and he died December 28.

Now, ever since that time—his death was reported in Cedar Grove a year after he died. And of course I had no proof of death, and I couldn't collect any insurance, and not even now.

Now, I appeal. And I have to sell my property. Now, without a proof of death, you can't get your will probated. The will was filed, but it never went to the orphans court.

And so now I am ill, and I can't take care of the property, and I have to sell it. What am I going to do about it, to sell it, and to be cleared of the accusation that I killed my husband? As long as I am reported insane, I have no right to sell anything.

Mr. FRANTZ. First, would you mind stating your name again for the record?

Mrs. WILLABOY. Mrs. Marie Willaboy, 664 Wallace Street, Orange, N.J.

Mr. FRANTZ. Well, now, because of the shortness of time here, and we do have several others who need to be heard, I don't believe we can take the time to go any further into the situation that you describe. I think that although these problems are usually taken care of or dealt with at the local level and by community agencies, it is quite possible that the assistance in the legal problems that some of the elderly people have should come in for some consideration, and we are very glad to have your suggestion.

Thank you very much.

Mrs. WILLABOY. You see, the report is in the local board of health office. I was there not long ago. And the board of health officer told me: Why don't you get yourself a lawyer?

It was his business to investigate, and he didn't. He still says I killed my husband. And how do I get it out of there?

I am 81 years old, and I don't have much longer to live, and I am not going to die and have it in the records that I killed him.

Mr. FRANTZ. Well, your problem as you describe it is fairly complicated, and it is something that we would not be able to have any judgment on without going into it much more carefully. I think that

the best idea would be for you to see the State attorney's office, or local community agencies, and they would be more able to help you with it.

Mrs. WILLABOY. And I gave so many dollars to lawyers, and they just try to push me in instead of helping me.

Mr. FRANTZ. Thank you very much.

STATEMENT OF J. APPLE, TRENTON, N.J.

Mr. APPLE. Well, I am just going to say a few words. I would like to answer some of the gentlemen from the chamber of commerce and the gentleman who spoke here a while ago.

Mr. FRANTZ. Yes. Would you give us your name, please?

Mr. APPLE. The fellow that worked in the shop is protected by the the hospitalization and pension. Well, I work in the shop. And my pension is $17 a month. Me and my wife work. And the whole thing amounts to $160. We were sick, both. I was sick, and I got a bill from the doctor, $450, $250 hospitalization pay, and when I was sick the same thing.

The medicine and the hospital cost 70 cents an aspirin pill. I know what the hospitalization paid for the medicine. I got a bill to pay $25. And this is the thing. How could a fellow manage on that without medical care?

Those gentlemen spoke that everybody is insured. I pay to get hospitalization. I pay $160 a year. That is after I got out of the shop, I had to apply. The factories don't pay for it. I have to pay for it.

So there are a lot of things that have to be done.

That is the only thing I say.

Mr. FRANTZ. Thank you, sir.

I wonder if you would state your name?

Mr. APPLE. J. Apple, 2210 South Bolton Avenue, Trenton.

STATEMENT OF JOAN HIGHLAND, MONTCLAIR, N.J.

Miss HIGHLAND. My name is Joan Highland. I am from Montclair, N.J.

I think you have to have strong stamina to stay this late.

I am going to save you a lot of time, because I had a speech prepared, here, and I sat here all morning, and I had a great deal to say, but I know at this point nobody is interested in listening to it. So I am not going to bore you.

Mr. Metzger ably presented everything I had to say. I am sure I couldn't do half as well as he could. But I stand for everything that he says.

And I want the Senator to know that I feel that this whole thing was conducted in a very biased way. He was very bored when anybody talked about anything that stood for the Kerr-Mills bill. He succeeded in dragging this thing out by having older people sit there and talk about a lot of stuff that just dragged and dragged and dragged and repeated.

He has succeeded in emptying this room so that there is nobody to listen to me. He is absent when I am ready to speak. And if this is the way you call an open, free meeting, and this is freedom, then I can't see it. I am thoroughly disgusted.

And I have only one message to leave with you and with him, and it is this: If you don't stop dangling the doctors around like a lot of puppets, they won't go back to the jungle. You all can go back to the jungle. You need the doctors. And don't forget that. With all the bills you think up and all you want to do, you need the doctors.

STATEMENT OF MARY KEEZIE, TRENTON, N.J.

Mrs. KEEZIE. My name is Mary Keezie, 409 Hudson Street.

The only thing I want is I want an apartment with no steps, because me and my husband got asthma, and we live in a place with 15 stairs that we have to climb. We don't get no heat or anything there. And I am under the welfare about a year now. Me and my husband is on the welfare. And that is all I can say.

I just want somebody to help me out on the stairway and have no stairs to climb. My husband and me got asthma, both of us. We go to the clinic every week. For a whole year now we have been going.

Mr. FRANTZ. Do you plan to apply for an apartment under public housing?

Mrs. KEEZIE. I did put an application in. You see, we can't climb the steps, because every time we walk the stairs we get that feeling.

That is the only thing I want them to help me out. And we are on the welfare a whole year now. My husband can't work, and I can't work. And we ain't collected no social security yet. He is 65 this March. He put an application in to collect it, but he didn't collect it yet.

