

# PROBLEMS OF THE AGING

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HEARINGS  
BEFORE THE  
SUBCOMMITTEE ON  
FEDERAL AND STATE ACTIVITIES  
OF THE  
SPECIAL COMMITTEE ON AGING  
UNITED STATES SENATE  
EIGHTY-SEVENTH CONGRESS  
FIRST SESSION

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Part 3—Los Angeles, Calif.

OCTOBER 24, 1961

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Printed for the use of the Special Committee on Aging



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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:

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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

Part 8.—Spokane, Wash.  
Part 9.—Honolulu, Hawaii  
Part 10.—Lihue, Hawaii  
Part 11.—Wailuku, Hawaii  
Part 12.—Hilo, Hawaii  
Part 13.—Kansas City, Mo.

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TUESDAY, OCTOBER 24, 1961

U.S. SENATE,  
SUBCOMMITTEE ON FEDERAL-STATE ACTIVITIES  
OF THE SPECIAL COMMITTEE ON AGING,  
*Los Angeles, Calif.*

The subcommittee met at 10 a.m., pursuant to notice, at the East Los Angeles College Auditorium, Los Angeles, Calif., Senator Clair Engle, chairman of the subcommittee, presiding.

Present: Senators Engle of California and Jennings Randolph, of West Virginia.

Committee staff members present: William G. Reidy, staff director; Dorothy McCamman, professional staff member; John Guy Miller, minority staff member; Patricia G. Slinkard, chief clerk.

Senator ENGLE. The Subcommittee on Federal-State Activities of the Special Committee on Aging will be in order.

I think it most appropriate that Los Angeles has been chosen as the city in which the Senate Special Committee on Aging opens its western hearings. This area has earned the right to widespread recognition as a mecca for retired persons—many of them attracted here from all parts of our country after their working years are over, but many more of them longtime residents who have spent their working lives contributing to the growth and vigor of this great city.

In the decade 1950–60, California's population 65 and older increased by half—a considerably faster rate than in the Nation as a whole. The 1960 census found 1.4 million aged persons living in California, and well over one-third of them are right here in the Los Angeles area. Of all the people in the United States who have passed their 65th birthday, California can now claim 1 in 12. Hence, when our subcommittee hears from Californians on their needs and resources in the field of aging, we listen to the voice of a significant proportion of all the Nation's aged people.

The distinction achieved by this section of the country as a gathering place for older people carries with it serious obligations. We must show that we are prepared to meet these obligations through a real concern for the economic and social welfare of all our people and a special concern for our older citizens.

I think Los Angeles and the entire State of California have taken these obligations seriously. There are many instances in which we can point with pride to pioneering efforts in the field of aging. But I think you will all agree that much more still needs to be done.

This hearing is intended to provide an opportunity for stock-taking—for assessing the needs of our older people; our resources for

meeting these needs at the Federal, State, and community level; and for determining priorities and next steps. Only through such periodic stocktaking can we move ahead with assurance that we are headed in the right direction.

Our subcommittee's special assignment concerns Federal and State activities. I do not need to tell you that this is a very broad charge encompassing a multiplicity of programs designed to meet a wide variety of needs. There is not a person in this room, I would venture to say, whose well-being is not vitally affected by these activities. Our assignment spans the total concern of the Special Committee on Aging and provides an opportunity for a broad perspective. Other subcommittees of the Senate Special Committee on Aging are emphasizing the subjects of retirement income, housing, and nursing homes. These special areas also come within the scope of Federal-State activities and will be claiming our attention here today.

To help us in this endeavor, we have an illustrious group of witnesses who can view California's special needs and achievements against the backdrop of the national situation. We will hear from State and local welfare officials about their programs. We also want the insights the university people and experts can provide. We want to hear from the employment office and from employers. Nursing home operators, doctors, and others in the health field can add to our knowledge. A special contribution can be made by representatives of the clergy, recreational leaders, and the voluntary organizations of senior citizens.

Above all, we want to hear from senior citizens themselves. In the other regional meetings of the Special Committee on Aging, the elderly people have been eloquent. In a State with nearly 1.4 million persons 65 years and older, I can personally meet only a small fraction of our older people. The appearance this afternoon of a number of our elderly will provide us with one of the most valuable elements of these hearings, the grassroots approach.

Because our time is so short, we can hear from only a fraction of the groups and individuals who have asked for an opportunity to appear here today. We have, therefore, placed limits on the length of our oral presentations but would welcome written statements for the record. We can assure you that we want to hear from every one of you. I personally can guarantee that any written statements will receive our careful attention.

Before introducing our first witness, I would like to present to you my good friend and colleague, Senator Jennings Randolph, of West Virginia. Senator Randolph, along with the then Senator John F. Kennedy and Senator Pat McNamara, of Michigan, was a member of the original Subcommittee on Problems of the Aged and Aging from which our Special Committee on Aging developed. He has a profound knowledge of the subject and a deep and compassionate interest in the problems of all our people.

I would like to say in addition that Senator Randolph is one of my very dear and one of my very close friends. He and I served together in the House of Representatives. I am especially grateful to him that he has taken his time to come from faraway West Virginia—which also has its problems, both in the area of employment and in the area of the aging—come in this instance from Miami, Fla.,

where he just made a major speech, to be here with us today. He will subsequently appear at other hearings.

Senator Randolph, I recognize you at this time for such remarks as you desire to make. Senator Jennings Randolph, of West Virginia.

**STATEMENT OF HON. JENNINGS RANDOLPH, A SENATOR FROM THE  
STATE OF WEST VIRGINIA**

Senator RANDOLPH. My kind colleague, the applause which has been given is an expression, and I am sure a sincere one, of the cogency of the comment on the problems of the aged that you have given in opening these hearings.

I wish to add my congratulations to those which you have expressed. Here in Los Angeles, and this is not a pleasantry, you have indeed earned a reputation, a merited reputation, by the special regard for and the intelligent programs carried on for older citizens.

We often hear, ladies and gentlemen, that we are a youth-centered culture and that our movies do much to foster this emphasis on the young and the glamorous. Yet here in this film capital of the world we find a deep and sincere concern for older citizens, a concern that has resulted in many outstanding developments, about which we shall hear more during this hearing.

I do recall 2 years ago the Senate Subcommittee on the Problems of the Aged and Aging, the predecessor to our present Special Committee on Aging, held hearings throughout the country. Your sister city, Senator Engle, to the north, San Francisco, was among the sections where we listened to the problems of older people and heard the viewpoint of the community and the solution to the problems of the specific community. As you have indicated, I was present and participated in those hearings.

One of the problems that came up repeatedly when we listened to the senior citizens of San Francisco was the need for a homemaker service, a service which would help our older people to live independently in their own homes instead of having, as they did, to go to the more expensively operated hospitals and nursing homes.

As a direct result of those hearings, the Senate subcommittee alerted the U.S. Congress to the need for Federal funds to help communities to develop these homemaker services, and funds now are available for such a service. We have received money which has been included in the budget of the long-term illness program of our Public Health Service, and new legislation has been enacted for community health services and facilities.

Now, during these past 2 years in both San Francisco and Los Angeles we have seen these programs of homemaker services established; but I understand that neither program, the one in Los Angeles nor the one in San Francisco, has the financial resources available to permit it to go full steam ahead, as it were, and requests for Federal project funds are now under consideration.

Of course, we wish this effort well. There is a great potential here, not only for serving the older people within this community, but for demonstrating to the rest of the Nation what can be done to improve the well-being of our older citizens.



Now, I am not implying that our hearings were responsible for the establishment of these homemaker services. You in the community, you had the creativeness, you had the resourcefulness, you had the followthrough, and so you had these programs upon the drafting boards prior to the hearings of 1959. I would not say that our committee has been responsible for the Federal funds, but we have through this committee generated, Senator Engle, an intense interest in the Senate and in the Congress generally for these community health services.

I do feel, in closing, that I can say that the interim action and the understanding we achieved through these hearings, the sharing of our views on Federal and State activities, and, more importantly, responsibilities, will do much in these hearings, I hope, to stimulate better services for our older citizens.

And to you, Senator Engle—I have a special privilege of being present today because, you are not only an old friend of House days, and now Senate service, but you are one of the most capable and courageous members of our national legislative body. What is done should contribute to the well-being and understanding of the older people, not only of Los Angeles but of the Republic as a whole.

Senator ENGLE. Thank you very much, Senator Randolph.

We have as our first witness today a man who needs no introduction to this audience, indeed needs no introduction in the whole State of California, or throughout the Nation. He has taken an intense and a compassionate and a friendly interest in the affairs and the problems of the aged and the aging. He is the Governor of the State of California, and I am proud and happy to welcome him to this hearing today and to say to him that we are deeply complimented that in his busy schedule he would take the time; and I am sure those who are here will recognize in his presence his interest in the problems in which they are so deeply concerned.

Thank you, Governor, for being here; and now you may proceed.

#### STATEMENT OF HON. PAT BROWN, GOVERNOR OF THE STATE OF CALIFORNIA

Governor BROWN. Senator Engle and Senator Randolph, let me say that I will file a prepared statement, I have one here, and I will probably shorten it considerably so that you will be able to hear the great number of witnesses that will want to be heard.

Senator ENGLE. Governor, if you will permit me to interrupt you, without objection, your entire statement will be made a part of the record, and you may proceed as you wish with reference to interpolations or additions.

Governor BROWN. Thank you very much.

(The prepared statement of Governor Brown follows:)

#### TESTIMONY BY GOV. EDMUND G. BROWN OF CALIFORNIA

Mr. Chairman, as Governor of California it is a pleasure for me to be here today. I would like to take this opportunity to congratulate you, Senator Randolph on your long and impressive service to the people of the United States, and your own people of West Virginia. I would also like to express again to our own Senator Clair Engle our gratitude for his leadership and his dedication to the problems of California.

The people of California are most aware of the work being done by the Senate Special Committee on Aging. We are pleased that you have selected California as one of the locations on your current schedule of nationwide hearings.

We understand why you selected California. Today there are 1,390,000 men and women 65 and over in California. That is 8.5 percent of our total population. Today 1 out of every 12 Americans over 65 lives in California.

As you also know, by late 1962 or early 1963 California will have the largest population of any State in the Nation. As our population grows, so do the numbers of our older citizens, and so do their problems.

In California we do not look on any of our people as statistics. But we cite the statistics to give some dimension to major problems of our society, which exist in California and throughout the Nation. We are determined to make further progress in solving the problems of individuals without suitable housing, without adequate medical care, without opportunities for jobs, and without sufficient income.

Let me make our position on these programs very clear.

We take the just and humane position that our senior citizens are not wards of the State. Rather, they are men and women who have led productive lives. They are men and women who have paid their way—who have made their contribution to this State and to our Nation.

We believe that human dignity in a democratic society must be maintained and that in their declining years, the aging are entitled to self-respect.

The assistance they receive is not charity, but their due.

In meeting the needs of our older people both the States and the Federal Government must assume leadership and responsibility. In some areas, because of the size and scope, their roles must be primary. In other fields the role of Government may be simply to encourage and stimulate voluntary local efforts.

Today your committee is interested in finding out what our senior citizens consider the proper role of Government. As the Governor of California I am vitally interested in all such expressions. But before the others speak it might be helpful if I review what the State of California has been doing about some of the problems of special concern to the aging. Much of what we have done flowed from our State Conference on Aging, held in Sacramento last October.

#### CALIFORNIA'S RECORD

At the outset, let me say that the past 2 years and particularly the past legislative session has been a time of accomplishment. The laws we now have represent the most comprehensive program for senior citizens ever enacted by any State in the history of the United States. We are justifiably proud of our program and our legislators who supported it.

We enacted legislation in five vital areas: Employment, housing, social welfare, community services, and health. All five involve close cooperation between the Federal Government and the State.

#### EMPLOYMENT

During the Governor's Conference on Aging last year, I pledged full support to combat age discrimination in employment.

One of the first actions taken in the department of employment under my administration was a sharp expansion of the counseling and job placement service to older workers.

The older worker is defined by the employment statisticians as over 45. Special attention to the problems of older workers is now being given in some 100 local area employment offices of the State.

We further supported a recommendation made during the State conference that our California Unemployment Insurance Act be amended to allow workers to begin job retraining programs at the beginning rather than after a prolonged period of unemployment. This recommendation recognized that much of our "hardcore" unemployment resulted from automation, which had left many older workers without the skills currently in demand in the employment market.

Today I am pleased to report that our new legislation has met these objectives.

First, the legislature approved A.B. 1976, which makes it unlawful for an employer to discriminate against persons 40 to 64 solely on grounds of age. This will help protect the rights of many older workers to seek, obtain, and hold jobs. I signed this bill enthusiastically. We believe that, as a result, it will be possible

for many more senior citizens to continue to contribute their talents and ability to our society.

Second, the legislature adopted our recommendation regarding the teaching of new skills to people displaced by automation and industrial change. Today a person out of work for these reasons may come to his nearest department of employment office and, if he indicates an aptitude, can begin learning a new trade or craft and still qualify for unemployment insurance benefits while in training. California leads all other States in this field.

Let me emphasize that the department of employment's older worker program will continue to expand its services. This program has already found jobs for about 240,000 older workers since it was expanded early in my administration. You will hear more about this program later today.

#### HOUSING

The second area of major concern is housing.

Many of our senior citizens are living, today, in conditions which can only be called deplorable. The need for available adequate housing for all our people is one of the most vital social problems of our time. It is a particularly acute problem for our older citizens.

In recognition of the real need for better housing, as well as other special needs the elderly have, we now have a maximum grant of \$166. It is available to those senior citizens who have need for it. This increase was made in an effort to equalize the program for all those recipients who are on old-age assistance in the State, whether or not they have income of their own.

Congress has recently passed the Housing Act of 1961. This comprehensive measure, an integral part of President Kennedy's legislative program, included strengthening of the provisions of the act designed to provide housing for senior citizens.

California has kept pace by passage of Senate Constitutional Amendment 10, which calls for a \$100 million bond issue to go before the people in November 1962. If approved by the voters, these bonds will make possible loans to various public and private organizations for construction of low rental housing projects for people over 60 with low incomes.

The passage of these bonds will make it possible for the State of California to cooperate with private enterprise in providing decent housing for several thousand older Californians—at rents they can afford to pay.

It is relevant to note here that California has taken many steps over the past 3 years to encourage a favorable business climate. It is a climate which encourages a competitive atmosphere in the marketing of bonds. Only last week, the State sold \$100 million in construction bonds at a favorable rate of interest which will save millions of dollars for the people of California over the life of the issues. Investors can be sure that the economy of this State is expanding on a sound basis and will continue to do so in the future.

I sincerely hope that the people of California will give their vigorous support to this bond issue. It is the height of false economy to deny to our older citizens decent housing, adequate medical care, and continued employment opportunity. This bond issue provides us with a way of alleviating the first of these problems.

Further, the legislature during 1961 approved my recommendation for a Governor's advisory housing commission. This commission will study and make recommendations regarding the housing needs of our rapidly growing population.

One of the early tasks which I will assign to this commission is to take a good, hard look at the special housing needs of our senior citizens. We hope the commission can propose ways which will enable us to benefit fully from the recent expansions of the National Housing Act affecting housing programs for our older citizens.

#### SOCIAL WELFARE

In the field of social welfare, I was determined to achieve a program which would make it possible for those living on public assistance to do so in greater dignity and security. I wanted to enact a legislative program which was fiscally sound, and yet would remove the injustices and inequities which existed in the program for the aged.

The series of bills which were introduced at my request and passed by the legislature have, I believe, achieved these goals.

There is now a "cost of living" factor built into our method of determining the grant. This protects the elderly against the rising cost of living in much the same way that industry and labor now recognize the need for adjustment for cost increases. The basic grant has been increased from \$95 to \$101 a month.

We have further recognized that medical costs are one of the most threatening of fears which beset our elderly people. Accordingly, we now have an outpatient medical care program for the aged which covers cost of medicine and physician services. This is done in cooperation with the Federal Government's medical care funds.

The Federal Government did not have a citizenship requirement imposed on the aged, but I found upon taking office, that the State of California did have this restriction. I am glad to say that the legislature passed a bill during the last session to remove this unjust requirement.

In recognition of the cost of living increase which has affected all of our people, we revised the scale on which we base the financial responsibility of relatives in California, and believe that we have a more reasonable and fair payment required of young people for their aged parents. We want our Californians to be able to save for their own retirement, as well as to be able to pay for the necessities of life which face them now. We feel that this change emphasizes voluntary support—not a coercive one—and think it will improve family relationships without interference from the State.

We are seriously concerned here in California with the training of professional people to carry out these tremendous programs.

We feel that Federal help is needed in this area, and urge that you give it your attention and support.

In the field of social work alone we must train approximately 5,000 social workers in the next 10 years. We have at the present 10,000 people in the State engaged in the public social welfare programs.

At my request the legislature established a fund, from which grants are made to local personnel in public social work enabling them to return to college for advance training. This is a small start toward a gigantic problem. Legislation was also passed permitting financing for inservice training in welfare departments, but much more needs to be done in this area.

#### COMMUNITY SERVICES

In a different area of concern, the legislature also recognized that our older people have social as well as material needs. Our aging citizens must have the respected role to which their lifetime of toil entitles them.

To accomplish this, many local communities have begun to build facilities that will provide an environment where independence and participation can be encouraged. These community centers for our older citizens can make vital contributions to the well-being of many, but their development should be accelerated.

The legislature therefore enacted a program of State matching to encourage more rapid development of community services for senior citizens. These services could also include visiting homemaker services which permit an elderly person to live alone for a much longer period of time than would otherwise be possible. To my knowledge it is the first program of its kind enacted in the United States.

It is, frankly, a pilot project. The amount appropriated is fairly modest. Nevertheless, I hope it will go far in speeding up these local programs. You will hear more about this pioneer program later from the chairman of the Citizens' Advisory Committee on Aging.

#### HEALTH

For the past 2 years a national struggle has been waged over the best way to finance medical and hospital needs of the aged. You are all familiar with the controversy. This summer, in a statement to the Ways and Means Committee of the House of Representatives, I repeated my position in favor of using the social insurance principles of the Social Security Act to finance the medical care costs of our aged citizens who are eligible for social security benefits. I deeply regret that no action was taken by Congress this year to enact the King-Anderson bill introduced as part of President Kennedy's comprehensive health program for the Nation.

I can think of no greater priority in the year ahead than the passage of a program of prepaid health insurance, based on the rights earned through the contributions of the individual and his employer.

But, in the absence of favorable Federal action, California took a major step toward meeting the toughest part of this complex problem; the problem of long-term hospital or nursing home care.

We did this by implementing the provisions of the Kerr-Mills Act passed by Congress last year.

I do not approve of the provision requiring a means test for those who do not receive old-age assistance. With this reservation, we did recognize that the program would benefit some older people, particularly those plagued with expensive, long-term illness.

Accordingly I recommended, and the legislature enacted, a program to assist the chronically ill. California Senate bill 325 provides for the full payment of such expenses as hospitalization after 30 days, nursing home care, and related outpatient services for the aged who are in need.

For fiscal reasons it was necessary to limit eligibility to people over 65 whose monthly incomes do not exceed maximum State old-age assistance grants, plus the cost of medical care. It is estimated that this move may benefit about 40,000 Californians during the first full year of the program's operation.

Health needs are great and cannot be met merely by financing hospital care and doctor bills. In California we have placed great emphasis on rehabilitation and prevention.

In our social welfare program, we liberalized the definition of "disabled" to cover a broader group of people for whom we may give rehabilitative services.

In our aged program we have stressed the use of rehabilitation for the elderly.

In the department of mental hygiene, we stress putting elderly patients who are able into family care homes out in the communities, where they may participate in the local activities of the area. During the last session, we passed enabling legislation permitting payment of a higher rate for patients on leave in family care homes. We regret, however, that the Federal policy does not allow financial participation to family care patients.

The Community Health Services and Facilities Act of 1961, passed by Congress, will permit us to step up nursing care of the sick at home, periodic health appraisals and education of personnel who are working on the care of the long-term ill or aged. We would appreciate Federal help in this and many other programs in which we work in partnership.

#### COORDINATED ADMINISTRATION

Under the new reorganization legislation which was introduced at my request, and after a long study by a special Governor's commission, the three departments of health, mental hygiene, and social welfare have been joined in a single agency.

I believe that this will provide better service for the people these departments serve, and will result in a more efficient administrative organization in State government.

#### CONCLUSIONS

These recent steps taken by the State of California only highlight some of the ways we are meeting the basic needs of our senior citizens. We cannot go into detail in other State programs in education, recreation, veterans' affairs, and vocational rehabilitation. I have barely alluded to activities between State departments and local groups and senior clubs.

As Governor, I am often asked to distinguish the proper boundaries for each level of government. Yet this committee knows that a precise answer is often impossible. Broad social problems have a way of ignoring geographical or political lines.

Yet in the area of help for the aging, some basic facts are clear.

The Federal government, because of its greater resources and the scope of its concern, must go even farther than it has in giving leadership and financial support to State and local efforts.

In some areas the Federal Government has the primary responsibility. This is true when the scope of the problem is such that neither States nor local communities can meet it alone.