And the only thing is I want to get with no steps. First floor will be all right. I won't have to climb all those steps I am climbing now. I have to walk down twice in the day, three times in the day, to take my garbage out and all. I am the only one who has to do it. My husband is sick and can't do it, and I am sick, myself. I have this asthma and have been going to the hospital now for about a year every week. Me and my husband goes.

That is the only thing I want. So we can't have so many steps to climb.

Mr. FRANTZ. The new——

Mrs. KEEZIE. We put an application in. They said they would try to get it for us.

Mr. FRANTZ. Thank you very much.

STATEMENT OF SUSAN ROSEN

Mrs. ROSEN. I am Susan Rosen.

I am going to be 62 years old. I am interested in golden age and the aging, and I was not going to take this microphone. But after hearing that really rude young lady—compared to me she is a young lady—I think she was very rude. I have been here since 10 o'clock this morning, and I have heard some wonderful people express themselves for a very good cause. And to say that she agrees with Mr. Metzger, with everything Mr. Metzger says—well, I don't agree with things he said.

You can't just brush it off the way she did. She was very rude, insulting, and I certainly wouldn't want to have anybody she agrees

with in this community. If I can have anything to say, I can say it.

Senator WILLIAMS. Thank you.

I guess I missed some fireworks. I will read the record with a great deal of interest, and we appreciate that warm, wonderful statement.

I guess this concludes a very productive day of discussion of very serious problems, and we are very much indebted to all that participated. And I am sure that when the committee convenes again in Washington in January, the record made in New Jersey will make a very significant contribution to the substantive program that we will now be working on in Congress in the coming year. Thank you.

(Whereupon, at 5 p.m., the hearing was adjourned.)

APPENDIX

[From the New York Times of Aug. 13, 1961]

REPORT FROM THE "FRENZIED FIFTIES"—MAN ON THE FAR SIDE OF THE HALF-CENTURY MARK GIVES HIS VIEWS OF THE YEARS A DOCTOR SAYS CAN DRIVE MEN TO "HYPOCHONDRIA, ALCOHOLISM, SUICIDE, EVEN MURDER"

(By James A. Michener [1])

[1] James A. Michener, the well-known author, admits a bit reluctantly that he is 54.

We men in our fifties have received quite a jolt.

Dr. John F. Briggs of the University of Minnesota warned us not long ago while addressing a meeting of the American Medical Association that we had now left our "foolish forties" and had entered our "frenzied fifties," where dreadful things could be expected to happen to us, including "hypochondriacism, alcoholism, suicide, or even murder."

The cause for this appalling collapse, said Dr. Briggs, was that in his late forties and early fifties a man can no longer hide from himself that "he has squandered his reserves of emotional, intellectual, and physical strength and realizes he no longer has what it takes to do everything he wants and needs to do."

Dr. Briggs said, "Fully half of American executives and professional men suffer at least some of the frustrations and anxieties of the frenzied fifties. Some never recover."

He said, "The symptoms are as clearcut as the rash that goes with scarlet fever, and the underlying cause is a failure to learn one's limitations early and to frame one's life within them."

Well, after hearing what was in store for me I went around walking on eggs. Whenever a whistle blew I figured it was the paddy wagon coming to haul me away, and I could imagine my friends mumbling as I left, "Poor Jim. He refused to face up to his limitations."

My gloom lasted 3 days. Then it was Saturday and I had to play four sets of red-hot tennis with my regular gang, and it occurred to me that these men were experts in this field of growing old and I decided to get their opinions.

Our tennis foursome is composed of exactly the kind of men Dr. Briggs was talking about. We are in his age group. We have been ambitious and hard working. Our jobs take us to New York, where we experience unusual pressures, but we stubbornly keep our homes in rural Bucks County, where we garden, love nature, transplant trees, and play tennis at any opportunity.

Graham Place, on whose court we play, had known real success as a cartoonist with a popular comic strip of his own. In his forties he shifted courageously to the production of animated cartoons for television, and has since lived an abnormally hectic life. He says, "What Dr. Briggs claims about the frenzied fifties is true. Then a man's life creeps up on him and snows him under unless he takes specific precautions. I've seen it happen to a lot of men, and one of the best protections is to maintain an active body in which an active mind can stay young."

When asked about tennis for men approaching 60, Place says, "If you play doubles and let the passing shots go right on past, it's probably as good an exercise as you can get. I used to play with Justice Hugo Black and I noticed the other day that when a reporter asked for an interview concerning Black's rumored retirement from the Supreme Court because of old age, the 75-year-old Justice replied that he hadn't time to talk because he was on his way to play a set of doubles."

It was Graham Place who convinced upper Bucks County that men who kept themselves in reasonable condition could play tennis even during the winter.

Last January, during the blizzard period, we dressed in ski suits, wore earmuffs and mittens, shoveled the snow off the court, and went ahead.

The second member of our foursome is an expert on tension. Erwin Swann, as vice president of a vigorous New York advertising agency, has for some years handled most of the high-pressure accounts. He says, "Dr. Briggs is wrong on only one point. In our crazy business the pressure is kept so high that the collapse he talks about is more apt to take place in a man's late thirties or forties. By the frenzied fifties the weaklings have been weeded out."

When asked how he managed to survive he says simply, "I keep an apartment in New York and I tell myself, 'This is where I work.' But I keep this silly little farm in Bucks County and every week I tell myself, 'This is where I live.' You know that nothing can keep me from coming home every weekend."

Swann says that he consciously releases tension by maintaining an interest in the fine arts, in philosophical reading and, while immured in the city, in nonstrenuous handball.

The third member of our doubles quartet is Hal Rushton, a senior captain in one of the world's major airlines. Not yet in his fifties Hal has perhaps come into more contact with the problem of aging and maintaining one's equilibrium than any of the rest of us, for he works in a field where good physical and mental condition is a constant concern.

"A man can earn something over $30,000 a year flying the big jets," he says, "but they demand $30,000 worth of performance. The incompetents go fast."

Like all pilots, Hal must submit himself for detailed periodic checks. "This keeps a guy from drinking, or staying up too late, or getting flabby about the belly, or wasting his eyes on television." Like the rest of us, he specializes in gardening and tennis.

It was Hal who made the most telling observation on the Briggs speech. He said, "I know what the doctor's talking about. Last week a senior pilot who used to be a terror with the ladies * * * a girl in every major European capital * * * said with some despair, 'It's really horrible to grow old.' A man in that frame of mind could run into a lot of trouble just like the doctor says."

When our foursome first formed up in a kind of gang warfare against the mental depressions of the fifties, some of our neighbors were amused. We are certainly not gazelles on the tennis court, and any self-respecting farm boy could accomplish in 15 minutes the gardening we do over a full weekend. And our wives thought we might be trying to prolong childhood a bit longer than was advisable.

Then three of our neighbors, men who had surrendered themselves to the luxury of melancholy, committed suicide. A man down the road was overtaken by hypochondria and there was constant evidence of the malaise that Dr. Briggs was talking about. It became apparent that men in their fifties were lucky if they stumbled upon some way of maintaining a reasonable degree of sanity.

Listen to what a famous television comedian told us when we discussed the problem with him. "I could sue this guy Briggs for writing that article. He's describing me exactly. For a period of 5 years I lived in a mortal hell. It started when I reached 50. I had a great contract at the Paramount Theater and was on top of the world.

"Then one day as I was going to work I became aware that all the buildings on Broadway were reaching down to smother me. I had to ask a man to help me across the street because the motorists were after me. When I went into the subway I had to keep myself pressed against the walls, because I was convinced the trainmen were going to drive their trains up over the platform to get me.

"When I got to my dressing room at the Paramount I fell into a terrifying despair and when I heard my music start up in the pit I started to scream. They took me out of the theater, canceled my contract, and for 5 years I was exactly like the good doctor describes. Suicide was out because of religious reasons and murder I don't go for. But the rest was so horrible and remains such a vivid memory that anything a man can do to escape such misery he ought to do."

When I asked the comedian what he thought had triggered his particular case, he said, "The sudden realization that I was 50 and that from here on things would never be any easier. Sex must have had a good deal to do with it. Also the long years when I was battling tooth and nail for success. Anyway, one day the whole thing exploded."

He concluded, "Let me put it this way, Mr. Michener. This experience was so terrifying that I wouldn't even wish it on Milton Berle."

My own experience with what might be called the frenzied fifties syndrome has consisted of three dramatic incidents. The first occurred when I was in my thirties. My boss was a Navy captain in his fifties, and one day on a hot tropical island he was forced to admit to himself that he would never make admiral. He was a big, rugged man who had led an active life and this sudden stoppage of his career was more than he could adjust to. Around 10 each morning he would flush up, burst into tears, lose control of himself emotionally, and become a shivering wreck for about half an hour.

I thought he was going out of his mind but the doctor to whom I reported the matter assured me, "He's just going through his climacteric." When I asked what that was he explained, "Everybody worries about the change of life that occurs in women. Well, it happens in men, too."

This knowledge was of little value to me when one morning the captain came into my office, looked at the curtains one of my enlisted men had hung, and started to shout, "Why doesn't anyone consult me about these things, Michener? Who told you you could put curtains up on my base?" In a frenzy of rage, trembling and with tears streaming down his face, he proceeded to tear down the curtains while I and my gang stood by in a state of shock.

I have since had to witness four or five similar cases which led ultimately to suicide or other personal tragedy. I'm certainly not able to identify the symptoms before the melancholia strikes, but when it happens I now know what it is that I'm witnessing.

The causes seem to be these: (1) a delayed admission to one's self that he has gone about as far along the road to success—whatever that is—as he is likely to go; (2) an awareness of a beginning physical deterioration; (3) a forced reevaluation of the role of sex in life; (4) the male climacteric, and (5) some otherwise trivial thing that throws one's life out of gear for the moment.

Regarding this last reason, I have never known a man caught up in this syndrome to collapse over any big reverse. Invariably it has been some inconsequential irritation that triggered the tears and the trembling.