Let me conclude, then, by offering four specific recommendations which I believe should be undertaken by the Federal Government at this time:

First: Enactment by Congress in 1962 of a program for health insurance for the aged, based on the contributory insurance principles of the Social Security Act.

Second: Further extension and improvement of such Federal programs of direct-loan financing and low-rent public housing with priority for loans for housing tailored in price for the older person.

Third: Further improvement and expansion of social security benefits. I favor such steps as—

Insertion of a cost-of-living clause in all benefits similar to the one we enacted here in California for those receiving public aids.

Substantial increases in the minimum social security benefits and in the maximum benefits.

Fourth: Increased Federal participation in the programs mentioned earlier in my talk in the field of health and welfare.

No level of government can abdicate its great responsibility to our aging citizens. I cannot emphasize too strongly that the Federal, State, and local governments must join to return to the aging a portion at least of the great contributions they have given to us all.

As a State, California has one of the highest standards of living in the world, and an economic outlook second to none. In the midst of plenty, we cannot and must not tolerate want and suffering on the part of those who made California the great State that it is.

I have stated my pride in our accomplishments of the past. We believe our 1961 State legislation goes far to emancipate the elderly from want, from the fear of sickness, from indignity, and from loneliness.

But there is more to do. We must meet our responsibilities fully at every level of government. I thank this committee for the privilege of giving my testimony, and I strongly urge your favorable consideration of my recommendations.

Governor BROWN. First, let me welcome you, Senator Randolph, to California. As the Governor of this State, I want you to know that all the people are happy that you are here. I hope your stay will be pleasant and fruitful, and if there is anything that I can do as Governor to make your stay more enjoyable, please do not hesitate to let me know. We are honored by your presence in our State.

And, of course, as far as Senator Clair Engle is concerned, to have him back in the State is always good news to the people. When he gets here I want you to know, even though it is a great big State, we feel the vibrance of his presence every time he comes in here, and I as the Governor am particularly happy to see him here.

Now let me begin by saying that the people of California are aware of the work being done by the Senate Special Committee on the Aging. We are pleased that you selected California as one of the locations in your series of nationwide hearings.

I think you should know, and it should be reported in the record, that by August of 1963 California will have the largest population of any State in the Nation; and, as our population grows, so does the number of our older citizens. We now have in California 1,390,000 citizens over the age of 65. The major premise upon which we operate as far as legislation in California is simply this: We do not look on any of our people as statistics, but we cite the statistics to give some dimension to major problems of our society, which exist in California and throughout the Nation. We are determined to make further progress in solving the problems of individuals without suitable housing, without adequate medical care, without opportunities for jobs, and without sufficient income.

Let me make my position and my philosophy on these programs very clear. We take the position that our senior citizens are not wards of

the State. Rather, they are men and women who have lived productive lives. They are men and women who have paid their way, who have made their contribution to this State and to our Nation.

We believe that human dignity in a democratic society must be maintained and that in their declining years the aging are entitled to self-respect. The assistance they receive is not charity, but their due.

In meeting the needs of our older people both the States and the Federal Government must assume leadership and responsibility. In some areas, because of the size and scope, their roles must be primary. In other fields the role of the Government must simply be to encourage and stimulate voluntary local efforts.

Following me I will have Mrs. Evans from the department of social welfare, Dr. Dan Blain of mental hygiene, and a representative of the department of public health, and I understand that they are going to sit as a panel, and you can ask any questions that you desire of them.

#### 1961 CALIFORNIA LEGISLATIVE PROGRAM FOR SENIOR CITIZENS

It is my opinion that the past legislative session that adjourned in June of this year was a real session of accomplishment. The laws we now have represent the most comprehensive program for our senior citizens ever enacted by any State in the history of the United States.

We enacted legislation in five vital areas: employment, housing, social welfare, community services, and health. All five involve close cooperation between the Federal Government and the State.

#### EMPLOYMENT

During the Governor's Conference on Aging last year I pledged full support to combat age discrimination in employment, and one of the first actions taken in the department of employment under my administration was a sharp expansion of the counseling and job placement services to older workers. The "older worker" is defined by the employment statisticians as over 45. I don't know whether that is a good definition or not. I know that I certainly don't feel like an older worker at my age, and I am considerably older than 45. But at any rate, we have to set an arbitrary limit, and that we have done.

Special attention to the problems of older workers is now being given in some 100 local area employment offices of the State. This program has already found jobs for about 240,000 older workers since it was expanded early in my administration.

We further supported a recommendation made during the State conference that our California Unemployment Insurance Act be amended to allow workers to begin job retraining programs in the beginning rather than after a prolonged period of unemployment. This recommendation recognized that much of our hard-core unemployment results from automation, which has left many older workers without the skills currently in demand in the employment market.

Today I am pleased to report that our new legislation has met these objectives.

First, the legislature approved a bill which makes it unlawful for an employer to discriminate against persons 40 to 64 solely on the

grounds of age. This will help protect the rights of older workers to seek, obtain, and hold jobs.

Second, the legislature adopted our recommendation regarding the teaching of new skills to people displaced by automation and industrial change. Today a person out of work for these reasons may come to his nearest department of employment office and, if he indicates an aptitude, can begin learning a new craft or skill and still qualify for unemployment benefits while in training. I think that California leads all other States in this field.

#### HOUSING

The second area of major concern is housing.

About a year ago, it may have been a little bit longer than that, we had a fire in San Francisco, Senators, and there were 21 people destroyed in this fire. Nineteen of these people were over 65, compelled to live in an old, broken-down hotel. At that time I determined that the prime thing that the people over 65 needed, the people receiving aid, was good, good housing that they could afford to pay for. Still today many of our citizens are living in conditions which can only be called deplorable.

Congress has recently passed the Housing Act of 1961. This comprehensive measure, an integral part of President Kennedy's legislative program, included strengthening of the provisions of the act designed to provide housing for senior citizens.

California has kept pace too, and we have just passed a constitutional amendment which calls for a \$100 million bond issue to go before the people in 1962. If approved by the voters these bonds will make possible loans to various public and private organizations for construction of low-rental housing projects for people over 60 with low incomes.

The passage of these bonds will make it possible for the State of California to cooperate with private enterprise in providing decent housing for several thousand older Californians at rents they can afford to pay. I intend to do everything that I possibly can as Governor to see that this bond act is passed by the people of my State.

Furthermore, the legislature during 1961 approved my recommendation for a Governor's advisory housing commission. This commission will study and make recommendations regarding the housing needs of our rapidly growing population.

One of the early tasks which I will assign to this commission is to take a good, hard look at the special housing needs of our senior citizens. We hope the Commission can propose ways which will enable us to benefit fully from the recent expansions of the National Housing Act affecting housing programs for our older citizens.

#### SOCIAL WELFARE

In the field of social welfare I was determined to achieve a program which would make it possible for those living on public assistance to do so in greater dignity and security. There is now a cost-of-living factor built into our method of determining the grant. This protects the elderly against the rising cost of living in much the same way that industry and labor now recognize the need for adjustment for cost



increases. The basic grant has been increased from \$95 to \$101 a month; and the maximum grant in special cases, under criteria laid down by the department of social welfare, is in the sum of \$166, which I think is the largest given by any State in the Union.

We have further recognized that medical costs are one of the most threatening of fears which beset our elderly people. Accordingly, we now have an outpatient medical care program for the aged which covers cost of medicine and physician services. This is done, of course, in cooperation with the Federal Government medical care program.

I am eliminating two or three pages in connection with other phases of this.

The Federal Government does not have a citizenship requirement imposed on the aged, but I found, upon taking office, that the State of California did have this restriction. I am glad to report that the legislature passed a bill during the last session to remove this requirement.

We are seriously concerned here in California with the training of professional people to carry out these tremendous programs. We feel that Federal help is needed in this area and urge that you give it your attention and support. In the field of social work alone we must train approximately 5,000 social workers in the next 10 years. We have at the present 10,000 people in the State engaged in the public social welfare programs.

At my request the legislature established a fund from which grants are made to local personnel in public social work, enabling them to return to college for advanced training. This is a small start toward a gigantic problem.

Legislation was also passed permitting financing for in-service training in welfare departments, but much more work needs to be done in this area.

Let me say in connection with that, too, I do believe that you can direct your attention to the great deal of paper and administrative work that must now be done by these social workers. In my opinion, if we could find some way to modify the redtape that we now have under the categoric aid programs, if we could do something like more rehabilitation in all fields of social welfare and give the money saved to the beneficiaries of social welfare, rather than to administrative work, I think we could make great progress.

#### COMMUNITY SERVICES

In a different area of concern, the legislature also recognized that our older people have social as well as material needs. Our aging citizens must have the respected role to which their lifetime of toil entitles them.

The legislature therefore enacted a program of State matching funds to encourage more rapid development of community services for senior citizens. These services could also include visiting homemaker services, which permit an elderly person to live alone for a much longer period of time than would otherwise be possible. To my knowledge this is the first program of its kind enacted in the United States. It is, frankly, a pilot project. The amount appro-

priated is fairly modest. Nevertheless, I hope it will go far in speeding up these local programs. You will hear more about this pioneer program later from the chairman of the Citizens' Advisory Committee on Aging, who is here.

#### HEALTH

For the past 2 years a national struggle has been waged over the best way to finance medical and hospital needs of the aged. You are, of course, all familiar with this controversy. This summer, in a statement to the Ways and Means Committee of the House of Representatives, I repeated my position in favor of using the social insurance principles of the Social Security Act to finance the medical care costs of our aged citizens who are eligible for social security benefits. I could think of no greater priority in the year ahead than the passage of a program of prepaid health insurance based on the rights earned through the contributions of the individual and his employer.

But in the absence of favorable Federal action California took a major step toward meeting the toughest part of this complex problem, the problem of long-term hospital or nursing care. We did this by implementing the provisions of the Kerr-Mills Act passed by the Congress last year.

California's Senate bill 325 provides for the full payment of such expenses of hospitalization after 30 days, nursing home care, and related outpatient services for the aged who are in need.

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Health needs are great and cannot be met merely by financial hospital care and doctor bills. In California we have placed great emphasis on rehabilitation and prevention, and in our social welfare program we have liberalized the definition of "disabled" to cover a broader scope of people for whom we may give these rehabilitative services.

In our aged program we have stressed the use of rehabilitation for the elderly.

In the Department of Mental Hygiene we stress putting elderly patients who are able into family care homes out in the communities, where they may participate in the local activities of the area. During the last session we passed enabling legislation permitting payment of a higher rate for patients on leave in family care homes. We regret, however, that the Federal policy does not allow financial participation to family care patients.

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## CONCLUSIONS

The recent steps taken by the State of California only highlight some of the ways we are meeting the basic needs of our senior citizens. We cannot go into detail in other State programs in education, recreation, veterans' affairs, and vocational rehabilitation. I have barely alluded to activities between State departments and local groups and senior clubs.

As Governor I am often asked to distinguish the proper boundaries for each level of government. Yet this committee knows that a precise answer is often impossible. Broad social problems have a way of ignoring geographical or political lines.

Yet, in the areas of health for the aging some basic facts are clear. The Federal Government, because of its greater resources and the scope of its concern, must go even further than it has in giving leadership and financial support to State and local efforts. In some areas the Federal Government has the primary responsibility. This is true when the scope of the problem is such that neither States nor local communities can meet it alone.

And let me conclude by listing some steps which Congress should take, in my opinion, at its next session to help our older citizens in their search for health and security with dignity.

First, Congress should enact a program of self-insurance for the aged based on the proven contributory principles of the Social Security Act.

Second, the program of direct Federal loans for low-rent public housing for the aging should be expanded. I can't think of any single area where I believe more can be done than to give the people over 60 good places in which to live and with prices that they can afford to pay.

Third, Congress should make further improvements in social security benefits and coverage, particularly benefit pay to the widows.

This Nation has the highest standard of living in the world. In the midst of plenty we cannot tolerate want and suffering among those who have made their life's contribution toward this high standard. At the same time I strongly recommend that Congress order a thorough review of the mass of welfare regulations which have reduced many of our social workers to the role of paperwork puppets. Too often the time of the social worker that should be spent on rehabilitation of his welfare clients is instead spent in signing forms, filling out requisitions, and approving checks.

We have just begun such a study in California. A welfare study commission which I appointed earlier this year already is at work on a complete review of welfare programs in California. When we have completed that study, or even on an interim basis, we will furnish this committee with the results of their studies. Our State programs are closely tied to Federal programs; however, any reforms we may wish to make in California must be accompanied by similar reforms at the Federal level.

I urge that you give these conclusions and recommendations your closest attention; and I thank you very much for this opportunity to appear before you and to tell you of some of the things that we have done in California, and some of our aspirations for the future.

Senator ENGLE. Thank you very much, Governor Brown; and you can certainly be proud of the splendid contribution that the State government has made under your fine administration for aid to the aged. We again want to express our appreciation to you for taking this time to be here with us and to initiate the western portion of these hearings with your testimony and with a review, as you have, of the efforts of the State of California in this field.

Senator RANDOLPH, do you want to say something?

Senator RANDOLPH. I would like to emphasize what Senator Engle has said. Governor Brown, your statement is a positive one; and it is made doubly so, not only by the clarity with which you have presented the facts, but it necessarily must have been the result of affirmative action which has been taken at the State level. And for that reason especially I commend your recommendations, which are an outgrowth in part of the experiences within this State, where there is such a high percentage of older people forming a constantly growing population.

For myself personally, I endorse completely the three recommendations which you have made for action in the Congress of the United States. They will not be easy of finalization, especially the first one in reference to medical care under the social security system. President Kennedy and many Members of the Congress, Senator Engle included, will work vigorously for the culmination of such an effort.

Again I congratulate you on the strength of your statement.

Governor BROWN. Thank you very, very much; and if I may be excused—

Senator ENGLE. Thank you, Governor, and we hope to see you again throughout other areas of the State of California.

Governor BROWN. We will see each other, Senator.

Senator ENGLE. Next we have a panel of five, headed by Mrs. Eunice B. Evans, chief deputy director of the department of social welfare, and including Dr. Daniel Blain, director of the State department of mental hygiene; Dr. Lester Breslow, chief, division of preventive service, department of public health; Miss Eleanor Fait, chief, older worker specialist program, department of employment, and Mrs. A. M. G. Russell, chairman of the Citizens Advisory Committee on Aging.

Mrs. Evans, do you have any particular line of procedure you want to follow? Would you like to commence with your statement and then introduce the other members of the panel?

Mrs. EVANS. I would be very happy to do it any way possible, Senator.

Senator ENGLE. Then you may proceed, Mrs. Evans. We will be very happy to hear your testimony, and then you may introduce the other members of your panel for their statements.

**STATEMENT OF J. M. WEDEMEYER, DIRECTOR, STATE DEPARTMENT OF SOCIAL WELFARE, PRESENTED BY MRS. EUNICE B. EVANS, CHIEF DEPUTY DIRECTOR**

Mrs. EVANS. We appreciate this opportunity to present information to your committee on the activities of the department in the field of the aging population of California. As a department of social welfare responsible to the Federal Government for the administration of

public assistance programs, our emphasis in the past has been on financial assistance to the needy only. The newer trends in thinking in the social welfare field go toward prevention of dependency and rehabilitation of those who are dependent. We in public assistance in California feel that this is a more constructive and positive way to help people help themselves.

However, you are here today to learn what the Federal Government can do to assist States in caring for their older residents. Foremost among the items which need further attention in our view is the need to extend to all aged the benefits of minimum coverage by the old-age and survivors' insurance program. While the number of people who lack retirement benefits has been materially reduced because of the progressive changes in Federal law over the past years, still there remain many not covered. There are 1,390,000 aged people in the population of our State. Of these, 965,600 are covered under OASDI, 426,400 are not, and of the 426,400, 126,400 are receiving old-age assistance benefits. They do not have coverage because they either have not worked, have not worked during appropriate periods and missed coverage, or they have worked in uncovered employment.

Because of the increased Federal social security protection this is a decreasing group, since a considerable number of the most needy do not have coverage they should be blanketed into the social security insurance program. To continue to deprive them of comparable benefits seems unjust, and creates an unnecessary complication for State welfare administration.

With the coverage of this group, public assistance programs may become what they were intended to be, and not what they are forced to be now in many instances, supplementation to the OASDI payments where they are inadequate for minimum living standards, or a retirement plan. It would permit State welfare programs to provide more adequately for those whose needs and circumstances require particular attention, and to develop services for all the aged, which are so necessary if senior citizens generally are to have an opportunity for full and satisfying living.

#### DEVELOPMENT OF SERVICES FOR AGED

Our second point relates to the development of services and facilities for the aged. Under the leadership of Governor Brown, legislation was adopted in our last session appropriating a small amount of money to be used in making grants to community organizations and agencies to stimulate the development of well-rounded services, activities, and protections for all aged. We believe this is the first such program in the country. The department has been receiving applications from local welfare departments for some very interesting local programs as a result of this new legislation. For at least the next decade, Federal aid should be given to States to match State and local funds expended for this purpose.

#### RESIDENCE REQUIREMENTS

The third area in which we recommend congressional attention is that of residence requirements. We believe that the present residence requirements are inconsistent with our basic democratic principles.

We believe that modification or elimination of these requirements is necessary and possible. [Five years out of last nine required; Five years must include the year immediately preceding date of application.] However, it can only be achieved if the Federal Government does two things:

(1) Establishes a uniform requirement with respect to State laws in this matter.

(2) Provides in its cost-sharing arrangements some equalization funds for those States where the number of aged is disproportionate.

As long as there are gross disparities between States in the adequacy of benefits and services to the aged, there is a considerable risk for States such as ours that have progressed rapidly in improving benefits and services.

The principle to be applied here is not unlike the principles that are used for equalization purposes in relation to tax efforts. It can, if necessary, be related to migration experience rather than to the aged as a proportion of the population.

#### EXCLUSION OF THE MENTALLY ILL

Another point which needs major attention is a thorough reexamination of the entire base for the exclusion of the mentally ill and psychotics from the benefits provided under the public assistance titles of the Social Security Act. I shall not go into this in detail, since it is being covered more adequately by others.

#### HOUSING

Adequate housing remains a major need for aged persons. Welfare departments in the State are not able to assume any direct responsibility for housing construction. We are well aware, however, that the housing allowances used in considering the public assistance grants are insufficient in light of the adequate housing available at that price.

We have a serious problem in the welfare field in attempting to gear housing allowances to a measure of the adequacy of the housing being provided. It is futile to undertake such a program unless decent low-cost housing is available. We urge that in future changes in the level of Federal financing of old-age assistance, attention should be given to a realistic consideration of housing allowances which are sufficient to secure utilization of decent homes.

#### SIMPLIFIED SHARING FORMULAS

There needs to be simplification of the various sharing formulas now employed in connection with the different public assistance titles. The present arrangement, although simplified considerably in the past several years, is still costly and cumbersome in the variety of formulas that it provides.

#### STANDARDIZATION OF AID

We believe that the Federal agency should take more leadership in bringing about equalization and standardization of levels of aid provided. At the present there is a wide disparity in assistance benefits

provided by the various States, which complicates the resolution of the residence problem of the States which we mentioned earlier.

We believe that more work and research along the line of the cost-of-living studies of aged population would be extremely helpful to States in assisting them to know what realistic costs must be met and in gearing their standards to a reasonable basis of adequacy. These studies should be made oftener and should cover a wider variety of living conditions.

#### ADMINISTRATIVE IMPROVEMENT

In conclusion, more consideration should be given to the improvement of administration and more emphasis should be placed on services as well as the meeting of economic need. We need to put emphasis on training of social work and other professional staff. We need to have demonstration and action programs to find new methods of solving problems on the Federal, State, and community levels. We need to simplify administration by reducing differences between categories which lead to complexities and difficulties in administration.

We need to lower caseloads so that social workers can give individual consideration to our aged, handicapped, and disadvantaged persons.

Our State has enacted legislation in this direction, but we need further Federal assistance in changing our public welfare program in these new directions.

Thank you very much for being able to give this testimony to you.

Senator ENGLE. Thank you very much, Mrs. Evans.

Unless you have objection we will call the other witnesses in the order in which I named them in first introducing the panel.

Mrs. EVANS. I would like you to meet Dr. Daniel Blain, the director of our department of mental hygiene here in California.

Senator ENGLE. Dr. Blain, we will be very happy to hear your testimony.

#### STATEMENT OF DANIEL BLAIN, M.D., DIRECTOR OF MENTAL HYGIENE, STATE OF CALIFORNIA

Dr. BLAIN. Senator Engle, Senator Randolph, ladies and gentlemen, the real things old people want are self-respect and the respect of others, to be wanted by someone, to be loved, to have something useful to do, to have a choice in what is being done with them; they want not so much a life that is worth while, but that they themselves be regarded as worth while.

I mention these things because you might wonder why a psychiatrist has any particular interest in this group over any other group. But the facts are that it is the lack of these particular things, these personal emotional needs that people have, and which get stronger as they get older—it is the lack of these which causes the symptoms of mental breakdown, disorientation, loss of memory, and frustration.

Therefore, in the department of mental hygiene we are particularly interested that these people who come our way get some kind of relief for this lack of respect and lack of love, and the lack of something useful to do.

We would like to say immediately that our big mental hospitals are not the best place to supply those things. They are far better supplied

at home, or nearby, where people live. But failing these things, therefore, some people do break down and apparently break mentally. The great majority are not mental patients, even when they have those symptoms.