It is also interesting that of our tennis foursome, all of whom have had an opportunity to watch this dramatic change occur, each member tends to put his major emphasis on a different cause. Graham Place, the cartoonist, thinks it comes from the sudden awareness of physical deterioration. "That's one great reason for keeping up a limited participation in games of some kind. If you don't check out, year by year, your increasing limitations you're an idiot. But if you accommodate yourself to them physically, you also adjust emotionally."

Erwin Swann, the advertising executive, suspects that a good deal of trouble stems from men's refusal to assess their career capacities accurately and acknowledge the insuperable consequences of their own limitations.

Hal Rushton, the jet pilot, says, "I think that anxiety about sex must account for a good many of these breakdowns. This is a more important factor than we like ot admit. After all, who cares if he can no longer run the hundred in 10 seconds flat? But significant changes in a man's sex life can throw him right off his rocker."

My own suspicion is that the base cause is probably the male climacteric, which means that sex plays a significant role, but in an automatic glandular sense rather than in a performing sense. Furthermore, a good many other glandular and emotional changes are also involved, so that sex becomes merely one contributing factor rather than the major cause.

My second brush with the frenzied fifties syndrome came with the crystal clarity that marked the advent of the comedian's trouble. I was walking along a country road on my 44th birthday when I was overtaken by a most startling awareness, evidenced by what seemed to be a voice, saying, "Michener, you're as good a man today as you will ever be. From here on out, everything is downhill."

I was standing at the time on a small hill that leads down to my home and I visualized the kind of 18th century drawing that used to accompany popular editions of "Pilgrim's Progress," except that I was the pilgrim and the road to be traveled was not of infinite length. From that moment on I saw myself entirely differently, as a man whose capacities would be yearly more and more limited. It was an experience more real and tangible, than many conversations I have subsequently held with corporeal people.

Ratification came dramatically. While adventuring behind Russian lines during the Hungarian revolution, helping refugees to escape to Austria, I was hit by the hammer of a minor heart attack which terrified me. I quickly recovered,

but some time later, when I wanted to fly to 55,000 feet with jets of the Strategic Air Command their doctors looked at my health record and I was somberly summoned into the office of the commanding general.

"Michener," he said bluntly, "SAC would be guilty of criminal conduct if it flew you to 55,000 feet. Every medical indication tells us that you might not get down alive."

I was put into the hands of a sensible doctor who fortunately viewed such cases as mere routine. He said, "You've had a minor little warning and from here on out it's up to you. You can either surrender yourself to being a cardiac cripple or you can work at the job of getting into tip-top condition." He launched me upon a program of losing weight, avoiding rich food, and exercise. When I asked if tennis was permitted he growled, "Why not?"

In the years that followed I have taken over the controls of an SAC jet at 40,000 feet, skin-dived to 65 feet, traveled around the world four times, engaged in two major revolutions, explored the deserts of central Asia and climbed the lower Himalayas. I have married, written four books, fought a couple of yearling bulls in Mexico, and mowed about 2,000 acres of lawn—or so it has seemed.

But I have also never lost the sound of that premonitory voice that spoke to me when I was 44: "From here on out, everything is downhill." I take a nap every day. I try to be in bed by 11 each night. In tennis games, when a ball is far off to one side, I let it go. And I remember that I am in what Dr. Briggs terms "the frenzied fifties."

I take most comfort from knowing men like the fine American painter, Lee Gatch, who lives across the river from me in New Jersey. Lee is 59, a tall, rugged, salty man who worked quietly for 30 years without much public recognition but with a growing reputation among the professionals.

"During this time," Gatch says, "I worked ahead on my own schedule. I painted as well as I knew how and tried to concentrate on the problems of art rather than those of illustration."

Suddenly, after years of hoarding his talents and his canvases, fame condescended to look his way. He was in his midfifties at the time and now his canvases sell at $8,500 each. For the past 3 years he has never had completed one to show in his studio. They have all been bought before they were finished.

Gatch says, "Success is not worth killing yourself for. I don't think a man ought to deviate one inch from whatever he thinks is the way to go. Then, when he reaches what you call the frenzied fifties, his character can sustain him through whatever happens. The men you're talking about, the men who crack up for such silly causes, they must have been off the line all the way along."

Having watched a lot of men handle this problem far less efficiently than Lee Gatch has done, I have concluded only one thing: "If in American society a man can live to age 65 without ending up in jail or the boobyhatch, he should consider himself a real success." I have about 10 more years to go, and I'm not sure I'll make it, but I think a man ought to give it the good old college try, and I intend doing just that.

New York Times magazine, Aug. 13, 1961 (pp. 15, 94–96)

Drawing by Abner Dean.

At 50—The Game of Life.

[From the Journal of Housing, July 1961]

NEW ELDERLY HOUSING IN TRENTON STRESSES COMFORT, ECONOMY, SAFETY

Even though opening date was a year and a half away, applications were coming in early this year for apartments in Trenton's Louis Josephson Apartments, due to open in July 1962.

The eight-story building, designed by Joseph Carchidi of Kramer, Hirsch & Carchidi, is said to be a "practical demonstration of how economical materials and methods of construction can be blended to provide a study of beauty and utility at minimum expense." Design features include both bath and shower, as a solution to the endless argument as to which the elderly prefer; the usual grab bars, nonskid flooring, middle-height cabinets and kitchen appliances, easily opened windows; sliding living-room wall window opening onto a private balcony; and a covered patio and open terrace. Reports Trenton housing authority executive director Joseph S. Tysowski: the New York regional office of the Public Housing Administration "has used [the Trenton design] as a model in many instances."