In the State of California we work on the premise that the problem of our geriatric population basically is a nonpsychiatric problem. It is a phenomenon involving a complex of social, economic, cultural, and medical factors.

Now, very briefly, for the department of mental hygiene, I think you should be reminded that this is the largest department of the State government. It spends \$140 million of your general fund money. It has 22,000 employees, and we are currently responsible for 75,000 patients.

The problem of those over 65 is a major one with us. In California, the number of patients aged 65 and over has increased from 18 percent of the total hospital population in 1940 to more than 31 percent in 1961.

About a fifth of all admissions into our hospitals are over 65. Seven percent of those who come in will never leave.

About 40 percent of those who come to our State hospitals, on the face of things and the most casual examination, don't belong there at all. Usually they come because there is no other place for them to go. Twenty percent of those who get in do need hospitalization for a few days in order to get a good diagnosis. After that they should go somewhere else, if there is anyplace else for them to go.

And so, as a humanitarian, I am tremendously distressed by the fact that so many older people are sent to us; and we admit, in fact, we plead with you to recognize the fact that this is not the best place for them. They are sent to us and they have to have some type of life for the rest of their lives. The overcrowded conditions under which we are forced to place them in dormitories and places where they have very little outside view, certainly are not the best places in which they could possibly be. Administratively, we have succeeded in reducing the total number of our patients, except for the people over 65, and they have essentially doubled in the last few years.

In California we have had some notably good legislation, and I, as a person who came here from the East only 3 years ago at the request of Governor Brown, find that the atmosphere here is far better than most places of which I know. Even in our own department we are able to do many things that other State hospital groups cannot do. Legislation does provide a method by which patients can be taken care of nearer home on a partnership basis between State government and local government.

We have the authority this year to transfer many of our patients to private institutions nearer their homes and pay the bill; that is, up to the average that we spend in our State hospitals, which this year is \$7.90 a day.

The increase in the rate for family care is one of the greatest things that has happened to us. The legislature permitted an increase of \$95 a month up to \$130, and we are currently operating at \$115. We have a leeway to expand this as times goes on.

Legislation that has been mentioned in relation to the department of social welfare is of particular interest to us, particularly that having to do with community services demonstrations, which will be



very useful for older people. There is no group of people in which preventive aspects of mental health are more easily demonstrated than in the older people. All we have to do is provide the things I mentioned in the beginning and they will not break down as fast as they are now doing.

I would like now to talk about assistance in long-term planning and here I shall refer to my prepared document.

Senator ENGLE. Without objection your entire statement will be made a part of the record.

I observed that you have ad libbed a good part of it. Your whole statement will be made a part of the record.

Dr. BLAIN. Right here I am going to use the prepared text and give you a little detail which we are particularly anxious to place before the Senate committee.

The State of California also needs the help of the Federal Government in extending its services to our senior citizens. Without discussing a wide variety of possible issues, I wish to refer specifically to one problem. Administrative interpretation of the law has precluded Federal participation in old age security grants to persons released from our State hospitals to live in family care homes. Denial of Federal participation in such OAS cases proceeds from what we believe to be the narrowest possible, and in fact, unreasonable interpretation of both the intent and the language of the Social Security Act.

This is borne out, I might say, by the fact that the Assistant Secretary of Health, Education, and Welfare sent me the copy of the report of the Committee on Social Security which we presented to the Congress about a year ago, in which they recognized that the language was antique and that this needed a very serious restudy.

The issue hinges on the authority of the hospital to recall a leave-of-absence patient in family care to the State hospital, and to exercise authoritative direction over him during his period of leave.

The nature of the family care program does not lend itself to the forms of control inferred by the Federal policy, and therefore should be interpreted as meeting standards of personal liberty currently held by the Federal Government to be a condition of participation. For example, no patient is placed in family care without his consent. Similarly, the caretaker may elect whether or not to accept a certain patient. Mutual agreement of patient and caretaker is the essence of the program. The role of the department is protective. There is no decree made as to the regime each patient will follow. Caretakers are instructed only in basic standards of care they must follow, just as are operators of licensed boarding homes for the aged in which federally supported old-age security recipients make their homes. The intent of family care is family life experience, a pattern of living out of harmony with the concept of control of the patient which appears to dominate the Federal policy.

The Federal policy denying financial participation to family care patients who receive public assistance appears to work against the concept of the patient as a citizen of the community, and to stress in a practical sense a largely inoperative condition called control as a basis for regarding him an institutional inmate rather than a citizen. That there are conditions on his existence in the community we cannot

deny, but this is true of many others—children beholden to their parents, infirm elderly patients to their guardian, you and I in relation to our neighbors.

In California we are striving to increase our effectiveness in dealing with the problems of aging as they relate to mental health. We appreciate your interest and solicit your attention to ways in which you can facilitate appropriate Federal sharing of our efforts.

Thank you very much.

Senator ENGLE. Thank you, Dr. Blain, for that very splendid statement. At this point in the record we will insert the prepared statement of the California Department of Mental Hygiene.

(The prepared statement follows:)

PREPARED STATEMENT OF THE CALIFORNIA DEPARTMENT OF MENTAL HYGIENE

(Statement submitted by Daniel Blain, M.D., director of mental hygiene)

Improved public and private health measures, economic circumstances, and protective services have contributed to a social phenomenon of dramatic proportions—the extension of human life by many years. Increased longevity is both a boon and bane in our society.

California, like other States, is confronted with the difficulties of an aging population. The area of our most immediate concern is the impact of the geriatric patient on our State hospital program. In California, patients aged 65 and over have increased from 18 percent of the total hospital population in 1940 to more than 31 percent in 1961, although only 8 percent of the State population is 65 or over. Approximately 1 in every 105 California residents in this age group is in a State mental hospital. Three out of every five patients aged 65 and over in our mental hospitals will remain hospitalized until death. Even though these older patients comprise 31 percent of the hospital population, only 7 percent of the patients being discharged alive are in this age group.

As director of mental hygiene in California, I am concerned about this problem on humanitarian grounds. Longevity has outrun our capacity and readiness to provide means for a similar qualitative maintenance of life. In his advancing years, the individual increasingly is subject to the hazards of life. While income dwindles, costs of needed services tend to rise. The oldster faces isolation and loneliness, and often for lack of appropriate local care, he suffers the wrenching displacement from his home to a distant State institution.

As a medical administrator, I am concerned. For the first time in more than a decade, we have achieved a small but significant diminution of our State hospital population, even in the face of steady increase in annual admissions. But, despite our best efforts, we have not stemmed the rise in the proportion of elderly persons in these same hospitals. Unless needs specifically dictate the necessity for State hospital care, a large, somewhat impersonal, State institution is not the facility of choice for an aging person.

Unnecessary admission of a person to a State hospital is an excessively costly medical and social procedure. Yet, we know from our own studies, that at least 40 percent of persons 65 years of age and over are admitted to our hospitals when they better could be served near at home. Another 20 percent of those admitted need only the diagnostic services of the State hospital, after which they better can be served by alternate local facilities. Once he is admitted, there is a tendency for a person to linger unnecessarily in the State hospital, with consequent erosion of former social contacts, active local interests, and self-respect.

In the State of California, we work on the premise that from the broad perspective of public health, the problem of our geriatric population basically is a nonpsychiatric problem. It is a phenomenon involving a complex relationship of social, economic, cultural, and medical factors.

The State of California has launched a vigorous research program financed from State funds, which involves both a highly technical as well as a broad sociological analyses of our aging population and their needs. We have been fortunate to have reinforcement of our efforts by the National Institute of Mental Health through a number of research grants.

For example, there is the study being carried on through our Langley Porter Neuropsychiatric Institute. This is a study of why older people are hospitalized.

At the other end of the spectrum, the department, with help from NIMH, is studying the social habilitation potentials for elderly persons now in the State hospital.

In addition, our department is funding numerous research programs solely from State funds, and presently has research teams located at eight State hospitals carrying on specific research studies and acting in an advisory capacity to other persons interested in or conducting research, a number of which have direct pertinence to the geriatric problem.

California has also been active in the field of developing legislation to facilitate our dealing effectively with this problem. In 1957 the State legislature approved the Short-Doyle Act for community mental health services, through which the State can help local communities by means of subventions to provide diagnostic evaluation of elderly persons seeking treatment for mental disorders, as well as for inpatient and outpatient treatment, consultation, and rehabilitation for the aged.

Senate bill 382 recently enacted, allows the department of mental hygiene to place State hospital patients on leave of absence in licensed hospitals or other suitable licensed facilities and to pay for such care at a rate not exceeding the average cost of care in State hospitals. This may be used as an alternate to State hospital care for selected older patients.

As a result of recent legislative action the department may pay a higher rate for our patients on leave of absence in family care homes, starting in January 1962. Because of the higher rate available we expect to expand our family care placements substantially. Such growth will benefit our older patients. More than 250 of our elderly patients now live in these foster homes as substitutes for their own homes which no longer realistically exist. Family care has taken the oldsters out of the routine of institutional living, and returned them to the normal patterns of household living, with all of the flexibility of schedule, the individual attention and the freedom of choice that are possible in a family. Patients released to this pattern of living have been emancipated from the rocking chair with the encouragement of social workers and family caretakers. They have developed active social lives of their own, by participating in community clubs, establishing and sustaining friendships, excursions to town, and brief out-of-town trips. One such patient in his sixties while attending the meeting of his social club was presented with a birthday cake. On this occasion, with tear-filled eyes, he stated that he had not received a birthday cake since childhood.

There are other legislative measures which will benefit our patients. Because they are not directly within our purview, I will not discuss them in detail. But, they are of keen interest to us, and we believe, may help materially in dealing with the problems of which I speak, hence I mention them briefly. Certain provisions have been made to eliminate citizenship requirements for some elderly persons so that they may be eligible for old-age security payments. Other legislation provides for an increase in allowances to be paid for special needs of OAS recipients. And still other legislation has increased the grant to OAS recipients and has tied the grant to the cost of living. Each of these measures contributes potentially to the economic and social stability of the elderly recipient in his home community. As more effective measures such as these provide the general health and welfare needs of our elderly population, the potential for social disorganization and disruption of normal patterns of living in the community will be reduced. The spectrum of hazards to which the elderly person is exposed will be narrowed, and proportionately, the likelihood of his being removed to a remote, large State hospital.

Senate bill No. 347, passed by the State legislature and titled "Community Services for Older Persons," provides State subvention to local public agencies in partial support of programs "to promote local community activities which will further the efforts of older persons, their families \* \* \* (and others) in accomplishing for older persons an opportunity to remain active and contributing members in their community to the fullest extent possible." We view this as an important measure because it is a beginning of needed encouragement to local communities to assist in the enrichment of the life of our later years, to avoid the stagnation, isolation, loss of self-esteem which too often erupt into acute psychotic episodes, and set one on the path to the State hospital. We can help prevent such tragedies.

Senate bill No. 325, may have significant long-term impact on the problem of unnecessary State hospital admissions for persons aged 65 and over. This bill provides assistance for aged persons who require long-term hospitalization and nursing home care and outpatient medical services upon release therefrom. Costs are financed by 50 percent in Federal funds and the remainder shared equally between the State and county governments, except that there is no county participation in outpatient costs. This program appropriately supports the location of medical and nursing services in the local community.

The State of California also needs the help of the Federal Government in extending its services to our senior citizens. Without discussing a wide variety of possible issues, I wish to refer specifically to one problem. Administrative interpretation of the law has precluded Federal participation in old age security grants to persons released from our State hospitals to live in family care homes. Denial of Federal participation in such OAS cases proceeds from what we believe to be the narrowest possible, and in fact, unreasonable interpretation of both the intent and the language of the Social Security Act. The issue hinges on the authority of the hospital to recall a leave of absence patient in family care to the State hospital, and to exercise authoritative direction over him during his period of leave.

The nature of the family care program does not lend itself to the forms of control inferred by the Federal policy, and therefore should be interpreted as meeting standards of personal liberty currently held by the Federal Government to be a condition of participation. For example, no patient is placed in family care without his consent. Similarly, the caretaker may elect whether or not to accept a certain patient. Mutual agreement of patient and caretaker is the essence of the program. The role of the department is protective. There is no decree made as to the regime each patient will follow. Caretakers are instructed only in basic standards of care they must follow, just as are operators of licensed boarding homes for the aged in which federally supported old age security recipients make their homes. The intent of family care is family life experience, a pattern of living out of harmony with the concept of control of the patient which appears to dominate the Federal policy.

The Federal policy denying financial participation to family care patients who receive public assistance appears to work against the concept of the patient as a citizen of the community, and to stress in a practical sense a largely inoperative condition called control as a basis for regarding him an institutional inmate rather than a citizen. That there are conditions on his existence in the community we cannot deny, but this is true of many others—children beholden to their parents, infirm elderly patients to their guardian, you and I in relation to our neighbors.

In California we are striving to increase our effectiveness in dealing with the problems of aging as they relate to mental health. We appreciate your interest and solicit your attention to ways in which you can facilitate appropriate Federal sharing of our efforts.

Senator ENGLE. Dr. Lester Breslow, chief of the division of preventive services, department of public health. Dr. Breslow, we will be delighted to hear you at this time.

**TESTIMONY OF MALCOLM H. MERRILL, M.D., CALIFORNIA STATE  
DIRECTOR OF PUBLIC HEALTH, PRESENTED BY LESTER BRES-  
LOW, M.D., CHIEF, DIVISION OF PREVENTIVE SERVICES, DEPART-  
MENT OF PUBLIC HEALTH**

Dr. BRESLOW. Thank you, Senator Engle and Senator Randolph. In presenting this statement I am speaking on behalf of Dr. Malcolm H. Merrill, the State director of public health.

Among the problems of older persons in our society, how to maintain health is of major importance. As with many other aspects of living, in health also we have given first attention to the problems of younger people.

With the progressive increase of our population reaching older age, we now face the accumulation of mounting problems such as the following:

(1) Thousands of older persons in our State alone are unnecessarily disabled after having suffered strokes, hip fractures, and other conditions for which they received merely custodial care and no rehabilitation.

(2) Professional health workers who have a limited view of the potential for improvement of the chronic disease problems of older persons, reflecting the past disregard of these problems by professional training schools, hospitals, and health agencies.

(3) Discouragement among older persons themselves who see our tremendous, modern medical facilities devoted to all kinds of health problems without due consideration to their own needs.

Your committee is all too familiar with this picture and the factual details that spell it out: The fact that they require more than twice as much hospital care and 12 times as much nursing care as the rest of the population. The California health survey shows that about one-tenth of the persons in the State 65-74 years of age, living outside of institutions, cannot get around without help or cannot carry on their usual activities because of chronic conditions; beyond age 74 the proportion increases to almost one-third.

Much of this chronic invalidism is due, not to the original disease process but to such things as the immobility resulting from confining patients to bed and failing to provide aggressive care aimed at restoring function.

Recently we have begun to learn that much of this disability can be prevented. New patterns of health service are emerging—rehabilitation for older persons as well as younger, active rather than passive nursing care, organized home care, and other services whose object is to maintain independence and avoid unnecessary institutionalization.

Here in California we have taken many steps to improve health care for older persons. Country hospitals have initiated rehabilitation in the so-called geriatric wards and found that, although the cost per day goes up, the number of days of hospital care required goes down for a net dollar saving per patient treated as achieving a better final result. Local health departments have started health screening programs for older persons to find cases of diabetes and other chronic conditions which are common in later life early enough to avoid complications; other local health departments have started home nursing and nutrition services for aged persons. Several community health agencies have inaugurated homemaker services and organized home care programs. Our State department of public health for several years has been promoting these services and utilizing Federal health funds to initiate them. Our California hospital and medical program for State employees, started by the Meyer-Geddes Act in the 1961 legislature and a part of Governor Brown's legislative program, will provide the same benefits to persons who retire from State services as to those still employed—and at the same premium rate.

With funds made available by the Community Health Services and Facilities Act of 1961, recently passed by the Congress, we intend to step up immediately the development of community health services

for older persons. We are currently working on plans to implement this legislation. Our intent is to work closely with local health departments and other community agencies to support new and expanded services such as nursing care of the sick at home, homemaker service, coordinated home care, health information and referral services, periodic health appraisal, improving nursing home care, and education of personnel engaged in care of the long-term ill or aged. We feel this legislation is a most important contribution toward the improvement of medical services to the chronically ill and aging.

What should be done further, and particularly by the Congress? We believe that Congress should enact legislation that would further assist the States to develop comprehensive State plans for community health services for the aged and long-term ill. Then Federal funds should be provided to help carry out those plans. That was the pattern adopted by the Congress in the Hill-Burton program which is helping to solve the critical shortage of hospital facilities. Its success is clear.

With further Federal support for State plans to develop community health services for the aged in a systematic and comprehensive fashion, as in the Hill-Burton hospital planning and construction program, we can make good headway, and the Congress and the people of the country will have greater assurance that available funds are being spent in an efficient and effective manner.

Senator ENGLE. Thank you very much, Dr. Breslow, for that excellent statement.

And the Chair would like to add for the record that he is a close friend of and over a long period of years has known Mrs. Mary Lasker, who has made an outstanding contribution to the solution of the health problems of this Nation, and that Dr. Breslow last year won the Albert and Mary Lasker Award for outstanding contributions to public health.

I congratulate you on that award, which is a great distinction indeed.

Our next witness is Miss Eleanor Fait, the chief of the older worker specialist program of the department of employment.

Miss Fait, we will be glad to receive your statement.

#### **STATEMENT OF MISS ELEANOR FAIT, STATE SUPERVISOR, SERVICES TO OLDER WORKERS, CALIFORNIA DEPARTMENT OF EMPLOYMENT**

Miss FAIT. Mr. Chairman, my name is Eleanor Fait. I am State Supervisor of Services to Older Workers for the California Department of Employment. I am representing Mr. Irving Perluss, director of the department. Mr. Perluss has asked me to express his regret that he is unable to be here personally.

Workers over 45 years of age in California totaled 2¼ million in 1960. By 1970, present estimates indicate a total of more than 3 million. This represents a California increase of 37 percent in this worker group as against an expected national increase of 20 percent. Thus, an increasing number of older workers in this State will want need, and deserve jobs.

Because of such labor force trends, there is a continuing responsibility on the department of employment to work toward the improvement of job opportunities for the older worker segment of our population.

My remarks today will be confined to developments since the period covered in our last report to this committee.

The department of employment placed more than 93,000 workers "over 45" in business and industry in 1960. This represents an increase of 10.2 percent over 1959, a significant figure in view of the general economic "downturn" prevailing in 1960.

We discussed before this committee 2 years ago the seven cities study conducted in 1956 by the U.S. Department of Labor and the important new information it brought to the field of employment security for older people.

This year, we surveyed the Los Angeles section of the study again and one phase of the older worker problem shows marked improvement in this 5-year period. The number of job orders containing upper age restrictions, received in our offices from employers in the Los Angeles area, has decreased by 50 percent.

Our department has long been interested in the varied problems facing the mature worker. The facts developed from the seven cities study caused us to accelerate our older worker program. These services received much encouragement from Governor Brown and, at his request, they have been expanded on a number of occasions.

One of the major features of our expanded program was the designation of full-time older worker specialists in all of the major employment offices in the State. Currently, there are older worker specialists in all of the more than 100 offices. Those in the large offices carry out their responsibilities on a full-time basis. Those in the smaller offices devote part of their time to providing a program suitable to the size and needs of their community.

Their responsibilities include job counseling and placement, conduct of employment clinics, development of retraining programs, studies of extent to which age is a factor in hiring participation on community committees on aging to assure that employment problems are considered in proper perspective to the overall problems of the older citizen, assistance to fraternal organizations and service clubs to help them implement their own programs for older workers, planning for employer institutes and use of information media to promote job opportunities for older workers.

The Governor's Commission on Employment and Retirement Problems of Older Workers, in its report this year commended the department of employment for its activity but feels that additional work is necessary to give greater emphasis to the needs of this special group. May I quote from the commission recommendations:

We recommend that the program of special assistance for older workers in the department of employment be expanded and intensified, and that additional Federal support be sought. While protective legislation and educational efforts can be of great help, there is no substitute for actual placement of specific job-seekers. Many older workers cannot be successfully placed through conventional employment service routines.

Individualized efforts beyond those made available to the general run of job-seekers are relatively expensive but are justified by the public interest in reintegrating the older worker \* \* \* experience with the present limited program of special assistance has been good; but rapid technological change, educational

obsolescence of older workers, and the growth of new industries and occupations make it imperative to intensify this program.

The Governor's conference on aging last October, the White House Conference on Aging in January, and this committee's hearings in California in 1959, all have served to heighten public interest in and place increased demands on the older worker specialists in our offices. In addition, the recent legislation on retraining and age discrimination, which the Governor has already outlined to you, add still new responsibilities to these staff specialists.

We continue to receive valuable encouragement and assistance from the Bureau of Employment Security. And we have been directed to carry on our program of education, information, research, study, and community organization, and to continue and expand our program of job counseling and placement. But the funds made available to us from the Bureau, even considering the substantial improvement in the budget for fiscal 1962, are inadequate for these activities, the need for which is reflected in the labor market trends I have already mentioned.