Economywise, the news for oldsters is good: tentatively, monthly rentals will range from $30 to $60, depending on income.

[From the Courier-News of Plainfield, N.J., Oct. 13, 1961]

AN AGE ISSUE

Older people—most of them, at least—don't like age labels.

It is easy enough for younger citizens to admonish their elders that they "should accept their lot cheerfully and philosophically." Only those who have become "senior citizens"—that's one of the labels—are not too happy about being segregated as "problem people."

Thoughtful elderly persons would be the first to admit their age category often brings problems of loneliness, premature unemployment, lack of an active interest, ill health, and loss of income.

Yet none of these troubles is as serious as the blow to personal dignity felt when citizens over a given age are discussed, worried over, and ministered to under the ungracious category of "old folks."

Age is not a question of years but of constitution and temperament, and the sooner geriatricians and social workers approach them as individuals, the sooner will our older citizens be rid of the labels.

[From the Trentonian, Jan. 28, 1961]

TRENTON JOINS NATIONAL MOVE TO PROVIDE "GOLDEN YEARS" FOR ITS SENIOR CITIZENS

When the White House Conference on Aging was held earlier this month in Washington, delegates from 50 States previewed the newest innovation in the movement to provide "golden years" for the Nation's ever-increasing population of senior citizens.

Underscoring the fact that the housing industry has joined forces with Government in an effort to solve the living needs of the aged were displays of two new dwellings designed especially for retired folks living on reduced incomes. One was a sample two-bedroom house, the other an efficiency apartment. Both are part of the Public Housing Administration's program which provides financial assistance to municipalities pioneering this move.

One of the cities quick to take advantage of this new Federal assistance program was Trenton, a city equally quick some years back to pioneer special community programs for senior citizens.

Now the Trenton Housing Authority, headed by Joseph A. Tysowski, is working arduously toward the early completion of a new housing project for the elderly— the Louis Josephson Apartments to be erected on Oakland Street.

Plans for the 152-family building were drawn up according to PHA specifications by Kramer, Hirsch & Carchidi and have been approved by the THA. Bids will be opened February 15 and Tysowski said it is hoped that construction will begin by April 1. Completion is expected by July 1962.

Named for the former city counsel, a man who did much to help the needy in his lifetime, the completed Louis Josephson Apartments will be a practical demonstration of how economical materials and methods of construction can be blended to provide a study of beauty and utility at minimum expense.

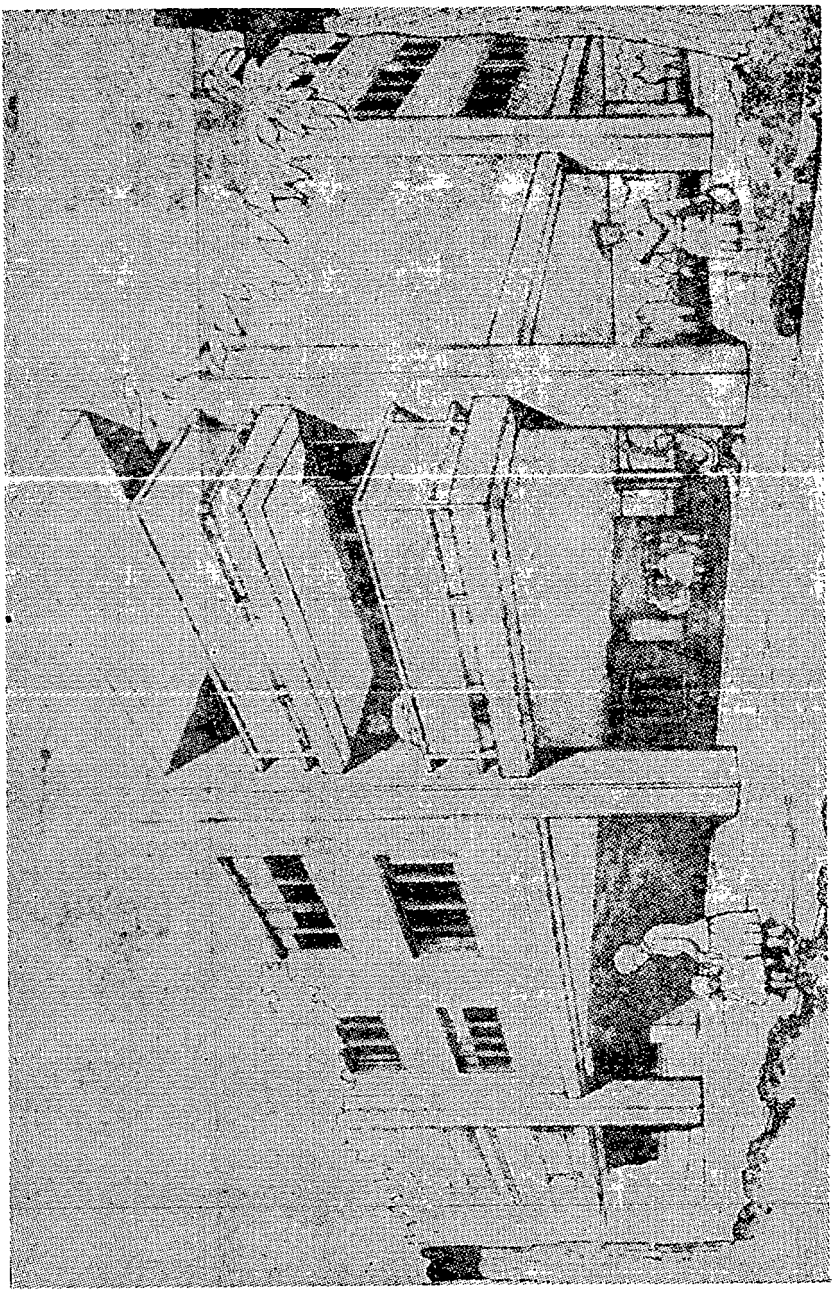
The eight-floor building will include 48 efficiencies (one room with pullman kitchen and bath) ; 16 two-bedroom apartments and 88 one-bedroom apartments. The first floor will contain a lobby with two self-service elevators, an administration office, a large community room with its own kitchenette, tenant storage facilities, a laundromat, and maintenance rooms.