Our estimates indicate that we could productively use time equivalents sufficient to support an additional 35 specialists.

Finally, we need additional Federal assistance in the area of research. Because gerontology is a very new research field, and employment problems of older workers an even newer aspect of this field, research data are lagging far behind the need for this information.

We, in California, feel particularly handicapped in our planning at a time when population pressures are forcing changes at a very rapid rate.

Thank you for this opportunity to appear before your committee. Our department will be very happy to provide more detailed information on any subject in which you have a further interest.

Senator ENGLE. Thank you very much, Miss Fait, for that very excellent and constructive statement.

The next witness is Mrs. A. M. G. Russell, chairman of the Citizens' Advisory Committee on Aging.

Mrs. Russell, I take it you do not have a prepared statement?

Mrs. RUSSELL. No. It is prepared, but it is not in duplicate.

Senator ENGLE. You do not have copies. You may proceed, and the court reporter will take what you have to say very carefully, I'm sure.

#### TESTIMONY OF MRS. A. M. G. RUSSELL,<sup>1</sup> CHAIRMAN, CITIZENS' ADVISORY COMMITTEE ON AGING

Mrs. RUSSELL. I am happy to have this opportunity of reporting to the members of the Senate Special Committee on Aging. We are pleased that you are in California today and that you are interested in the additional ways the Federal Government can work with the States and local communities.

<sup>1</sup> Mrs. Russell has been a member of the Citizens' Advisory Committee on Aging since 1956, when it was first formed by legislative action. Since 1959, she has served as the chairman of the committee. She has achieved national recognition for her work as a leader in many voluntary activities as well. Mrs. Russell is past president of the Peninsula Volunteers organization, which has achieved national recognition for its sponsorship of Little House, the outstanding senior center in the country, located in Menlo Park, Calif. She also serves as chairman of the San Mateo County Committee on Aging and was the Governor's designee to the White House Conference on Aging.



You have already heard the excellent report of the Governor and several State departmental representatives concerning recent legislative and administrative actions which illustrate the interest California has in this regard. I shall talk about three subjects today which we believe are important at any discussion of Federal-State activities in California affecting older people.

The first is the Citizens Advisory Committee on Aging and its place in the present pattern of State and local services for the aging. The second is the responsibility of the local community and its citizens, with particular reference to the pioneering step taken this year by the legislature to encourage community services. Finally, we have some thoughts on direction and emphases which we think are needed.

The Citizens Advisory Committee on Aging was established in 1956 by the California Legislature to advise the Governor on the problems and needs of the senior citizens of California. It is an independent agency of State government and consists of 12 members, 8 citizens selected by the Governor on the basis of their demonstrated interest, and 4 members of the legislature.

The legislative members constitute an interim committee on aging. The committee and its professional staff work closely with an inter-departmental committee on the problems of aging, composed of representatives of State departments with major responsibilities toward older persons.

The Citizens Advisory Committee on Aging has three main functions:

- (1) To study of the problems of aging in California, and to recommend to the Governor steps for their solution.
- (2) To act as an information center.
- (3) To assist communities of the State in developing programs for their senior citizens.

Recent legislation added (4), to work together with other departments and agencies of the State government for more effective State programs and services.

In meeting these responsibilities the committee stresses action by the local community. For instance, it works with voluntary groups of all types, as well as local governments. However, recognizing that needs of older persons cannot all be met locally, the committee is also interested in new legislation.

For the last session of the legislature the committee made several recommendations to the Governor. These included the modification of relatives' responsibility, increased grants for persons receiving old-age security, and the State-financed program of housing for senior citizens.

Later the members of the committee gave their active support to other proposals made by Governor Brown in his 1961 legislative program. One of these was the measure described by the Governor which established a program of State matching grants to promote local services for older persons.

We are very enthusiastic about this new program, which began last month under the administration of the State department of social welfare. Under its provisions State grants will match local contributions for a wide variety of community service projects. Many of these will be joint projects between local public agencies and private.

groups. Several will include some of our excellent senior citizen groups. Some funds will be used to improve facilities used by senior citizen activities.

It is a program of real potential and has already stimulated much interest. We are proud that California has taken this forward step and are pleased that our committee will serve as an advisory group.

However, these efforts will only be successful if responsibility is taken by the citizens of our local communities. This may be accomplished through local or county committees on aging representing both public and private interests.

California has a number of such committees, with their most important functions being: coordination, planning, and the utilization of community resources. We are finding, as this new program gets underway, that the communities which are ready to take action and submit projects are often those that have had an effective committee on aging for some time.

Today I would like to point up some of the directions which I believe the Federal Government and the State and the communities should be taking at this time in programs and services which they provide.

In California we have many programs in many fields offering many services to senior citizens. We have Federal programs, such as social security, the State programs which have been described today, and we have numerous local programs.

For example, last year, in cooperation with the Governor's conference and the White House Conference on Aging, a study was made and a directory prepared of the leisure time activity programs for older people in California. The directory lists 344 programs, including 41 active center programs. The number of senior clubs reported appears and indeed is impressive when compared to developments in other places.

One of the significant findings of this study was the proportion of California senior citizens who participate in such programs—only about 9 percent do so. It is obvious that these programs, and one like them, are not reaching many thousands of seniors in California.

If a similar survey were made in other areas, such as housing, social welfare, and health facilities, et cetera, probably a similar pattern would be found.

Why is this? I believe it is because much of what we have done up to now in these various fields has been for the most part on a small scale, often on a demonstration basis. What we need to do now is to go in depth and fully develop and expand many services, programs, and facilities which now operate all too often on a token basis because of limited funds or limited public interest.

How can the Federal Government help to encourage this fuller and broader approach? First, it could continue to provide both the funds and leadership which have proved to be necessary in such areas as income, housing, health, and research.

Second, there should be developed greater coordination and communication among the various Federal programs so that gaps and lack of proper emphasis to the needs of older people are eliminated and more effective services proposed. Some of this has recently been accomplished by the new office set up in the Federal Housing and Home Finance Agency to coordinate the three major Federal housing programs for the elderly. I also think the recent increased appro-

priation for an expanding program by the special staff on aging in the Department of Health, Education, and Welfare was a very constructive step, and I hope other Federal programs can be given such strengthening in the future.

Third, I would urge that both planning and action by either the Federal Government and the State involve participation by senior citizens themselves. This is why your committee, for instance, is so well received throughout the Nation.

Fourth and last, I believe that the Federal Government, in cooperation with the States and their representatives, should develop a workable plan for implementation of the recommendations of each of the 20 sections of the White House Conference on Aging. This, as I see it, is a commitment which we have already made at all levels, local, State, and Federal, to the older people of our Nation. Thank you.

Senator ENGLE. Thank you very much, Mrs. Russell.

I want to express my appreciation to this panel, to you, Mrs. Evans, Dr. Blain, Dr. Breslow, Miss Fait, and you again, Mrs. Russell, and to say that, in combination with the Governor's statement, it shows excellent preparation. You not only told us, with respect to the Governor's testimony and the details that you provided, the constructive steps that you are making at the State level, but in addition you have in each instance suggested to us means by which the Federal agencies can be more helpful to you and more helpful in the solution of the problems of the aging. I want to tell you that we are grateful to you for the wonderful contribution that you have made to this record.

Senator Randolph?

Senator RANDOLPH. Governor Brown, although not now present, spoke of the excessive paperwork in connection with the programs for the aged and welfare efforts generally. I think we have a very pertinent example in the Internal Revenue Service finally recognizing to a greater degree the need for simplification of its forms; and in West Virginia within a few weeks our National Computer Center, which processes electronically the returns, will actually come into being. So what the Governor of this State has said is certainly valid, and it comes with impact on a medical care program, as it does in other areas as well. We can and must simplify the returns of one type or another which are demanded to be filed from the private citizen or the business entity.

Dr. Evans, I would wish to commend you for having advocated a change of residence requirements. We are a mobile people today. I will not go into the fact of the movement of men and women from one area to another, including the movement of citizens from one State to another. Of course, when they come to California we can well understand that this is the final movement, but that is because of the lush land in which you live, and climatic conditions which are very favorable to enjoyable life.

But this residence requirement is important, and you have a direct recommendation that you have made to the Congress of the United States, and I think that it is one that we can give very careful attention to in the second session, Senator Engle, this matter of residence requirement. Even now States are beginning to realize that there should not be the long residence requirement as we once had it for a voting privilege within a State. Not that you want fly-by-night

voters, but when people move from one State to another they shouldn't have to live there a long, long time to establish that voting responsibility.

Now, Dr. Blain, I compliment you upon what you have indicated is necessary in a more realistic interpretation of the old-age security grants in connection with those persons who live in family-care surroundings after having been discharged from the mental institutions. I think Congress can well follow your suggestion, and certainly I think this committee will be doing good work as it thinks in terms of an affirmative recommendation in this area.

Will you clarify for me, Dr. Blain, exactly what you meant by the percentages of over 18 percent 20 years ago as against over 31 percent now? Are these mental patients or are they patients in the State hospitals who are in the aged group?

Dr. BLAIN. They are patients in the State hospitals in the aged group. And I would be willing to say that many of them shouldn't be there. But in 1950, 18 percent of our total population was over 65, and now, in 1961, 31 percent are over 65. We made the point that many of these would be far better taken care of elsewhere; and many of them are not primarily mental cases at all, but there was no other place for them, so we are taking care of them.

Senator RANDOLPH. I believe your statement said 1940. You now say 1950. That is why I used the reference of 20 years.

Dr. BLAIN. I believe it is 20 years, sir; instead of 10.

Senator RANDOLPH. There has been this rather rapid increase.

Dr. BLAIN. Yes; you are quite right, it is 1940. Most of our figures we are comparing are for the last 10 years, so I got into the habit of saying 1950.

Senator RANDOLPH. Now, often in the Senate we are slow coming to the point, and I haven't yet reached the point about which I asked. Are these mental patients?

Dr. BLAIN. Yes. They are in a mental hospital.

Senator RANDOLPH. All mental patients?

Dr. BLAIN. They are diagnosed as mental patients before they come to us and sent to us on a commitment from the court; but we feel we do not agree frequently with the diagnosis, and frequently they get over their initial confusion, disorientation, in a few days, which shows that although they appeared to be mentally ill at the time, actually they were suffering from a temporary reaction to some frustration. Usually that is what happens and they are in our hospitals, and there is no place for them to go.

Senator RANDOLPH. Then there can be a period of readjustment and treatment which would remove this person from the so-called designation as a strictly mental patient, isn't that true?

Dr. BLAIN. That is correct.

Senator RANDOLPH. And that is desirable.

Dr. BLAIN. That is what we are trying to do.

Mrs. EVANS. And, Senator Randolph, may I clarify one point on this? Under the Federal social security law psychotics are held outside of being eligible for assistance. However, the definition of "psychosis" such as is interpreted through the Department of Health, Education, and Welfare is not a modern definition of "psychosis" that follows the trend of the new thinking and the new diagnostic basis as it has been set up, the official psychiatric agencies, and this is one of the places where we have problems. The second problem is, as Dr. Blain

mentions, that as long as they are under the control of a State hospital they cannot receive any funds, and family care certainly may be under the supervision, but certainly not the control as it appears to us.

Senator RANDOLPH. I think your supplemental statement is very helpful; and I must not detain the members of the panel longer. Miss Fait, you spoke of research in gerontology and it is a new field, as you have indicated. Perhaps one of the most difficult problems to which we have to adjust ourselves as legislators is the fact of change and the scope of change. You bring a good point here.

I reiterate what the Senator from your own State has said, that many have spoken here with helpfulness. The presentations will contain material which the staff as well as the members of the committee will profit by studying.

Senator ENGLE. I compliment you individually and collectively, as I did the Governor, and we are especially flattered that you would take the time you have obviously taken to make the constructive sort of presentation that you have made today. Thank you very much, each and all of you.

Our next witness is Miss Barbara Rosien, coordinator of the State senate committee on aging.

Let the Chair say that in some instances the Chair has broader biographical material with reference to these witnesses than their present titles, some biographical material indicating the broad background in this field; and, without objection, those who wish to supplement the biographical statement following their introduction may be permitted to hand to the staff additional information, if it is not presently in our hands, and it will be added to the record, because it is helpful very often to understand, in reading a person's statement, the background from which that person speaks, especially if it is a background of long training and experience in the field. The Chair, rather than reading each one, would read only the current and present title.

Miss Rosien is the coordinator for the State senate committee on aging, headed by Senator Hugh Burns, of Fresno, with whom I served in the State senate and who was one of my great, great friends.

We welcome you here, and we will be glad to have your statement at this time, Miss Rosien.

#### **STATEMENT OF MISS BARBARA ROSIEN,<sup>1</sup> COORDINATOR OF THE CALIFORNIA STATE SENATE SUBCOMMITTEE ON HOUSING AND RECREATIONAL NEEDS OF ELDERLY CITIZENS**

MISS ROSIEN. Chairman Engle, Senator Randolph, because of the time involved here my statement will be brief.

Each member of the committee has been given a lengthy study made by our Senate as its contribution to the housing and recreational

<sup>1</sup>Biographical data of Miss Barbara Rosien: Assistant executive director, Housing Authority of the City of Los Angeles. First employee of the authority from 1938 to the present; coordinator, California State Senate Interim Subcommittee on Housing and Recreational Needs of Elderly Citizens, 1957 to present; commendatory resolution adopted by California State senate, January 1959, in appreciation of Miss Rosien's services as coordinator of California State Senate Interim Subcommittee on Housing and Recreational Needs of Elderly Citizens; member, the Governor's Citizens' Advisory Committee on Aging; delegate and program participant, White House Conference on Aging, 1961; member, National Association of Housing and Redevelopment Officials; member, National Housing Conference, Inc.; member, California Association of Press Women; member, Greater Los Angeles Press Club; member, Publicity Club of Los Angeles; educated in Los Angeles schools; born in Los Angeles, Calif.

needs of the elderly citizens of this State. (The report is entitled, "Housing and Recreational Needs of Elderly Citizens.")

I am the coordinator of the California State Senate Subcommittee on Housing and Recreational Needs of Elderly Citizens and have occupied that position since the committee was organized in 1957.

During the 5 years this committee has been in existence, the California State Senate, under the leadership of President Pro Tempore Hugh M. Burns, has for the first time in the history of the State given serious consideration to the housing and recreational needs of senior citizens of our State. The committee has issued two reports; the first in 1959 and the second in 1961.

I am submitting with my statement six copies of the committee's 1961 report for your information and file.<sup>2</sup>

In order to conserve the time of the committee, I will limit my remarks to a brief summary of the committee's findings together with one or two recommendations which may be of interest to you.

Our committee in both its 1959 and 1961 reports found that there exists in the State of California an acute shortage of safe and sanitary accommodations for elderly persons of low income which has resulted in thousands of our senior citizens being denied adequate housing at rents they can afford to pay. They also found that the number of elderly persons in our State is rapidly increasing and unless emergency steps are immediately taken to provide additional housing which meets their needs, this shortage will constitute a grave menace to the health, safety, and welfare of all the citizens of our State. They found that housing for the aged, contrary to popular belief, is not an integral part of the basic problem of merely increasing the supply of housing for the general population. Housing for the aged must be geared to their own special needs. The continuing progress made in providing decent housing for the population as a whole has contributed little if anything in providing decent shelter for the aged. Housing especially designed to meet the needs and means of our lowest income older persons is still virtually nonexistent in this State. The committee found that the basic problem of providing adequate housing for the aged results from the disparity between the costs of such housing and the ability of low-income elderly persons to pay for it. For this reason the committee concluded that the major part of this problem cannot be solved without Government financial assistance.

Based upon this committee's studies, and again under the able leadership of Senator Burns, the 1961 regular session of the California State Legislature enacted senate constitutional amendment No. 10 and senate bill 414, which, if approved by the voters at the general statewide election in 1962, will provide \$100 million of the State's borrowing power to be made available in the form of long-term self-liquidating loans to local nonprofit public and private corporations to provide low-rent rental housing for its senior citizens. This program, again, if approved by the voters, will, at no cost to the State's taxpayers, provide a start toward meeting the most urgent housing needs of our State's lowest income elderly families.

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<sup>2</sup> The report referred to has been filed with the committee.

You will note that this program involves only rental housing. No sales housing program was included in this legislation for the reason that it was felt that existing Federal programs of Federal financial assistance in this area were adequate, provided that the agencies of the Federal Government administering them got off the dime and carried out the intent of Congress.

This brings me to one or two recommendations which may be of interest to the committee.

First, I would suggest that your committee give serious consideration to implementing existing federally assisted housing programs for the elderly to the extent of providing adequate community facilities in addition to the shelter facilities presently being provided. I have in mind adequate community halls, clinics, infirmaries, sheltered workshops, and similar facilities which would be of assistance to the senior citizens occupying these projects. This should not only be provided for rental housing projects but should also be a requirement of sales housing projects. In other words, our studies reveal that the community life of this segment of our population requires special attention and facilities to be successful and I don't believe shelter, alone, is enough.

Second, I believe that it would be helpful for your committee to review some of the federally financed local urban renewal programs which involve displacing site occupants to the end that you are satisfied that the elderly persons so displaced are being adequately rehoused in comparably located housing and at rents that they can afford to pay as required by Federal law.

I know that each local community is required to certify that all persons displaced by such programs will be adequately rehoused; however, I also understand that in some cases there has been quite a gap between these certifications and the adequate relocation of the elderly. I am not at all satisfied that the special housing needs of these persons are either being recognized or if they are recognized that they are being adequately met. Our studies have revealed that most of our senior citizens experience extreme difficulty in adjusting to new and strange environments. I do not believe this fact is sufficiently recognized and acted upon by many of those responsible for these relocation programs.

I wish to compliment your committee upon their interest in this subject and for your courtesy in permitting me to make this brief statement.

Senator ENGLE. Thank you very much, Miss Rosien, for that excellent statement.

I am very glad indeed that the State senate, under the capable leadership of Senator Hugh Burns, is continuing to study this program. I have observed that you intend to do more about housing for the elderly, the leasing of housing.

I also note that you say on page 3 of your statement that the rental housing program does not include "sales" for the reason that—

existing Federal programs of Federal financial assistance in this area were adequate, provided that the agencies of the Federal Government administering them got off the dime and carried out the intent of Congress.

Now, we initiated the first of those here in the State of California, as you know. I should be better informed on this, but it was my

impression that that program in the East had not authorized sales. Can you inform me on that point?

Miss ROSIEN. There are many new programs that have recently been enacted by this present administration, which includes some sales housing, but I don't know to what extent the program has been implemented.

Senator ENGLE. Oh, yes, our general housing program would include that.

Miss ROSIEN. But it's the implementation of these programs, Senator Engle, at the local level, getting the programs into action, getting the projects actually built. This is a very slow and tedious procedure, and this is where we think it should be speeded up, because when you reach the age of retirement you can't wait 100 years to get a decent place to live, as you know.

Senator ENGLE. We had a way of doing that up in the country where I come from. We just built a fire under the mule, and that caused him to move, and we will just have to build a fire under some of these fellows back there to get them to move.

Miss ROSIEN. If that is what it takes, I'm in favor of it.

Senator ENGLE. Thank you very much for your statement, and would you pay my special respects to my old friend Senator Hugh Burns and the members of his committee?

Miss ROSIEN. Thank you, I will do that, Senator.

Senator ENGLE. Our next witness is Dr. Margaret S. Gordon, associate director of the Institute of Industrial Relations at the University of California.

#### STATEMENT OF DR. MARGARET S. GORDON,<sup>1</sup> INSTITUTE OF INDUSTRIAL RELATIONS, UNIVERSITY OF CALIFORNIA

Dr. GORDON. Chairman Engle, Senator Randolph, I am very happy to be here.

During the last decade we have made remarkable progress toward meeting the economic problems of older people, and yet I believe most people would agree we still have a long way to go. Rather than repeat the points I made when I appeared before the Senate Subcommittee on Aging 2 years ago or in the statement which I submitted on request to your Subcommittee on Retirement Income last July,<sup>2a</sup> I should like to devote particular attention today to some of the economic problems facing elderly persons in California and their implications for Federal legislation.

The employment problems of older persons in California are similar to those in many other parts of the country. Moreover, the State

<sup>1</sup> Margaret S. Gordon, Institute of Industrial Relations, University of California, Berkeley, Calif. Professional position: Associate director, Institute of Industrial Relations, 1954. Committees, etc.: President, Western Gerontological Society; member, Governor's Commission on Employment and Retirement Problems of Older Workers, 1959-60. Publications: "Employment Expansion and Population Growth: The California Experience, 1900-1950," University of California Press, 1954; "Unemployment Insurance" (a popular pamphlet) with Ralph W. Amerson (1957); numerous articles and papers on economic problems of older persons.

<sup>2a</sup> See "The Aged and the Aging in the United States," hearings before the Subcommittee on Problems of the Aged and Aging, Committee on Labor and Public Welfare, U.S. Senate, June 16-18, 1959 (Washington, 1959), and "Retirement Income of the Aging," hearings before the Subcommittee on Retirement Income, Special Committee on Aging, U.S. Senate, July 12-13, 1961 (Washington, 1961).



employment service has taken a number of steps toward meeting these problems.

The income problems of elderly persons in California, on the other hand, present certain unusual features. For this reason, I should like to emphasize some of California's special problems in the field of income maintenance for older persons.

Per capita income in California is well above the national average, and earnings levels have always been relatively high in the State. Furthermore, the cost of living has risen rapidly in the last two decades, along with the State's spectacular economic growth. In keeping with this situation, old-age-assistance standards in California are relatively high. In May 1961, California ranked fifth among the States in its average monthly payment to old-age-assistance recipients, which amounted to \$93.10. It ranked third in average money payments—excluding vendor payments for medical care—which amounted to \$71.15. In 1961, the maximum basic grant for old-age-assistance recipients was raised from \$95 to \$101, effective at the beginning of 1962, while, for those with special needs, the amount that could be received, together with income from other sources, was raised from \$115 to \$166.

In the light of these relationships, it is surprising to find that average OASDI benefits received by aged beneficiaries in California barely exceed the national average, and this has been true for a good many years. In December 1960—the latest month for which State figures are available—average benefits paid to retired workers in California amounted to \$75.09 as compared with \$74.04 for the Nation as a whole. Comparisons were similar for wives' and widows' benefits. Or, to put the matter somewhat differently, California ranked only 15th among the States in terms of average old-age benefits to retired workers, whereas it ranked 6th in per capita income in 1960.

There appear to be several factors that may help to explain this. One is the presence in California's aged population of a significant proportion who have migrated here recently from other States and whose earnings records, in many cases, were built up in States with lower wage levels.

Although most people who migrate to California are relatively young adults, the stream of elderly migrants is by no means negligible in relation to the size of the older population in the State. It has been estimated that net migration during the 1940's accounted for 12.2 percent of the State's population in the 65-year-and-older bracket in 1950.<sup>2</sup> Of even greater interest are some unpublished data from the California health survey of 1954-55, which show that about a sixth of all Californians aged 65 and older at the time of the survey had migrated to the State since the beginning of 1945 and nearly 1 in 12 had moved here since the beginning of 1950.<sup>3</sup>

<sup>2</sup> E. S. Lee, A. R. Miller, C. P. Brainerd, and R. A. Easterlin, "Population Redistribution and Economic Growth. I. Methodological Considerations and Reference Tables" (Philadelphia: American Philosophical Society, 1957), p. 114.

<sup>3</sup> It should be noted that the year of migration refers to the year of the individual's most recent move to California.

TABLE 1.—Persons aged 65 and over, by year of most recent move to California, 1954-55

Year of most recent move	Number	Percent
Have not lived outside State.....	278	10.7
Moved to State before 1945.....	1,890	72.6
Moved to State:		
1945-49.....	223	8.6
1950-54.....	212	8.1
Total.....	2,603	100.0

Source: California health survey, 1954-55, California State Department of Public Health (tabulation arranged through the courtesy of Dr. Lester Breslow, chief, division of preventive services). For further information on the survey, see "Health in California," California State Department of Public Health (Berkeley, 1957).

The chances are strong that a sizable proportion of these elderly migrants had come from the west-north Central and west-south Central States, which together have accounted for nearly a half of all migrants to California in recent decades.<sup>4</sup> There is also evidence, as we might well expect, that recent elderly migrants may include a somewhat higher proportion of disabled persons than the older population as a whole. In this connection some special tabulations based on the California health survey of 1954-55, which I arranged to have carried out several years ago, are of considerable interest.

TABLE 2.—Persons aged 65 and over, by year of most recent move to California, sex, and work status, 1954-55

[In percent]

Year of most recent move	Working	Reason for not working				Total not working	Total
		At home	Unable to work	Something else (job)	Something else (retired, etc.)		
Men							
Have not lived outside State...	32.3	1.6	10.2	-----	55.1	67.7	100.0
Before 1945.....	26.7	.4	12.7	0.6	59.5	73.3	100.0
1945-49.....	40.4	-----	12.8	-----	46.8	59.6	100.0
1950-54.....	17.5	-----	17.5	-----	64.9	82.5	100.0
Average.....	27.6	.5	12.8	.5	58.5	72.4	100.0
Women							
Have not lived outside State...	6.6	68.2	7.3	1.3	16.6	93.4	100.0
Before 1945.....	7.8	75.4	5.6	.3	10.6	92.2	100.0
1945-49.....	9.3	62.8	9.3	-----	18.6	90.7	100.0
1950-54.....	4.3	63.4	8.7	-----	22.6	95.7	100.0
Average.....	7.6	72.7	6.7	.4	13.2	92.4	100.0

Source: See footnote to table 1.

<sup>4</sup> Margaret S. Gordon, "Employment Expansion and Population Growth: The California Experience, 1900-1950" (Berkeley and Los Angeles: University of California Press, 1954), p. 162.

TABLE 3.—Persons aged 65 and over in the Los Angeles, San Francisco, San Diego, and all other areas, by year of most recent move to California, sex, and work status, 1954-55

[In percent]

Year of most recent move	Los Angeles area		San Francisco area		San Diego area		All other areas	
	Year of most recent move	Percent working	Year of most recent move	Percent working	Year of most recent move	Percent working	Year of most recent move	Percent working
Men								
Have not lived outside State.....	3.5	22.2	17.1	28.4	3.2	(1)	14.9	35.7
Before 1945.....	78.7	26.7	69.8	29.4	69.4	41.9	73.1	25.2
1945-49.....	8.6	36.4	8.0	33.3	11.3	(1)	5.3	50.0
1950-54.....	9.2	14.9	5.1	(1)	16.1	(1)	6.7	28.0
Total.....	100.0	26.3	100.0	28.4	100.0	40.3	100.0	28.3
Women								
Have not lived outside State.....	2.7	(1)	26.3	6.7	1.5	(1)	13.5	6.8
Before 1945.....	77.7	8.6	57.4	7.7	70.5	10.2	72.2	6.8
1945-49.....	11.8	12.2	8.6	6.9	7.4	(1)	6.4	-----
1950-54.....	7.8	6.1	7.7	7.7	20.6	(1)	7.9	-----
Total.....	100.0	9.1	100.0	7.4	100.0	8.8	100.0	5.8

<sup>1</sup> Too few cases. Percentages have not been computed when the base is smaller than 20.

Source: See footnote to table 1.

Another factor which may help to explain the surprisingly low level of average old-age benefits in California is the relatively high proportion of women in the State's elderly population. I suspect, also, that relatively poor employment opportunities for older men following World War II, and perhaps, also, in more recent years, may have contributed to somewhat lower earnings records than might be expected on the basis of the relatively high earnings level in the State.<sup>5</sup> It will be possible to analyze these relationships more fully when the 1960 census data become available in greater detail.

#### LIVING COSTS

For those elderly OASDI beneficiaries, at least in the larger metropolitan areas of the State, who do not have appreciable amounts of income from other sources, the problem posed by high living costs is a difficult one. In the Los Angeles area, average benefits for an elderly retired couple at the end of 1960 amounted to about \$125 a month, or about \$1,500 a year.<sup>6</sup> Yet the revised elderly couple's budget, recently published by the U.S. Bureau of Labor Statistics, indicated that in the autumn of 1959 a retired elderly couple living in

<sup>5</sup> The 1950 census indicated that the median income of men aged 65 and over in urban areas of California was slightly smaller than the corresponding median for all urban areas in the Nation, the labor force participation rate of these men was relatively low, and the unemployment rate was considerably higher than in urban areas generally. That a low labor force participation rate on the part of elderly men tends to be associated with relatively poor employment opportunities is suggested by the significantly high inverse correlation rate which was found between the proportion of men aged 65 to 74 in the labor force and the unemployment rate in 151 metropolitan areas in 1950. See Margaret S. Gordon, "Work and Patterns of Retirement," in R. Kleemeier, editor, "Aging and Leisure" (New York: Oxford University Press, 1961), ch. 2.

<sup>6</sup> The average wife's or husband's benefit in the Los Angeles area was \$41.62. This suggests that the average monthly benefit received by an elderly couple was about \$125.

rented quarters in Los Angeles would have required \$3,111 a year for a modest, but adequate, level of living.<sup>7</sup> Housing costs for homeowners who owned their homes free and clear—and the majority of elderly couples do—would probably have been about 30 percent lower,<sup>8</sup> but on this basis budgetary requirements for elderly homeowners would have been about \$2,880 a year in Los Angeles in 1959. According to Ewan Clague, the Commissioner of Labor Statistics, the budget for a single aged person living alone would be about 60 percent of the budget for a retired couple, which would suggest a budget of \$1,867 for an elderly person living in rented quarters in Los Angeles in the autumn of 1959.<sup>9</sup>

At the end of last year, average widows' or widowers' OASDI benefits in the Los Angeles area amounted to \$58.54, or approximately \$708 a year, while average old-age insurance benefits were \$75.72 a month, or about \$912 a year. The recent increases in widows' benefits and in minimum benefits adopted by Congress will, of course, increase these averages somewhat, but it seems clear that there will continue to be a wide gap between benefit amounts and budgetary requirements for sizable numbers of OASDI beneficiaries who do not have appreciable amounts of income from other sources. And, as all the available data on the income status of the aged have indicated, the percentage who have very little income from other sources is especially high among the aged widows.

Average benefit amounts in the San Francisco area tend to be a little higher than in Los Angeles, but so are living costs, so that the relationships between benefit amounts and budgetary requirements are quite similar to those in Los Angeles.

By now there is widespread awareness of the fact that the budgetary requirements of elderly persons have been particularly affected during the last decade by the relatively rapid rise in hospital and other medical costs. The comparatively pronounced increase in housing costs, especially for renters, has also had a similar effect, though to a less marked degree. In this connection, a study of housing for the elderly in California, carried out by Wallace F. Smith under the auspices of the real estate research program of the University of California, is of special interest. His findings indicated, among other things, that 63 percent of the elderly couples and individuals living in rented dwelling units in California in 1960, could not, on the basis of their estimated income status, afford to pay as much as \$50 a month for rent.<sup>10</sup>

#### RECIPIENTS OF OASDI AND OAA

In the light of our discussion thus far, it comes as no surprise to discover that a comparatively large proportion of aged OASDI beneficiaries in California also receive old-age assistance benefits. With average old-age benefits well below the basic old-age assistance grant

<sup>7</sup> See Margaret S. Stotz, "The BLS Interim Budget for a Retired Couple," *Monthly Labor Review*, 83 (November 1960), 1141-1157.

<sup>8</sup> See "Retirement Income of the Aging," p. 90 n.

<sup>9</sup> *Ibid.*, p. 90.

<sup>10</sup> Wallace F. Smith, "Housing for the Elderly in California" (Berkeley: Real Estate Research Program, Institute of Business and Economic Research, 1961), p. 5. See also, some interesting material on the proportion of elderly persons facing problems with the cost of rent in "Alameda County's Old People," reported by the county committee on aging (Oakland: Council of Social Planning, Alameda County, mimeographed report, 1960), p. 40.

and with a wide gap between average old-age benefits and living costs, at least in the large metropolitan areas of the State, a good many old-age insurance beneficiaries must turn to the old-age assistance program for supplementary support. In February 1960, 15.1 percent of the aged OASDI beneficiaries in California were also receiving old-age assistance, as compared with 6.7 percent in the Nation as a whole. Furthermore, a relatively high proportion of California's old-age assistance caseload consisted of OASDI beneficiaries, 47.9 percent, as compared with 28.5 percent for the Nation.<sup>11</sup>

Clearly, there are several aspects of this situation that give rise to concern. One is the effect on the State's fiscal position. As a State with average old-age assistance payments exceeding the amount for which matching Federal funds are available, California's share of her old-age assistance expenditures is comparatively high in any case. But it is clear that her old-age assistance burden could be reduced if OASDI benefits came closer to meeting the living costs of aged beneficiaries.

A more critical consideration, from the point of view of the development of our social security system, concerns the appropriate relationship between OASDI and OAA benefits, and the effect of this relationship on the long-run development of the two programs. Granted that California's situation is not entirely typical, the problem exists in varying degrees in all the States. The general expectation is that, as the OASDI program approaches maturity, the number of OAA recipients will continue to decline, and the old-age assistance program will serve as a source of support only for those relatively few people in the aged population who, for some unusual reason, cannot qualify for OASDI benefits or for benefits under some other public retirement program. However, unless OASDI benefits come considerably closer to meeting the budgetary requirements of the elderly than they do today, the trend may well be in the opposite direction—particularly if the tendency toward greater reliance on public assistance to meet the medical costs of the needy aged continues and MAA recipients are counted in with OAA recipients. Private pensions will provide an answer for a good many, but not for most employees of small firms, who are rarely covered, for agricultural workers or domestic workers, who are never covered, or for many workers who are covered today but will not have worked long enough under any one plan at the time of retirement to qualify for benefits.

#### CONCLUSIONS

In conclusion, as I indicated in my statement for the Subcommittee on Retirement Income, I believe Congress should aim at a substantial improvement in the average level of OASDI benefits during the next decade—accomplished, preferably, in a series of steps rather than in one major change. Secondly, I would urge adoption of a program for financing medical care for the aged through OASDI—perhaps the most important single step that could be taken to reduce the gap between the incomes and budgetary requirements of many elderly persons. Thirdly, I believe that widows' benefits should be increased to at least 85 percent of the primary benefit amount, or perhaps more.

<sup>11</sup> Social Security Bulletin, 23 (December 1960), p. 18.

Whether they should be increased to 100 percent is a debatable question, in view of the problem of equity as between widows and retired female workers. On the whole, I should prefer to see the major part of the needed increase in widows' benefits take the form of a general liberalization of the benefit formula.

Finally, I would hope that very careful study might be given during the next decade to the future development of our policy with respect to the age of retirement under OASDI. As average life expectancy increases, there is much to be said for a policy that would encourage later retirement. In this connection, it must be kept in mind that, although the age of retirement under the Social Security Act is entirely permissive, it has clearly had an influence on policies requiring retirement at age 65 in private industry. The current unemployment problem has given rise to sentiment in favor of earlier retirement, but our longer run policies should be based on the expectation that it will be possible to bring the unemployment rate down to a more satisfactory level. I should like to see careful study given to a combination of policies which would encourage workers who are in good health to continue working beyond age 65, while those who are disabled could qualify for disability benefits on a somewhat less restrictive basis than at present. A later age of retirement would make possible an improvement in the benefit structure while at the same time holding down the total costs of the program.

Senator ENGLE. Thank you very much for that excellent statement—with some surprising figures, I may say, with reference to the problems particularly here in California. I was surprised to learn that our average is lower.

I am interested also in the footnotes and in the tabulations which are attached to your statement; and without objection they will be made a part of the record following your statement in order that they may appear in the record.

Thank you very much for appearing before us and for your testimony.

Our next witness is Dr. John Gussen, who is the director of the department of psychiatry, Cedars of Lebanon Hospital.

Dr. Gussen, we are happy to have you here, and we will welcome your contribution to this hearing.

**STATEMENT OF JOHN GUSSEN, M.D.,<sup>1</sup> DIRECTOR, DEPARTMENT OF PSYCHIATRY, CEDARS OF LEBANON HOSPITAL, LOS ANGELES**

Dr. GUSSEN. Thank you very much.

Senator Engle, Senator Randolph, I feel it is a great privilege to be here and to be allowed to testify.

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<sup>1</sup>Dr. John Gussen is a graduate of Columbia University, College of Physicians and Surgeons, and interned in medicine at the New York Hospital Cornell Medical Center. He received his psychiatric training at the Payne Whitney Clinic of the same medical center. Following assistantships in child and adult psychiatry in Sweden for 1 year, he became assistant professor of psychiatry at the University of Oklahoma School of Medicine and director of the outpatient department at the University of Oklahoma Medical Center. He then went to the University of California School of Medicine in San Francisco, where he held an assistant professorship in psychiatry, and developed the so-called Day-Night Hospital at the Langley Porter Neuropsychiatric Institute. In September 1959 he was appointed director of the department of psychiatry at Cedars of Lebanon Hospital. He is associate clinical professor of psychiatry at the University of Southern California School of Medicine, and is attending psychiatrist at the Cedars of Lebanon Hospital and on the attending staff of the Los Angeles County Hospital. He is a member of the American Psychiatric Association Committee on Leisure Time and Its Uses and a member of the Board of Trustees of the Senior Citizens Association of Los Angeles County, Inc.

I will, with your permission, add two very brief points to the prepared statement, and possibly insert an ad lib.

Basic human needs lie in three areas: good physical health, good emotional adjustment, and financial security. These needs are even more pronounced when, in the course of normal aging, an individual's resistance to both physical and psychological stresses is decreased and the stresses inherent in aging itself are added.

It is of the greatest importance to put the relationship between physical and psychological factors in their proper perspective, as serious misconceptions exist in this area. Problems of physical health and problems of emotional health can in no way be separated from each other. They are different sides of one and the same question. It has become quite clear that a normal aging period is much more dependent on emotional adjustment resulting from past experiences and the present life situation than it is on physical health. Physical health itself and bodily changes of aging are themselves greatly influenced by emotional factors. Many an older person has gone physically downhill after psychological stress. It is my contention that we have made a serious mistake in the past in concentrating too exclusively on physical factors, frequently disregarding the emotional ones.

Successful aging depends to a large extent on the maintenance of self-esteem and security, and this, in turn, requires that two basic needs be met. One is to have something worthwhile, useful, and enjoyable to do with one's time. In other words, be active in one form or another. The other is to have frequent contacts and good relationships with other people—friends, and if possible, with family. Both these factors result in a feeling of being useful, needed, and wanted, and these are essential to self-esteem and well-being.

The programs I propose seem to me of crucial importance in these areas and are, therefore, in my opinion worthy of both Federal and State support.

The emphasis in what I propose is throughout on prevention so that serious disability may be avoided if at all possible, and so that the older person may be able to help himself to the best of his capabilities rather than be a burden on others.

(1) First and foremost, there exists a need for the older citizen to have a specific place to turn to for counseling and advice on any and all problems that might arise, be they physical, psychological, or financial. I therefore propose the establishment of community senior citizen counseling or guidance centers. Such centers must have resources for investigating the specific situation. The functions of such a guidance center may include many other forms of helping activities, or may simply end with referral to the proper agencies for resources. Such guidance centers must become well known to the community so that the ever-recurring question, "Where do I turn for advice?" can be answered.

(2) The need for enjoyable, useful, as well as recreational activities and for frequent contact with people would be well served by consistent support of what in my opinion is one of the most important recent developments, that of so-called senior citizen centers and day centers. With relatively limited resources, such centers have already shown their worth. Much more could be accomplished if their resources should be increased in two primary respects: (a) That of

staying open through the day and the week rather than, as so many must do today, operate in a marginal, intermittent way in inadequate physical facilities, and (b) making experienced help and advice easily available to them. The senior citizens guidance centers may well be equipped to furnish such help.

(3) It is an everyday experience in medical and psychiatric practice to be forced to advise custodial or hospital care for older people who may be incapacitated psychologically and physically and thus cannot live entirely by themselves without care. This could frequently be avoided if there could be established residential facilities for older people, where some kind of community living is provided and encouraged and where counseling and help is easily available. In many instances such facilities could be made partially or wholly self-supporting. A second form of providing residential facilities would be the establishment of a "foster home" program for older people. This is an ad lib. This has been started by the State of California, by the family care program, and I think it is a very promising one.

Hospitalization could thus be avoided or terminated for many and the psychological and financial rewards are potentially infinitely greater than the cost of such a program.

(4) The next point concerns the establishment of outpatient clinic units for older people. I am again and again appalled by the picture of an older person frequently visiting a multitude of different specialty clinics in a large community clinic without having a relationship to any one physician, accumulating a multitude of varicolored pills, and never receiving help for the real difficulty. This is not only poor medical care, but also immensely costly. Underlying psychiatric difficulties, such as depressions or simply loneliness and frustration, manifesting themselves in a variety of physical complaints, are frequently the source. Much suffering would be avoided and much disability prevented if community clinics had both the knowledge and the resources to allow older people a relationship to one physician who becomes their family physician as it were, meeting both their physical and psychological needs.

Short- and long-term psychotherapy and general education sessions have shown themselves to be immensely valuable and should be freely available in such outpatient clinic units. Where such a system has been instituted, there has been a considerable decrease in the percentage of clinic visits and the prescription of medicines, as such programs have enabled older persons to lead a more useful and well-adjusted life. Such clinic units would simultaneously serve as diagnostic, therapeutic, and possibly training centers.

And now come the points that were omitted in my prepared statement. It is of utmost importance that training and research in the area of aging be encouraged. I am aware that this is going on now, but at this moment there are very, very few medical schools and very, very few graduate training programs where any attention at all is paid to the special problems of the care of aging, the problems of aging, and the research in aging. In order to both supply the additional knowledge that is needed and in order to fill the tremendous need of trained personnel in all these programs, it is crucial that both education and research be furthered.

And I am inserting a final point. Apart from discussing new programs it has struck me again and again in the various communities



in which I have worked that there exists very poor coordination of existing facilities and that there frequently is a great redundancy in the services rendered, so that a great deal of efficiency could be gained and a great deal of cost could be saved if services as they now exist were better coordinated.