Each of the upper floors will consist of 19 apartments, each opening onto its own private balcony through an easily operated living room window wall where tenants may get a breath of fresh air without going outdoors.

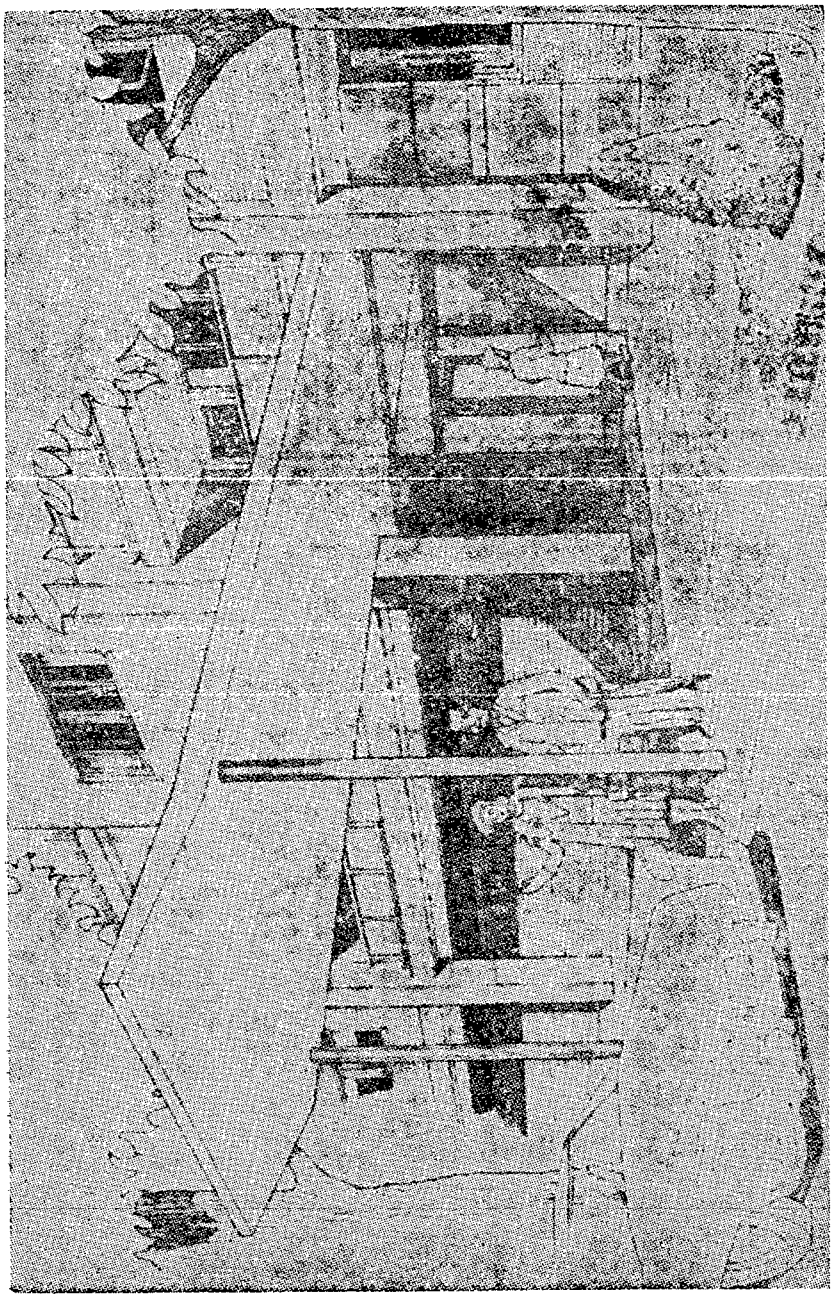
Among the many safety features incorporated into the plans will be grab rails in the showers, nonskid flooring, middle-height cabinets and kitchen appliances and easily opened windows. Unlike many public housing projects, the Trenton apartments will include both bath and shower— thanks to the use of budget-priced materials. Another innovation in public housing will be enclosed heating and plumbing, also provided for by special planning and use of economical materials.