Many more points could and need to be mentioned. I feel, however, that it is more advantageous on an occasion like this to concentrate on a few clearly defined issues rather than scattering attention throughout a large number. I therefore respectfully submit this proposal as read. I feel the rewards for its implementation would be great. That we live in highly critical times, I need not emphasize. It is at times like these that more than ever a nation needs all its resources to meet the challenge, and one of its most important resources is, can be, and should be its older citizens.

Senator ENGLE. Thank you very much, Dr. Gussen, for that very, very fine statement, and we appreciate your contribution to this record.

I especially noted your emphasis on securing some kind of citizens guidance for the elderly so that when they go into these various periods of transition they get the kind of help that they need.

Dr. GUSSEN. Yes, this is very, very important.

Senator ENGLE. This is an excellent contribution to the record. Thank you.

Dr. GUSSEN. Thank you.

Senator RANDOLPH. We are helped today by the careful manner in which the statement has been prepared, not only by your testimony but by other testimony. It is provocative in measure, as you understand; it is challenging in nature, as you indicate. We will be helped by what you have said.

Senator ENGLE. Our next witness is Mr. Arthur H. Tryon, executive director, Los Angeles County Committee on Affairs of the Aging and Los Angeles County Division of Senior Citizens Affairs.

Mr. Tryon, we are happy to have you here today. I assume that you do not have a prepared statement.

Mr. TRYON. I do not, Senator.

Senator ENGLE. We will be glad to hear you; and the court reporter, of course, will record very carefully your remarks.

**STATEMENT OF ARTHUR H. TRYON, EXECUTIVE DIRECTOR, LOS ANGELES COUNTY COMMITTEE ON AFFAIRS OF THE AGING AND LOS ANGELES COUNTY DIVISION OF SENIOR CITIZENS AFFAIRS**

Mr. TRYON. Senator Engle, Senator Randolph, I am not going to make the presentation I had originally intended, because I realize you are running late and want to get on with it. I have submitted my report to you, which is self-explanatory. However, I should like to add one or two things.

The county of Los Angeles, in an attempt to cooperate with the Federal and State Governments, has made it possible to put into the field civil service employees who are charged with the responsibility of working with municipal, city, and other agencies within the county. We think we have been fairly successful to this end, but there is one thing that I think has been overlooked—and, having been in this business for some 15 years, perhaps understandably.

But of the great effort that is expended, and the money, toward alleviating many of the problems of the senior citizen, it seems to me there is badly lacking the coordination or lines of communication through out the entire country. For instance—now, this has been touched on several times by previous persons who have testified—it is rather difficult for us to learn just what the Federal program is. I recognize that we do get some consultation from the citizens' advisory committee of the State; however, they are not adequately and properly staffed to give to us at the county level the material that we need to cause local committees to be developed in some 73 cities within Los Angeles County whereby their own resources could be developed and other action to take care of their own citizens.

I make that one recommendation, gentlemen—and you most certainly have had some expert testimony this morning, and I won't go into those phases—but if you could give some consideration to how we can utilize the efforts and money to a better degree and get it down to the grass roots level the county of Los Angeles would certainly appreciate it very much. Thank you.

(The prepared statement of Mr. Tryon follows:)

PREPARED STATEMENT OF ARTHUR H. TRYON, EXECUTIVE DIRECTOR, LOS ANGELES COUNTY COMMITTEE ON AFFAIRS OF THE AGING AND LOS ANGELES COUNTY DIVISION OF SENIOR CITIZENS AFFAIRS

The Los Angeles County Committee on Affairs of the Aging is a committee of 45 community leaders appointed by the Los Angeles County Board of Supervisors for 2-year terms.

The committee is charged with concerning itself with the well-being of senior citizens of Los Angeles County, and to advise with the board of supervisors on matters relative to this purpose.

The Los Angeles County Division of Senior Citizens Affairs is a division of the department of charities and is staffed by civil service employees.

The function of this division is to act in an advisory capacity to the Los Angeles County Committee on Affairs of the Aging who in turn are advisory to the division, regarding the well-being of senior citizens.

Both the committee and the staff have, since their inception in 1955, worked as a team in the initiation and development of demonstration projects covering a wide variety of activities designed to meet or alleviate the problems of senior citizens within the county.

A few such projects are as follows, most of which have had the endorsement of the community agencies, organizations, industry, labor, government, and other groups:

(1) Junior friendly visiting project: A project wherein the Camp Fire Girls, Girl Scouts, and other junior organizations visit senior citizens in boarding and nursing homes and perform such services as needed by the oldsters and possible of accomplishment.

(2) Assisting with the organization of local committees on aging, designed to meet and alleviate such problems or needs as senior citizens may encounter at the local level.

(3) Assisted with the organization and incorporation of the present Los Angeles County Senior Citizens Association, which consists of approximately 180 golden age clubs.

(4) Assisted with the organization of the Retired Civil Service Employees of Los Angeles County.

(5) Have held indoctrination courses for nurses of the various hospitals within the county.

(6) Assisted in the development of a preretirement counseling program for numerous organizations and serving on panels with and including the Veterans' Administration and Army Corps of Engineers.

(7) Assisted with the organization of Retired Employees of International Ladies' Garment Workers Union, United Auto Workers, and other labor organizations.

(8) We played a very important part in having the Metropolitan Transit Authority consider favorably the granting of a reduced transit fare to our senior citizens during off-peak hours, and have assumed the responsibility of processing all of the applications made by our senior citizens and seeing that they received their reduced fare permit card. This entire operation has entailed the use of volunteer senior citizens at the control center. They consisted almost entirely of retired county employees who have done such an outstanding job that private industry has stated that their dedication, authority, and efficiency has surpassed that of younger paid employees—adding weight to the oft-repeated statement that we are losing much ability, talent, and experience in our practice of placing the older person on the shelf.

These are just a few of the many, many projects, programs, and accomplishments that we have initiated and worked on during the past 6 years. We would like to refer you to case study No. 10 of "Guideposts to Effective Action in Aging," by the U.S. Department of Health, Education, and Welfare, entitled "The Los Angeles County Senior Citizens Service Center."

Our stated objectives for the next 5 years include the setting up of as many local committees on aging as possible, each initiating and conducting needed demonstration projects within the areas involved, such committees to be sponsored by mayors, city councils, various agencies and organizations at the local level. These committees are offered the opportunity to affiliate with the Los Angeles County Committee on Affairs of the Aging. In addition, we will establish countywide committees, consisting of all of the directors of health at municipal government level, universities, industries, and so forth. The same will be done with librarians, dietitians, educators, and directors of such services as offer a resource for senior citizens. In this manner, we will have a countywide-committee of specialists on most areas of concern regarding the welfare of senior citizens.

#### CONCLUSION AND RECOMMENDATION

Our greatest need from the standpoint of statewide participation and coordination of this challenging organizational objective is more involvement on the part of the Citizens Advisory Committee On Aging for the State of California. The assistance and cooperation of individual State agencies, i.e., employment, social service, and so forth, with our committee and division, is excellent.

The need, it would appear, is for the State legislature to expand the Governors' committee and staff to the point where it will be possible for our county committee and division of senior citizens affairs to receive more consultation advice and a public exchange of current activities being conducted by other committees, agencies, and organizations elsewhere in the State and Nation, which is not now possible due to limited budget.

In addition, I am given to understand that there is practice on the part of the Federal Government to deal with State governments regarding its interests and resources, and, in effect, all areas relating to the Federal Government's participation or involvement in matters concerning the welfare of senior citizens. This practice is understandable and undoubtedly would be of great value to the local levels if the State were equipped to pass on the information in detail to the county level, where it could then be disseminated to local municipal levels. This needs to be done to a greater extent than is now being done. We recommend that either the Federal Government make funds available to the States or the States increase its budget for this purpose in order to be of greater service to our senior citizens at the local level.

This report intends no criticism of either the Federal or State Government by its practice or current activity, but rather is offered as a suggestion for consideration of each.

It is rather obvious that with the great activity being conducted at various State and local levels in the interest of senior citizens, that could an exchange of ideas and experiences be available through each community, it would most certainly produce the necessity of each committee having to learn by experiencing its own mistakes when it could profit from those made by other communities, and in turn, other communities would receive great benefit from the successful prosecution of projects in another area.

Senator ENGLE. Well, I may say to you that in my opinion local people always handle money better than State people, and State people handle money better than Federal people. The further government:

gets away from the people, the more bureaucracy you have and the less efficient we are in the handling of the money. The members of the city council, the members of the local groups, who have to go right on the street every day and face the people downtown, do a little better job in my opinion. And I have been at all levels of government. I served as district attorney, State senator, a member of the House of Representatives, and now the U.S. Senate, and my opinion on that hasn't changed at all—and that is, that the closer the government is to the people, the better we use the money.

We are certainly glad to have you here today and—

Mr. TRYON. May I add one thing to that, Senator? I wasn't speaking particularly of money, I was speaking of the successful projects that had been initiated and completed throughout these United States, and, where there is a need for a similar project in another area, we have no way of knowing the experience of the first area as to how they accomplished this successfully. And we stumble through; each area is doing that on its own.

I am not critical in the least of the Citizens Advisory Committee. I don't see how they do as much as they do with what they have, Senator; but it is more than the money. And, of course, everything is tied in with money, but more than that is how can we learn the successful operations that Cleveland, Columbus, Detroit, Boston, and other places have had and not have to stumble through it and find it out ourselves?

Senator ENGLE. That is the job of coordination we in the Federal Government should do. Thank you very much for your statement.

The next witness is Mr. A. W. Hale, a member of the board of directors of the Welfare Planning Council for the Los Angeles Region. He was also a representative to the White House Conference on Aging.

Mr. Hale, we will be very happy to have your statement at this time.

#### STATEMENT OF A. W. HALE,<sup>1</sup> BOARD MEMBER, WELFARE PLANNING COUNCIL, LOS ANGELES REGION

Mr. HALE. Thank you, Senator Engle; Senator Randolph.

The Welfare Planning Council, Los Angeles Region, and its five area offices have for many years not only maintained an active interest in meeting the health, welfare, and recreation needs of the aging, but have assumed leadership in various areas of community planning to provide services for our senior citizens. In addition, the council has encouraged the development and expansion of direct services to the aged.

As you know, the aging are at times used as pawns for the special interests of some organizations. These organizations hold out promises to the elderly of specific services in return for their votes or their support. Unfortunately, some organizations do not visualize the effects on the total community when they advocate one special program or cause on behalf of the elderly. In this manner, greater emphasis is given to income maintenance, for example, than to hous-

<sup>1</sup> Member of board of directors, Welfare Planning Council, Los Angeles Region; acted as program chairman, Los Angeles Conference on Aging, 1960; resource person, Governor's Conference on Aging, 1960; and representative of Welfare Planning Council, Los Angeles Region, at White House Conference on Aging.

ing or leisure time activities. A balanced Federal, State, and local program for meeting the health, welfare, and recreation needs of the aging is necessary.

The Welfare Planning Council believes that the major job necessary in the field of aging is to coordinate all activities in the interest of the aging themselves, and to strive for deeper understanding on the community level. It is the policy of the Welfare Planning Council to look at the total needs of the community, and to maintain a position of leadership without undue influence on the part of special interest groups.

The mental, physical, and economic needs of the senior citizens are substantial now and will become larger in the future unless adequate community planning is provided. The well-known fact of increased longevity and the vastly increasing aged population will compound these needs. Another fact not so well known is that one person out of three over age 65 has a living parent, which means two generations of aged. Obviously, community planning must be strengthened if those who are aged now and those who will reach age 65 in the next few years are to lead happy, healthy, and useful lives in retirement.

The Welfare Planning Council's board of directors have decided that the council's role should be to help individuals and families prior to age 65, and who will be our eventual senior citizens. Adequate preparation for old age can assist the employed individual over 50 to be self-maintaining after retirement in all or many of the areas mentioned earlier. As a result, the Welfare Planning Council is exploring the entire area of preretirement as it relates to individuals, families, industry, labor, and the community, to determine the most effective role the council can assume on a planning level. The basic question that needs to be answered is whether preretirement should involve broad community planning, or whether this is a matter for the individual determination of management, businesses, and labor unions. Through the involvement of both public and private community leaders, this question will be looked at next spring at a workshop on preretirement planning.

The council is currently engaged in several other activities for the aged. These include a conference to report to the community on two important home medical care projects, the effects on the elderly of relocation in an unplanned urban renewal project, the development of a research design measuring medical care needs and utilization as seen by the aged themselves, the implementation of the mental health survey recommendations as they relate to the aged, and on November 6 a council assembly will be held to discuss the impact of new trends in payment for medical care. The assembly will hear from experts in government medical programs, group medical care, and insurance. Naturally, these sources of payment have an influence on the health care of the aged.

I am pleased to have had this opportunity to review briefly some of the Welfare Planning Council's activities in the interests of our senior citizens. We are pleased your committee is undertaking these hearings throughout the country for the purpose of improving services for the aged.

(The material referred to previously follows:)

## THE AGED POPULATION OF LOS ANGELES COUNTY

(Prepared by the research department, Welfare Planning Council,  
Los Angeles region)

## INTRODUCTION

This brief, descriptive analysis of the aged population of Los Angeles County relates the aged to incorporated and unincorporated places (see tables I and II). This report also includes a rank order of incorporated places according to the proportion of aged within each place (see table III). Since there are no clearly defined unincorporated name-places, the regional planning usage is most frequently followed to define unincorporated areas. Thus, what here is called Dominguez Unincorporated, may be called Carson by others. Map I is solely intended as a guide to the various unincorporated areas. No attempt is made to accurately follow each incorporated and unincorporated boundary since our aim is primarily to indicate the major unincorporated areas. Similarly, since failure to follow precise boundaries of unincorporated areas does not significantly influence the proportion of aged therein, no attempt is made to proportionally assign by estimation or by enumeration districts those aged within a census tract under several incorporated and unincorporated jurisdictions.

Finally, table IV and map II deal with OAS cases by the smallest reporting unit utilized by the Bureau of Public Assistance—The 11 BPA districts. The old age security population is enumerated during April and August of 1960 and 1961, to provide temporal comparability with the census date (April 1960) and to indicate the stability of this population.

## SOME GENERAL FACTS ABOUT THE AGED

There are, for the purposes of this report, 6,038,771 persons in Los Angeles County. Of this number 240,518 or 3.9 percent are between age 60 and 64. Over half a million persons—553,238—are 65 and over. This number represents 9.1 percent of the population of Los Angeles County. The proportion of aged in the county differs but little from the State average of these categories, 3.7 and 8.8 percent respectively. These proportions, which do not differ from the national average should be kept in mind when evaluating the figures presented in the tables.

## DISTRIBUTION OF THE AGED BY LOCATION

Examination of tables I and II reveals that older persons are not evenly distributed throughout the county. The most general relationship that can be discerned is between socioeconomic status of the community and aged clustering. In general, the higher the socioeconomic status, the greater the proportion of aged. There is no clear-cut relation between community size and proportion of aged. The aged distribution pattern is not expected to prevail among the OAS population since the needy who are OAS recipients are not likely to be found in higher socioeconomic areas.

A comparison of maps I and II will show that areas within the county show a coincidence of OAS districts and unincorporated areas. By and large, the highest incidence of OAS cases occur within incorporated areas if such cases are randomly dispersed, as a comparison of maps I and II will show.

## SEX AND AGING

Only brief mention should be made of the sex of aged persons. Since women on the average, tend to live longer than men, because more females than males are born, an expected finding emerges in tables I and II. The finding referred to is that there are in most instances proportionally more aged women than men in each place.

## OTHER POPULATION AND HOUSING CHARACTERISTICS

As a caution it should be noted that many variables influential on almost any consideration of life habits and living arrangements have been excluded from this report. Race, income, and family relatedness are especially important in considering the potential and problems of older persons. Since this report only summarizes one major variable, this caution should be borne in mind in the course of any planning evaluation of these statistics.

TABLE I.—The aged by sex as a percent of the total population in cities of Los Angeles County

Name of city	Total			Age 60-64						Age 65 and over					
	Total	Male	Female	Total	Percent	Male	Percent	Female	Percent	Total	Percent	Male	Percent	Female	Percent
Alhambra.....	54,807	25,098	29,709	3,408	6.2	1,494	2.7	1,914	3.4	8,633	15.7	3,191	5.8	5,442	9.9
Arcadia.....	41,005	19,734	21,271	2,005	4.8	933	2.2	1,072	2.6	4,227	10.3	1,777	4.3	2,450	5.9
Artesia.....	9,993	4,993	5,000	252	2.5	124	1.2	128	1.2	612	6.1	297	2.9	315	3.1
Avalon.....	1,536	792	744	90	5.8	49	3.1	41	2.6	150	9.7	66	4.2	84	5.4
Azusa.....	20,497	10,165	10,332	458	2.2	223	1.0	235	1.1	1,102	5.3	512	2.4	590	2.8
Baldwin Park.....	33,951	16,912	17,039	954	2.8	455	1.3	499	1.4	2,436	7.1	1,123	3.3	1,313	3.8
Bell.....	19,450	9,399	10,051	953	4.8	467	2.4	486	2.4	1,995	10.2	825	4.2	1,170	6.0
Bellflower.....	26,467	13,295	13,172	1,481	3.3	685	1.5	796	1.7	3,009	6.7	1,362	3.0	1,647	3.6
Beverly Hills.....	44,846	23,312	22,534	757	1.7	394	1.4	363	1.3	1,537	5.8	663	2.5	874	3.3
Bradbury.....	30,817	12,911	17,906	2,585	8.3	1,060	3.4	1,525	4.9	5,044	16.3	1,997	6.4	3,047	9.8
Burbank.....	805	350	455	32	3.9	18	2.2	14	1.7	223	27.7	50	6.2	173	21.4
Burbank.....	90,155	43,804	46,351	3,697	4.0	1,808	2.0	1,859	2.0	7,508	8.3	3,054	3.3	4,454	4.9
Claremont.....	12,633	6,041	6,592	342	2.7	123	.9	219	1.7	1,715	13.5	523	4.1	1,192	9.4
Commerce.....	9,555	4,831	4,724	220	2.3	122	1.2	98	1.0	395	4.1	205	2.1	190	1.9
Compton.....	71,812	35,305	36,507	1,782	2.4	829	1.1	953	1.3	3,677	5.1	1,530	2.1	2,147	2.9
Covina.....	20,124	9,616	10,508	583	2.8	247	1.2	336	1.6	1,464	7.2	554	2.7	910	4.5
Cudahy.....	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Culver City.....	32,163	15,779	16,384	1,123	3.4	538	1.6	585	1.8	2,076	6.4	814	2.5	1,262	3.9
Dairy Valley.....	3,508	1,787	1,721	102	2.9	65	1.8	37	1.0	130	3.7	74	2.1	56	1.5
Downey.....	82,505	41,365	41,140	2,272	2.7	1,196	1.4	1,076	1.3	4,598	5.5	1,921	2.3	2,677	3.2
Duarte.....	13,962	6,965	6,997	269	1.9	131	.9	138	.9	749	5.3	231	2.0	468	3.3
El Monte.....	13,163	6,431	6,732	500	3.7	237	1.8	263	1.9	1,182	8.9	508	3.8	674	5.1
El Segundo.....	14,219	7,197	7,022	401	2.8	193	1.3	208	1.4	737	5.1	298	2.0	439	3.0
Gardena.....	35,943	17,847	18,096	947	2.6	457	1.2	490	1.3	2,097	5.8	934	2.5	1,163	3.2
Glendale.....	119,442	55,005	64,437	7,178	6.0	3,090	2.5	4,088	3.4	17,660	14.7	6,552	5.4	11,108	9.2
Glendora.....	20,752	10,169	10,583	519	2.5	255	1.2	264	1.2	1,401	6.7	584	2.8	817	3.9
Hawthorne.....	33,935	16,501	16,534	864	2.6	401	1.2	463	1.4	1,850	5.6	789	2.2	1,111	3.3
Hermosa Beach.....	16,115	7,918	8,197	594	3.6	238	1.4	356	2.2	1,687	10.4	614	3.8	1,073	6.6
Huntington Park.....	11,492	5,815	5,677	506	4.4	229	1.9	277	2.4	1,254	10.9	561	4.8	693	6.0
Industry.....	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Inglewood.....	63,390	30,741	32,649	3,167	4.9	1,448	2.2	1,719	2.7	6,629	10.4	2,745	4.3	3,884	6.1
Irwindale.....	1,518	1,041	477	48	3.1	27	1.7	21	1.3	68	4.4	37	2.4	31	2.0
Lakewood.....	67,126	33,279	33,829	1,163	1.7	530	.7	633	.9	2,099	3.1	892	1.3	1,207	1.7
La Puente.....	24,723	12,441	12,282	229	.9	107	.4	122	.4	532	2.1	237	.9	295	1.1
La Verne.....	6,516	3,132	3,384	235	3.6	111	1.7	124	1.9	804	13.2	338	5.1	526	5.1
Lawndale.....	21,740	10,989	10,751	489	2.2	255	1.1	234	1.0	991	4.5	444	2.0	547	2.5
Long Beach.....	344,168	172,056	172,112	15,945	4.6	7,007	2.0	8,938	2.5	43,327	12.5	16,953	4.9	26,378	7.6
Los Angeles.....	2,479,015	1,197,818	1,281,197	110,972	4.4	50,259	2.0	60,713	2.4	253,993	10.2	104,525	4.2	149,468	6.0
Lynwood.....	31,614	15,357	16,257	1,240	3.9	571	1.8	669	2.1	2,494	7.8	1,056	3.3	1,438	4.5
Manhattan Beach.....	33,934	16,766	17,168	778	2.2	320	.9	452	1.3	1,636	4.8	609	1.7	1,027	3.0
Maywood.....	14,588	7,269	7,319	699	4.7	349	2.3	350	2.3	1,335	9.1	569	3.9	766	5.2
Mirada Hills.....	22,444	11,197	11,247	171	.7	77	.3	94	.4	293	1.3	109	.4	184	.8
Monrovia.....	27,079	12,807	14,272	1,240	4.5	554	2.0	686	2.5	3,692	13.6	1,446	5.3	2,246	8.2

Montebello.....	32,097	15,561	16,536	1,296	4.0	615	1.9	681	2.1	2,510	7.8	1,087	3.3	1,423	4.4
Monterey Park.....	37,821	18,503	19,318	1,228	3.2	602	1.5	626	1.6	2,705	7.1	1,112	2.9	1,593	4.2
Norwalk.....	88,739	44,158	44,581	1,493	1.6	695	.7	798	.8	2,967	3.3	1,269	1.4	1,698	1.9
Palos Verdes Estates.....	9,564	4,741	4,823	255	2.6	129	1.3	126	1.3	456	4.7	186	1.9	270	2.8
Paramount.....	27,249	13,609	13,640	736	2.7	374	1.3	362	1.3	1,437	5.2	655	2.4	782	2.8
Pasadena.....	116,407	52,749	63,658	6,711	5.7	2,686	2.3	4,025	3.4	20,443	17.5	6,858	5.8	13,585	11.6
Pico Rivera.....	49,160	24,483	24,667	920	1.8	439	.8	481	.9	1,747	3.5	742	1.5	1,005	2.0
Pomona.....	67,157	32,532	34,625	2,161	3.2	936	1.3	1,225	1.8	6,146	9.1	2,508	3.7	3,638	5.4
Redondo Beach.....	46,986	23,265	23,371	1,347	2.8	632	1.3	715	1.5	3,351	7.1	1,348	2.8	2,003	4.2
Rolling Hills.....	1,664	821	823	59	3.5	35	2.1	24	1.4	79	4.7	34	2.0	45	2.7
Rolling Hills Estates.....	3,941	1,989	1,952	46	1.1	21	.5	25	.6	71	1.8	32	.8	39	.9
Rosemead.....	15,476	7,466	8,010	645	4.1	316	2.0	329	2.1	1,517	9.8	604	3.9	913	5.8
San Dimas.....	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
San Fernando.....	16,093	7,720	8,373	639	3.9	272	1.6	367	2.2	1,548	9.6	668	4.1	880	5.4
San Gabriel.....	22,561	10,688	11,873	1,224	5.4	599	2.6	625	2.7	2,713	12.0	1,110	4.9	1,603	7.1
San Marino.....	13,658	6,438	7,220	910	6.6	427	3.1	483	3.5	1,499	10.9	681	4.9	818	5.9
Santa Fe Springs.....	16,342	8,249	8,093	196	1.1	86	.5	110	.6	353	2.1	160	.9	193	1.1
Santa Monica.....	83,240	39,052	44,197	4,698	5.6	2,042	2.4	2,656	3.1	11,918	14.3	4,455	5.3	7,463	8.9
Sierra Madre.....	9,732	4,577	5,155	444	4.5	182	1.8	262	2.6	1,261	12.9	466	4.7	795	8.1
Signal Hill.....	4,627	2,273	2,349	234	5.0	115	2.4	119	2.5	529	11.4	239	5.1	290	6.2
South El Monte.....	4,850	2,497	2,353	125	2.5	66	1.3	59	1.2	331	6.8	168	3.4	163	3.3
South Gate.....	53,831	26,007	27,824	2,629	4.8	1,279	2.3	1,350	2.5	5,112	9.4	2,063	3.8	3,049	5.6
South Pasadena.....	19,706	8,688	11,018	1,175	5.9	463	2.4	692	3.5	3,114	15.8	1,060	5.3	2,054	10.4
Temple City.....	31,838	15,278	16,560	1,527	4.7	727	2.2	800	2.5	3,695	11.2	1,466	4.6	2,129	6.6
Torrance.....	100,991	50,337	50,654	1,849	1.8	861	.8	988	.9	3,372	3.3	1,386	1.3	1,986	1.9
Vernon.....	401	219	182	14	3.4	8	1.9	6	1.4	37	9.2	25	6.2	12	2.9
Walnut.....	934	455	479	37	3.9	15	1.6	22	2.3	84	8.9	39	4.1	45	4.8
West Covina.....	50,645	25,405	25,240	1,775	1.5	348	.6	427	.8	1,407	2.7	613	1.2	794	1.5
Whittier.....	33,603	15,652	18,011	1,799	5.3	736	2.1	1,063	3.1	5,005	14.8	1,857	5.5	3,148	9.3
Total, all cities.....	4,943,584			206,392						482,408					

<sup>1</sup> Incorporated after the date of the 1960 U.S. Census.

Source: U.S. Bureau of the Census. "U.S. Census of Population: 1960. General Population Characteristics, California." Final Report PC(1)-6B. U.S. Government Printing Office, Washington, D.C., 1961.



TABLE II.—The aged by sex as a percent of the total population in unincorporated areas of Los Angeles County

Name of area	Total			Age 60-64						Age 65 and over					
	Total	Male	Female	Total	Percent	Male	Percent	Female	Percent	Total	Percent	Male	Percent	Female	Percent
Altadena.....	34,539	16,253	18,280	1,657	4.8	691	2.0	966	2.8	4,273	12.3	1,635	4.7	2,638	7.5
Avalon.....	24,097	11,415	12,682	1,063	4.3	496	2.0	567	2.3	2,392	9.6	940	3.8	1,451	5.8
Calabasas-Malibu.....	11,896	6,185	5,711	432	3.6	215	1.8	217	1.8	775	6.5	394	3.3	381	3.2
Compton.....	41,324	20,344	20,980	896	2.1	438	1.0	458	1.1	1,854	4.5	815	2.0	1,039	2.5
Dominguez.....	50,421	25,560	24,861	951	1.9	488	1.0	463	.9	1,625	3.2	817	1.6	808	1.6
Glendale.....	8,796	4,360	4,436	251	2.9	122	1.4	129	1.9	550	6.3	232	2.7	318	3.6
Huntington Park.....	18,712	9,247	9,465	582	3.1	295	1.6	287	1.5	431	2.3	215	1.1	216	1.2
Inglewood.....	8,983	4,626	4,357	327	3.6	153	1.7	174	1.9	630	7.0	273	3.1	357	4.0
Long Beach.....	15,689	7,849	7,840	315	2.0	176	1.1	139	.9	494	3.2	203	1.3	291	1.9
Marina Del Rey.....	17,837	8,534	9,303	1,146	6.5	560	3.2	586	3.3	1,890	10.6	811	4.6	1,079	6.0
Palos Verdes.....	29,436	14,674	14,761	794	2.7	393	1.3	401	1.4	1,649	5.6	773	2.6	876	3.0
Pasadena.....	27,744	13,324	14,420	1,247	4.3	594	2.2	553	2.1	2,458	8.7	1,002	3.6	1,456	4.1
South Gate.....	40,228	19,437	20,791	1,657	4.1	829	2.1	828	2.0	3,776	9.3	1,635	4.0	2,141	5.3
West Hollywood.....	28,870	13,656	15,214	2,070	7.2	905	3.1	1,165	4.1	4,051	14.0	1,640	5.7	2,411	8.3
Montebello.....	104,270	50,803	53,467	3,398	3.3	1,634	1.5	1,764	1.8	7,422	7.1	3,289	3.2	4,133	3.9
El Monte.....	24,608	12,427	12,180	638	2.6	320	1.3	318	1.3	1,538	6.2	756	3.1	782	3.1
Industry.....	55,065	27,781	27,284	983	1.7	483	.8	500	.9	1,996	3.6	920	1.7	1,076	6.9
Monrovia-Arcadia.....	14,357	7,089	7,268	534	3.7	256	1.8	278	1.9	1,119	7.8	476	3.3	643	4.5
Monterey Park.....	22,391	10,937	11,454	899	4.0	446	2.0	453	2.0	2,252	10.1	977	4.4	1,275	5.7
Norwalk.....	2,536	1,248	1,288	31	1.2	10	.4	21	.8	29	1.1	18	.7	11	.4
South San Gabriel.....	8,944	4,348	4,596	308	3.4	191	2.1	117	1.3	703	7.8	281	3.1	422	4.7
Verdugo.....	18,338	8,889	9,449	628	3.4	306	1.6	322	1.8	1,159	6.3	472	2.6	687	3.7
West Covina.....	18,538	9,234	9,304	227	1.2	114	.6	113	.6	511	2.8	202	1.1	309	1.7
Bell.....	21,789	10,932	10,857	528	2.4	279	1.3	249	1.1	1,077	4.9	504	2.3	573	2.6
North County.....	57,200			12,300						15,300					
Total, all unincorporated areas <sup>2</sup> .....	706,608			23,862						49,954					

<sup>1</sup> Estimated proportion of aged in North County derived from county average.

<sup>2</sup> Differences between the total population reported here and the total unincorporated population reported by the U. S. Bureau of the Census derive from the assignment of split census tracts to incorporated jurisdictions as discussed above.

Source: U. S. Bureau of the Census. "U. S. Census of Population 1960. Population and Housing Characteristics, Advance Table I."

TABLE III.—Rank order by proportion of aged in cities of Los Angeles County

Rank	Name of city	Percent of population 60 and over	Total population	Rank	Name of city	Percent of population 60 and over	Total population
1	Bradbury.....	31.6	805	38	Baldwin Park.....	9.9	33,951
2	Beverly Hills.....	24.6	30,817	39	Redondo Beach.....	9.9	46,986
3	Pasadena.....	23.2	116,407	40	Culver City.....	9.8	32,163
4	Alhambra.....	21.9	54,807	41	South El Monte.....	9.3	4,850
5	South Pasadena.....	21.7	19,706	42	Glendora.....	9.2	20,752
6	Santa Monica.....	20.9	83,249	43	Artesia.....	8.6	9,993
7	Glendale.....	20.7	119,442	44	Bell Gardens.....	8.6	26,467
8	Whittier.....	20.1	33,663	45	Gardena.....	8.4	35,943
9	Monrovia.....	18.1	27,079	46	Downey.....	8.2	82,505
10	San Marino.....	17.5	13,658	47	Hawthorne.....	8.2	33,035
11	Sierra Madre.....	17.4	9,732	48	Rolling Hills.....	8.2	1,664
12	Long Beach.....	17.1	344,168	49	San Gabriel.....	8.1	22,561
13	La Verne.....	16.8	6,516	50	El Segundo.....	7.9	14,219
14	Signal Hill.....	16.4	4,627	51	Paramount.....	7.9	27,249
15	Claremont.....	16.2	12,633	52	Azusa.....	7.5	20,497
16	Temple City.....	15.9	31,838	53	Compton.....	7.5	71,812
17	Avalon.....	15.5	1,536	54	Irwindale.....	7.5	1,518
18	Huntington Park.....	15.3	11,492	55	Palo Verde Estates.....	7.3	9,564
19	Inglewood.....	15.3	63,390	56	Duarte.....	7.2	13,962
20	Arcadia.....	15.1	41,005	57	Manhattan Beach.....	7.0	33,934
21	Bell.....	15.0	19,450	58	Lawndale.....	6.7	21,740
22	Los Angeles.....	14.6	2,479,015	59	Dairy Valley.....	6.6	3,508
23	South Gate.....	14.2	53,831	60	Commerce.....	6.4	9,555
24	Hermosa Beach.....	14.0	16,115	61	Pico Rivera.....	5.3	49,150
25	Rosemead.....	13.9	15,476	62	Torrance.....	5.1	100,991
26	Maywood.....	13.8	14,588	63	Norwalk.....	4.9	88,739
27	San Fernando.....	13.5	16,093	64	Lakewood.....	4.8	67,126
28	Walnut.....	12.8	934	65	West Covina.....	4.2	50,645
29	El Monte.....	12.6	13,163	66	Santa Fe Springs.....	3.2	16,342
30	Vernon.....	12.6	401	67	La Puente.....	3.0	24,723
31	Burbank.....	12.3	90,115	68	Rolling Hills Estates.....	2.9	3,941
32	Pomona.....	12.3	67,157	69	Mirada Hills.....	2.0	22,444
33	Montebello.....	11.8	32,097	70	San Dimas.....	-----	-----
34	Lynwood.....	11.7	31,614	71	Cudahy.....	-----	-----
35	Monterey Park.....	10.3	37,821	72	Industry.....	-----	-----
36	Bellflower.....	10.0	44,846	-----	-----	-----	-----
37	Covina.....	10.0	20,124	-----	-----	-----	-----
-----	-----	-----	-----	-----	Total, all cities.....	-----	4,943,584

TABLE IV.—Old-age security cases according to BPA districts,<sup>1</sup> April and August 1960-61

Districts:	1960				1961			
	April		August		April		August	
	Per-cent	Num-ber	Per-cent	Num-ber	Per-cent	Num-ber	Per-cent	Num-ber
1.....	8.3	8,046	8.3	8,113	8.5	8,217	8.6	8,244
2.....	6.7	6,446	6.6	6,346	6.5	6,269	6.5	6,229
3.....	4.6	4,476	4.5	4,418	4.5	4,327	4.4	4,257
4a-4b.....	6.8	6,764	7.0	6,760	7.0	6,794	7.1	6,842
5.....	4.3	4,200	4.3	4,186	4.3	4,182	4.4	4,210
6-22.....	11.3	10,993	11.2	10,842	11.2	10,840	11.3	10,860
7.....	11.8	11,493	11.8	11,405	11.9	11,421	11.9	11,422
8.....	6.5	6,327	6.7	6,389	6.6	6,348	6.6	6,286
9-23.....	8.8	8,582	8.8	8,584	8.8	8,459	8.8	8,462
10.....	15.4	14,997	15.4	14,803	15.3	14,596	15.1	14,439
13-21.....	15.5	15,128	15.4	14,876	15.3	14,613	15.2	14,411
Total cases.....	100.0	97,452	100.0	96,722	99.9	96,067	100.0	95,662

<sup>1</sup> Since the populations within BPA districts vary, differences in proportion of OAS cases by district may be eliminated by controlling for size of district.

Senator ENGLE. Mr. Hale, I want to compliment you on that statement and say that I not only compliment you on what you have done but on, as indicated in the latter part of your statement, the current program in which you are engaged, because I believe that if more planning went into preretirement there would be less difficulty after retirement. Your statement has been a valuable contribution to this record, and we thank you for it.

Mr. HALE. Thank you.

Senator ENGLE. The next witness is Mr. Thomas H. Edwards, vice president, Senior Citizens Association of Los Angeles County, Inc.

We are very glad to have you here, Mr. Edwards, and we will welcome your statement at this time.

**STATEMENT OF THOMAS H. EDWARDS, VICE PRESIDENT, SENIOR CITIZENS ASSOCIATION OF LOS ANGELES COUNTY, INC.**

Mr. EDWARDS. As a representative of the Senior Citizens Association of Los Angeles County, Inc., consisting of 180 clubs and 30,000 or more members, I wish to express our appreciation for the opportunity to state our views before this committee in regard to the needs of all senior citizens.

We realize that the major problems lie in the fields of housing, medical aid, and hospitalization, but there are other areas in which assistance could and should be given.

We took a poll of 85 of our 180 clubs, personally interviewing from 3 to 88 members of each club. We feel that this is a high sampling of our membership and that the results can be considered conclusive.

In regard to hospitalization and medical aid, 70 percent were in favor of prepaying under a social security plan and 59 percent reported that they did not have adequate protection. We feel that it is imperative that a method be found to reduce the cost of medical aid for senior citizens, either by the social security plan or by group insurance which will continue on the same basis as before retirement.

In the housing field, the poll found that 48 percent of the members do not own their homes, and 46 percent would either rent or buy into a low-cost senior citizen apartment project. At present, the majority of so-called low-cost housing projects are sponsored by churches and other organizations; however, with the initial entrance fee and monthly charges, they are not very reasonable. Therefore, if anything is to be accomplished, it will, no doubt, have to be done by the Federal or the State Government.

We hope that the \$100 million bond issue for low-rent housing for senior citizens, which is on the 1962 State ballot, will be passed, but it must not isolate or segregate senior citizens, and adequate transportation must be provided.

Much more help by the various communities could be given to the aging and the aged at a very small cost in comparison to that spent on youth; senior citizens are members of the community, and should be included in all activity planning and participation. Many communities have no facilities for senior citizens. We feel that multi-purpose facilities, accessible to senior citizens, should be provided, also programs designed to stimulate mental and physical health. Also, free transportation should be provided for meetings; school buses could probably be used for this purpose.

The following are also needed: more homemaker service with fewer restrictions, "Meals On Wheels," and legislation for better supervision of eye, ear, dental, and medical devices and advertisements covering so-called health aids. Our poll showed that 90 percent were in favor of clinics for regular checkups; i.e., stay-well clinics.

Some concerted effort should be made to provide parttime employment for senior citizens. Forty-five percent stated that their income was not adequate for their present needs, and 70 percent felt that the Federal, State, and local governments have responsibility to help solve the problems confronting older people.

We hope that this statement, based on the opinions of a large segment of the senior citizen population, will be of material assistance to members of this committee in their effort to solve these important problems.

Senator ENGLE. Thank you very much, Mr. Edwards, for that excellent statement.

We have not been able to complete the roster of witnesses scheduled for this morning. They will be here this afternoon. We will try to get through with the program early enough in the afternoon so that members of the audience, the senior citizens themselves, may have an opportunity to address the committee with such remarks as they would desire to make. The subcommittee, however, necessarily adjourns at 4:30 this afternoon, because of the schedule in another city, and the airplane reservations require us to leave at that time.

We are going to hurry along, and we hope that this afternoon, after hearing the regularly scheduled witnesses, we may have some time left to hear from these of you in the audience.

With that announcement the subcommittee will stand in recess until 2 p.m., when we will resume. Thank you very much.

(Whereupon, at 12:45 p.m., the subcommittee recessed until 2 p.m. of the same day.)

#### AFTERNOON SESSION

The subcommittee reconvened, pursuant to recess, at 2 p.m. During the recess, Senator Engle and Senator Randolph chatted with Tatzumbie DuPea, age 112, to obtain her views on the problems of the aging. Mrs. DuPea, a Piute Indian woman, was born on July 26, 1849, in Lone Pine, Calif., near Mount Whitney. She is the oldest social security beneficiary of record on the Pacific coast.

Mrs. DuPea now receives the minimum social security benefit of \$40 a month. Her social security credits were earned from bit parts she had in motion pictures after the social security law became effective in January 1937. She has appeared in the following famous pictures, "Cimmaron," "The Massacre," "Laughing Boy," and "20 Mule Team." The last picture was directly related to her homelife as from the age of 4 months she lived with her grandmother in a hogan near the location of Death Valley Scotty's castle.

Mrs. DuPea is an active member of the Death Valley 49'ers and plans to attend the annual reunion on November 9 and 10 of this year.

At the present time, she lives with her oldest son, who is 60 years of age in their home on West 12th Street. Mrs. DuPea has been very active in the Los Angeles area. During World War I she helped raise \$3,500 in war bonds in a war bond rally in Pershing Square. She also has been a member of the First Methodist Church of Los Angeles

and states that she enjoys visiting churches of all denominations. In April of this year she flew around Los Angeles in a helicopter as part of the dedication ceremonies for the new Lee Tower.

Mrs. DuPea expects to live many more years, and she attributes her longevity to the fact that she does not drink or smoke, keeps regular hours, and has tried to live a quiet, serene life. Outside of an occasional rest period in the afternoon, she sits on her front porch most of the day doing beadwork and is happiest when she visits with her neighbors or her family.

Senator ENGLE. The subcommittee will be in order for the continuation of the hearings. My colleague, Senator Jennings Randolph, of West Virginia, will be here in just a few moments, but because we are tight on time I would like to get underway.

Our first witness this afternoon will be Mr. George McLain, chairman, California Institute of Social Welfare. We all know him very well. I knew him when I served in the State senate, and I knew him when I was in the House of Representatives, and he has been frequently in Washington.

We are glad to have you here, Mr. McLain. We know that you speak for a great many of the elder citizens of our State, and we welcome your statement today.

**STATEMENT OF GEORGE McLAIN, PRESIDENT, NATIONAL LEAGUE OF SENIOR CITIZENS; CHAIRMAN, CALIFORNIA INSTITUTE OF SOCIAL WELFARE; MEMBER, GOVERNOR'S COMMITTEE ON AGING; DELEGATE, WHITE HOUSE CONFERENCE ON AGING**

Mr. McLAIN. Thank you very much, Senator Clair Engle, our own Senator from California.

I wish to express the sad note here from many thousands of elderly people who couldn't attend this hearing today. They realize how important it is, but unfortunately so very few of these elderly people have automobiles, and therefore they don't have the transportation to come way out here. Our meeting today might just as well have been held back in Washington, D.C., because of the transportation difficulties. I understand that they would have to change buses about three times. I do hope that in the future your staff will hold these hearings in the metropolitan areas so that these elderly people can come out and attend these most important meetings.