Coordinated to the new concept of housing for the elderly, where the social problems must be considered as well as the residential, these new apartments will offer much in the way of recreation. In addition to the community room and kitchen, plans include a covered patio, open terrace, and a landscaped lawn where horseshoe and shuffleboard courts will offer many opportunities for the making of friends and creating new interests.

That there already is a vast interest has been evidenced by the fact that numerous rental applications have been filed with THA. According to Tysowski, applications will be accepted from men and women 65 years of age or older and widows over 62 years of age. Although rentals have not been established as yet, Tysowski said the range probably will be from $20 to $60 per month, depending on the income of the residents.



Recreation is a prime factor to be considered in the development of housing for the elderly, and the Louis Josephson Apartments will offer a community room, covered patio, open terrace, and a landscaped outdoor recreation center for its residents. This drawing by Kramer, Hirsch & Carchidi of the rear of the proposed building on Oakland Street shows the covered patio opening from the community room, and a portion of the landscaped grounds.



A canopied main entrance lends a luxurious look to the Louis Josephson Apartments, but in reality the Trenton Housing Authority project is a low-budget development conforming in every detail to the code of the Public Housing Authority. The look of elegance is achieved by careful planning and the utilization of economical materials and construction methods.

HOUSING FOR SENIOR CITIZENS, NEW BRUNSWICK, N.J.

The public housing program has almost from its inception been a social enigma. Intended as a social environmental producing force it has become, instead, an antisocial producing jungle. Contrary to promoting neighborhood growth, it has promoted neighborhood decomposition. The major faults lie in their programing, their planning and perhaps most obvious of all, their design.

Early to recognize the need for reforms and even refreshing new attitudes toward a more significant public housing program was the PHA's regional office in New York. Under the directorship of Herman Hillman, it is becoming a creative force in the shaping of a much improved social and physical environment. Spearheading a concentrated and coordinated housing program to provide not only better housing but also better community conditions, it means to enforce slum prevention in addition to its slum clearance program.

It has demonstrated its enlightened policy with the approval of the New Brunswick Housing for the Aged project. This radical departure from the "prisonlike" character of standard public housing design was the deliberate result of the understanding, persistence, and courage too, that the Authority and the architects shared. Frequent interchanges of recommendations and criticisms led to such design, planning, and structural innovations as a flexible apartment-size module, a staggered window pattern correlated with an expression of the slab at each floor to cause a more interesting facade, an integrated window and spandrel panel unit, and a cantilevered slab system. The intent was to achieve, most of all, housing that was human, friendly, and attractive. That such was accomplished was due only to the mutual cooperation of the regional office and the architects involved. In itself, the housing for the aged at New Brunswick is a case for the continuance of a national public housing

GENERAL DESIGN PROGRAM

This project, specifically designed for the aged, brings emphasis to the concept that the elderly should be physically separate yet socially an integrated part of the community.

The site, restricted in size, is immediately adjacent to a low-rent housing group of four 9-story apartment buildings recently completed.

In evolving a concept of living for the elderly in public housing, the architects strove: (1) to provide a quality and quantity of space that would yield a simple informal and pleasant mode of living that most housing developments seem to lack; and (2) to achieve an esthetic that would erase the stigma generally associated with public housing design.

PLAN ELEMENTS

Development of the concept is based on the living unit's central core, an efficient compact mechanical and storage hub. This identical nucleus lends itself readily to apartment size required.

The basic module is a one-bedroom unit. The combination of two modules can be readily converted into a zero- and two-bedroom unit by the closing of two soundproof doors or wall panels. This affords the ability of achieving flexibility in apartment size and distribution without additional construction or alteration, nor would there be any need to change the basic core.

The basic one-bedroom apartment is devoid of waste space, and all have cross-ventilation. The net floor areas are above PHA minimum and yet gross area is below PHA criteria. A tenant who is bedridden may be served efficiently from the kitchen, and one restricted to a wheelchair may navigate the unit with great ease.

GENERAL FEATURES

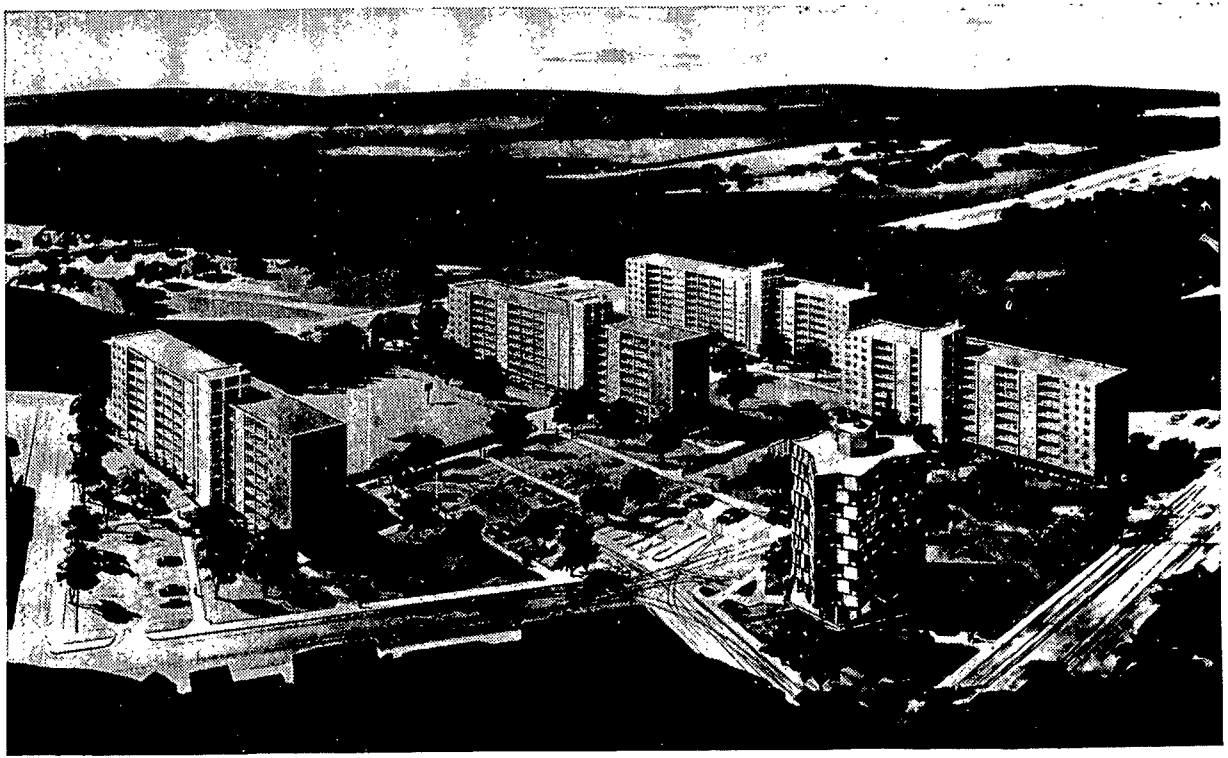
The building includes eight typical floors consisting of six 1-bedroom modules, and a floor of nine efficiency units. The upper ground floor level includes a spacious and brightly lighted lobby, a large community room containing a small kitchen unit, welfare officer facilities, and three additional efficiency units.

The building sits on a podium at this level which shall serve the community room as a protected outdoor walk and sitting area and provides access to the gardens surrounding the project. This parklike area was specially designed for the exclusive use of the elderly, creating for them a quiet and pleasant atmosphere to sit, walk, and enjoy recreational activities. It will be defined and protected from the surrounding neighborhood by pierced screen walls and heavy planting areas. Included, shall be a recreational area, shuffleboard, and a sitting area protected by a colorful canopy with integral lighting for use on warm evenings. The lower level includes entry from the adjacent parking area, storage, and mechanical equipment areas.

The circular corridor at the building core enables tenants to reach their apartment entrance regardless of the direction they take from the elevator and reduces the distance thereto.

Among the many safety features incorporated in the design of the structure there is the complete elimination of stairs to climb (except for the emergency fire stair). Tenants enter the building from a gently sloping walk. The core contains two self-service elevators (eliminating the need to use the stairs should one fail to operate). The central corridor will have a railing around its perimeter as an added feature specifically designed for the elderly. Bathrooms will contain grab bars at the tub and water closet. Fixtures are arranged on both walls so that a clear aisle along the tub will be accessible to tenants confined to wheelchairs. The bathrooms will have nonskid floors.

Other safety features in the apartment design include windows with sash projecting into room for washing purpose, which will eliminate the need to climb stools. Another design feature of the window prevents any possibility of falling out of the window.



PERSPECTIVE,
HOUSING FOR THE ELDERLY, NEW BRUNSWICK, NEW JERSEY

Kitchen cabinets were also specially designed so that wall cabinets are lower, affording ease in reaching the upper shelves without climbing stools or step-ladders.

Common building materials and a carefully studied color scheme were handled in such a manner throughout the project as to help create an attractive and inviting environment as opposed to the accustomed institutional character of public housing projects.

STRUCTURAL

The structure is basically a two-column cantilever system using a 7-inch flat-plate reinforced concrete slab. The slab cantilevers beyond the columns to support the exterior wall. The need for a perimeter beam was thus eliminated and the number of columns and foundation reduced. A comparative analysis of the two-column cantilever system versus the typical columnar cage made by the architects and engineers, proved the cantilever system to be more economical.

ELECTRICAL

Apartments will have a master TV antenna system outlet in each living room. Lighting fixtures were carefully selected to be consistent with the architectural design. Walk and garden lighting is designed to provide a pleasant atmosphere for evening outdoor activities.

HEATING AND VENTILATING

The heating system consists of a two-pipe, up-feed, low-pressure, vacuum-return steam system. Convector units are mounted to the curtain wall window panels and specially designed to prevent their becoming a hazardous element to elderly tenants.

All interior toilets are provided with special ventilating systems.

PLUMBING AND RELATED INFORMATION

Space behind base cabinets obtained by pulling them out to allow lowering of wall cabinets is utilized for concealed plumbing lines.

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