Senator ENGLE. May I comment just to say that we regret it too. The problem our staff faced was that we couldn't find an auditorium of sufficient size around town available for this date to accommodate the numbers of people we expected, and as a consequence of it we had to come farther away than we wanted to come. We understand that if we had been closer and more immediate to the transportation facilities that our elder citizens could use they would be here in greater numbers.

Mr. McLAIN. That's correct.

Senator ENGLE. And I think you can be assured that whenever it is possible to do so we intend to go downtown so that they can be present and have a chance to participate in these matters of such great importance to them.

Mr. McLAIN. Mr. Chairman and members of the committee, my name is George McLain, with headquarters at 1031 South Grand

Avenue, Los Angeles, Calif. I am chairman of the California Institute of Social Welfare, and president of the National League of Senior Citizens, with representation in all 50 States. Both these organizations are nonprofit corporations, continuously engaged in dynamic activities aimed at improving the lot of our deserving elders. Our work requires the employment of 56 full-time employees, in addition to thousands of volunteer workers conducting a nationwide educational program.

For the past 20 years we have maintained an efficient welfare counseling service which deals primarily with the problems of those on public assistance here in California. Our experience with thousands of cases brought to our daily attention, and the national pension conferences we have held, have gained us detailed knowledge of the defects of our Federal social security and State old-age assistance programs.

The funds to maintain our many activities come from the general public in the form of dues, donations, and subscriptions to our newspaper, the Senior Citizens Sentinel. Our success for more than 20 years in conducting such a full-scale operation should be additional proof to this committee when we say that the needs of our senior citizens are far from being met, and their plight continues to be a serious one.

As you distinguished gentlemen must have learned during previous hearings, there is bitter discontent among the elderly of this great Nation, and drastic steps must be taken to alleviate the suffering and hardships the aged must accept under our present programs. The needs of the elderly fall into three classifications: economic, medical, and housing.

ECONOMIC—INCOME

This year Congress increased the minimum payments under old-age and survivors insurance to the primary beneficiary from \$33 to \$40 a month; increased widows' benefits and lowered the age of men applicants to 62.

The chart below—reprinted from the report issued by the Committee on Ways and Means regarding the Social Security Amendments of 1961—shows clearly that it is impossible for those who must depend primarily on their old-age insurance benefits to maintain themselves with even the mere necessities of life.

I would like to ask you, Mr. Chairman, if you would be kind enough to have this chart reprinted in the record?

Senator ENGLE. Without objection the chart will be made part of the record at this point.

(The chart referred to previously follows:)

*Examples of monthly payments beginning August 1961*

Average yearly earnings after 1960	\$800 or less	\$1,800	\$3,000	\$4,200	\$4,800
Retirement at 62.....	\$32.00	\$58.40	\$76.00	\$92.80	\$101.60
Retirement at 63.....	34.70	63.30	84.40	100.60	110.10
Retirement at 64.....	37.40	68.20	88.70	108.30	118.60
Retirement at 65.....	40.00	73.00	95.00	116.00	127.00
Wife's benefit at 62.....	15.00	27.40	35.70	43.50	47.70
Wife's benefit at 63.....	16.70	30.50	39.80	48.40	53.00
Wife's benefit at 64.....	18.40	33.50	43.60	53.20	58.30

Mr. McLAIN. Thank you very much, Senator.

#### SOCIAL SECURITY

We recommend and support H.R. 141 by Congressman King which (1) provides Federal social security laws be amended to guarantee that every elderly citizen shall have an income of not less than the amount established by Congress in the minimum wage law—\$173.33 per month. In other words, if the individual's income from all sources is less than \$173.33 the Government will make up the difference. (2) By the Federal Government becoming a third participant to the social security fund, no further increases in social security deductions from the worker or the employer will be necessary. (3) Recipients be allowed to earn \$2,400 a year to augment their income. (4) Under present law there is no limit imposed against the earnings of a recipient at age 72 or over. The age should now be lowered to 70 years or over. (5) The applicant age for women be lowered to 55 and that of men to 60, in order to counteract unemployment caused by automation, et cetera.

#### PUBLIC ASSISTANCE

An uninformed person may suggest those receiving a small amount of Federal old-age benefits apply for State old-age assistance to augment their income. Unfortunately, many States will not accept anyone who receives any amount of a social security payment; some States will allow such payments but deduct all of it from their State aid regardless of whether or not their needs are met. Only a few States, like California, have a so-called special needs allowance where the recipient is allowed to combine his outside income with State aid to meet his actual need.

While the Social Security Act has been in effect for 25 years, the Public Assistance Section has not been brought up in step with the times. The States have been permitted to individually impose all of of the vicious provisions of the Elizabethan poor laws, outmoded years ago in Great Britain. Here it has caused a hodgepodge of 50 different States with 50 different public assistance programs, no two alike. Paupers oaths, shame lists, unreasonable residence requirements, lien laws, deduction for homeownership, discrimination because of sex, strict limitation of real and personal property, responsible relatives laws, overzealous welfare workers, costly duplication of administration, and recipients prohibited from retaining even the smallest of earnings.

We propose: (1) We propose that Congress authorize the Secretary of Health, Education, and Welfare to establish a floor on what constitutes a "needy person," below which no State shall be allowed to go. This will help to establish a uniform, nationwide administration of public assistance and allow recipients some measure of human dignity.

During this session of Congress only a measly \$1 a month increase was voted for the most needy of the Nation's aged, those on public assistance, and this to expire next year. Congress has imposed a ceiling of \$65 a month on Federal matching funds to the States for monthly payments. This unrealistic attitude acts to penalize those

States, like California, who desire to concern themselves with the real needs of their aged.

We recommend (2) that Congress remove the ceiling on the matching of Federal funds for public assistance. I can assure you there can be no fear on your part that the 50 State legislatures will be overgenerous to their needy aged.

While Congress has lowered the voluntary age for applicants for old age and survivors benefits under social security to 62 for both men and women—with a penalty deduction—they failed to make a correspondingly lowering of age in the public assistance program. Therefore, we recommend (3) the age be lowered to 62 for applicants for old-age assistance.

Americans are taught from birth the principles of self-help. We admire self-made men, but when we get old and have lived up all our savings, our Government comes along and says, "Here's a little hand-out for you. It is probably not enough for you to live on decently, but if you try to earn any money to improve your position, you will be penalized. We will take away your handout." I say it is not fair. We propose (4) that Congress take the handcuffs off the needy elderly by allowing them, without penalty, to earn at least \$50 a month at babysitting, gardening, or whatever other light employment they can find.

Congress still allows the States to impose a 5-year residence requirement. Some of the States maintain this requirement. Others only require 1 or 2 years. Some require no residence. The time has now come when (5) Congress should abolish all residence requirements or at least provide that the State shall not impose a greater residence than 1 year.

In the administration of public assistance, Congress provides for a single administration, but they allow the States, the counties, and even municipalities to administer public assistance. This has caused all sorts of problems and expense. Recently we had the un-American spectacle of the persecution of the helpless poor of Newburgh, N.Y. This crackdown on "chiselers" fizzled out. After a lot of noise, it was found there were no unqualified persons receiving aid. This sort of thing is now, and has been going on in California upon the part of some boards of supervisors and county grand juries against our public assistance program for years. A continuous cold war rages between the county supervisors and the State regarding policy, with the needy in the middle. The recipients are always the victims of this bad publicity, and live in constant fear of losing their aid.

California's public assistance program is administered by the State and the 58 counties. Because of this duality of administration there is a constant duplication with the accompanying exorbitantly high costs. Administration cost alone amounts to \$52,500,000 a year—a shameful waste of the taxpayers' money—resulting in a cluttered application of the laws. We recommend (6) that Congress amend the laws to provide for State administration only. This would save the State of California from \$10 to \$20 million a year, which could be put to a more appropriate use among its needy citizenry.

While California does not impose liens, the counties take advantage of the illness of an unfortunate pensioner to demand liens on his home for hospitalization—a cruel and inhuman act—one that appears



barbaric in this day and age—one that multiplies the mental despair of the elderly. It is inconceivable that this practice should be allowed by Congress, especially when Congress is generous to the States in the matching of funds for medical and health care. I cannot stress strongly enough this unwarranted picking of the bones of the poor upon the part of the counties, and (7) we look to Congress to put an end to it.

For the information of this committee it has been found the average age of a California recipient of public assistance is 71 years. The average life expectancy, while on the rolls, is 5 years.

At this morning's hearing State leaders explained the new welfare laws passed by this session of the California Legislature. I am pleased to advise you that these fine measures were created by us—sponsored by us—or endorsed and supported by us. During the 6 months of the legislative session I and my legislative assistant appeared and testified before all of the hearings on these bills. This we have been doing for the past 20 years. This is the reason why California can make claim to having the best social welfare structure of any State in the Union.

#### HOSPITAL AND HEALTH CARE

We Americans are subjected to the appalling and outrageous campaign now being conducted by the American Medical Association and the physicians and surgeons lobby against President Kennedy's sponsored program to provide hospital and health care under H.R. 4222, introduced by Congressman Cecil King of California, and coauthored by Senator Clinton Anderson of New Mexico. This bill simply provides that those under social security out of their salaries can contribute toward their own hospitalization and health care in their old age. It gives them freedom of choice. Yet the political doctors admit to the raising and spending of a \$2½ million fund to mislead the American people and bring pressure against Members of Congress to vote against this humane bill. Many of the most widely recognized members of the medical profession take issue with the AMA. They have publicly proclaimed their support for the bill—and deplore the stand taken by the American Medical Association.

Countless books and magazines have published data available outlining in detail the vicious medical, drug, and hospital evils perpetuated against the sometimes helpless and unsuspecting American people. I earnestly urge that this committee recommend an investigation similar to the Senator Kefauver drug investigation. A thorough investigation of the monopolistic trend and the inhuman tactics employed by the American Medical Association and their allies.

#### LOW-RENT HOUSING

The California Institute of Social Welfare is the sponsor of two large FHA-insured rental projects for the elderly in Fresno and in Los Angeles County.

For a number of years we have been campaigning for direct 50-year loans at 3½ percent interest in order to create quality low-rent housing. We were delighted when President Kennedy included this in his recent housing bill. I appeared both before the Senate and the

House Subcommittees on Housing and spoke in behalf of the features of the President's bill dealing with housing for the elderly. I was successful, through the help of Congressman Clem Miller, California, and Congressman Albert Rains, of Alabama, in getting the adoption of an amendment to permit the transfer of a project from FHA to the direct loan program. After the bill was passed and signed by the President, we applied to Robert C. Weaver, Administrator, Housing and Home Finance Agency, to transfer our Fresno project to this new program. It would permit us to lower from \$10 to \$15 a month the rentals of our elderly occupants. This would, in fact, truly create quality low-rent housing through a nonprofit private enterprise venture. This is the type of housing so desperately needed by the majority of the elderly of our State and Nation.

Robert Weaver notified us of his acceptance of our application for a direct loan under date of July 20, 1961. However, to date, while Congress has appropriated millions for this purpose, and despite an allout effort on our part back in Washington, D.C., no action on our application has been forthcoming.

The direct loan program for housing for the elderly under the Kennedy administration, while promising so much, has been a great disappointment to the low-income elderly of the Nation.

We fail to understand why we, as a legitimate and nationally recognized organization of oldsters who seek to create the type of housing most urgently needed by senior citizens, should be discriminated against. I appeal to this committee to investigate this delay and please do something about it. Thank you.

Senator ENGLE. Mr. McLain, do you know of any instance in which they have made the sort of transfer that you applied for to Mr. Weaver under a type of housing such as you have proposed at Fresno?

Mr. McLAIN. No, I have no knowledge of any transfer of any project.

Senator ENGLE. What I am trying to find out is whether or not easterners are getting off with all the hams and the blackstrap and we are getting nothing, or whether or not Mr. Weaver is just failing to implement a program authorized by Congress. There is a difference, you understand.

You cannot say definitely whether or not any of these applications—and presumably there are others, similar to the one that you made—have been granted or disapproved?

Mr. McLAIN. I have no knowledge of any such transfer.

I want to say this, Senator, to the audience here: That you have been of great help to us in getting this project in Fresno, along a lot of rough roads.

Senator ENGLE. I am very proud of that project, incidentally, and I know you are.

Mr. McLAIN. I want to say that I have had discussions with you, not only in your office, but also on the floor of the Senate, in the outside waiting room, where you and I have spent a considerable amount of time in my trips back to Washington, and also trips of my legislative assistant, James Evans, who has mentioned time after time how courteous and helpful your office has been in helping us in the problems of our senior citizens.

Senator ENGLE. We have already discussed the question with reference to this particular application. I think, though, that the funda-

mental question ought to be answered, and that is whether there are other applications pending, whether those applications have been acted upon, how they have been acted upon, and specifically why this one, the application of which was accepted—and I observed in his letter, he didn't say "approved," he said "accepted"——

Mr. McLAIN. Yes, sir.

Senator ENGLE. And I don't know what "accepted" means.

Mr. McLAIN. That means they will take it.

Senator ENGLE. He should have used the word "acknowledged."

Mr. McLAIN. Very good.

Senator ENGLE. In any case, you can be perfectly sure that we are going to get the answers to those questions, and you will be provided with the answer to those questions.

Otherwise, I want to say to you that here, as in times past through your long legislative experience, you have presented to this committee a concise and a constructive statement which is most valuable for our record, not only because of what you said in it, but because you represent, more than any other single individual in this State, more of the elderly people than any man I know of.

Senator Randolph.

Senator RANDOLPH. Mr. McLain, I recall your testimony of 2 years ago in San Francisco.

Mr. McLAIN. I was very delighted this morning, Senator Randolph, to see you again present on this panel here in California, because we had the experience of the first hearing in the McNamara committee in San Francisco where you were present, and by this time I would imagine that you would have an extraordinary knowledge of the problems of our senior citizens. And I would like to say this for the benefit of the people who are here: That if Congress had accepted the recommendations of your committee the problems of the elderly would have been solved a long time ago.

Senator RANDOLPH. Mr. McLain, I believe that the recommendations of the subcommittee were valid. They were not the final answers, of course, because we were groping, as it were, to a degree. We recognize that. However, we were thinking in terms of improvements.

But I wish to simply say—I must be very careful in the choice of my words, for I do not want to be misunderstood—I do believe that in the present administration—and I am not identifying it because of the party in power or the personality in the White House—there is a philosophy in this field which will more nearly meet the needs of the aged in this country than we have had in the White House administration for many, many years.

Although in the 1st session of the 87th Congress we have failed to do that which I desired in many instances, I feel that certain groundwork has been laid and certain progress has been made. It is my hope—it is more than a hope, it is a belief—that in the 2d session of the 87th Congress, you, Mr. McLain, and those for whom you speak, and the senior citizens generally in California and throughout the Nation, will find that further definite goals will be nearer realization than ever before in this country.

Mr. McLAIN. Wonderful.

Senator ENGLE. Thank you very much, Mr. McLain, for that very fine statement. We appreciate it.

Mr. McLAIN. Thank you very much.

Senator ENGLE. The next witness is Dr. Isidore Ruskin, Southern California Physicians Committee for Elderly Care Through Social Security. Dr. Ruskin.

**STATEMENT OF DR. ISIDORE RUSKIN, SOUTHERN CALIFORNIA PHYSICIANS' COMMITTEE FOR ELDERLY CARE THROUGH SOCIAL SECURITY**

Dr. RUSKIN. Senator Engle, I have with me two associates, Dr. Daniel R. Mishell and Professor Assali, both of whom you met last Wednesday evening, and we are presenting our statement together. I would like to have them come up here to the platform now.

Senator ENGLE. I agree that both Dr. Assali and Dr. Mishell should be up here with you, and we will be delighted to have them join you in your presentation.

Dr. Nicholas Assali is chairman of the Southern California Physicians Committee for Elderly Care Through Social Security. Dr. Daniel R. Mishell is a practicing physician.

We are glad to have this panel of doctors here. We are very pleased to have your testimony, and you may proceed now in your own fashion.

Dr. RUSKIN. Thank you.

I would like to identify myself. I am Isidore Ruskin, M.D., a practicing psychiatrist in private practice in the city of Los Angeles. I am affiliated with the Los Angeles County Medical Association, the California Medical Association, the American Medical Association, and the appropriate southern California and American psychiatric associations.

With me here are Dr. Daniel Mishell, who is a surgeon and gynecologist in private practice in Beverly Hills, and Prof. Nicholas Assali, who is a consultant and research professor and surgeon at the University of California, Los Angeles, in the field of gynecology and related subjects; and we are all members of the Southern California Committee for Eldercare Through Social Security under the King-Anderson bill.

I have here a statement which is a reprint from the Los Angeles County Medical Association in which we have presented the case for the King-Anderson bill and which was published in the Los Angeles County Medical Association, by invitation, September 7, 1961, and we would like to leave this with the committee. There is included in this same reprint the statement of the American Medical Association. I do not have their authority, though it is part of the reprint, to present this as a statement on their behalf. And I wish to make this very clear, that though it is included as part of the presentation that is in the written brief here, I do not have their authority to present it as part of their statement, or any of their statement.

Senator ENGLE. Is it your intention, Doctor, to read from this statement?

Dr. RUSKIN. No, it is not.

Senator ENGLE. Without objection, the statement made for the case of the King-Anderson bill offered by Dr. Ruskin will be made a part of the record at the end of his remarks. And without objection also, if the American Medical Association, which printed it, wants

equal space in the record for their statement, that will be permitted also. But it will not be placed in the record without their request. However, if they do request it, they can have their shot at it too. This is a free country.

Now, you may proceed.

Dr. RUSKIN. Man's eternal search for the "fountain of youth" has brought about improved standards of living in medical care. These have led inevitably to increased longevity at old age; but, instead of a renewal of youth, to the problems of senescence.

In our society, which is work, money, and youth-oriented the aged are treated as obsolete, disinherited, and rejected. The realization of his impaired capacity for mastering the problems of daily living is an emotional trauma to the aging. He is already relegated to involuntary retirement; he is denied the opportunity to obtain satisfaction in the only way he knows how. He is separated from his home, his job, his companions, and usually also from his spouse and children. He has to accept in most instances a reduced standard of living and status compared to what he had previously enjoyed.

At his age his anxieties make him less able to adjust in his attitudes and relationships to others, and this in turn increases his disturbances.

Poverty and disease go together. Poverty produces disease, disease produces poverty. Mental and emotional illness therefore inevitably become the concomitants of old age. We doctors are largely responsible for bringing so many people to old age, and we therefore have a continuing obligation to maintain them in as good physical and mental health as science and our society can provide. We still have not discovered the "Fountain of Youth," but we could do a great deal more than we are doing if the financial foundation was available for the things we already can do.

It is my suggestion that the doctors continue to practice medicine the best way they know how and let the arrangement for financing the medical care of the aged or other members of the community be left to those who are skilled in social and economic functions.

I am chief psychiatrist at the Los Angeles Jewish Home for the Aged. I am proud to be associated with this institution, because I believe we are pioneering in advanced methods of physical and mental therapy. This institution has 315 residents, and unfortunately we have an equal number on our waiting list.

The average age on admission is about 78, and the average age of the resident is 84. In the last 10 years since we have instituted an active psychiatric program we have increased age by 7 years, and the number of residents who have had to be separated from the home to be sent to a State hospital by reason of mental disturbances has been decreased by about 90 percent.

Our average cost for caring for a resident, exclusive of capital cost, is about \$2,000 a year, and we could do more for them if we had more money. Our home can be considered almost a pilot model of what a home should be. We Jews have always had a high reputation for community and charity activities, and not the least of them has been the observance of the fifth commandment. Notice I didn't say the "fifth amendment." But I must admit that our long waiting list and the failure to provide even better financial support for those in the home attest to the fact that private charity no longer meets the needs of the aged.

I can give you numerous examples of the type of psychiatric problems of aging. Last Thursday I was at the home making preadmission examinations for those who might be eligible to come to the Jewish Home as residents. A man of 68 presented himself. His story briefly is as follows:

He had lived in Cleveland for most of his life, having come there from Russia. He was married. He had a fruit stand. He was not a very prosperous individual.

In 1948, by reason of the fact that his wife was ill, he came to California. She died here in 1954. He returned to Cleveland, where he was briefly employed for 2 years, but the work was too difficult for him and he went on welfare.

By this time he was becoming eligible for social security, and at the age of 65 he was given \$48 per month. He came to California in 1958. He was not eligible for welfare, he was not eligible for old-age pension, and he has attempted to live on \$48 per month. He pays \$30 a month for rent, he has \$18 to live on.

He attempted to get medical care at a neighborhood clinic but was unable to get it. He was advised to go to the county hospital. He could not afford to take those trips because it would cost him \$1 busfare each trip. He therefore had to engage in private charitable requests. Finally someone steered him to the Jewish Home for the Aged. I saw him, and we have determined that he is eligible and to be urgently in need of admission.

Now, in the meantime, even though we are doing everything we can to admit him, it still will take 2 months to process his application. We have in the meantime raised some money for him, we are getting a room for him near the home, and he can eat at the home.

Another case is that of a person who is at the home. She is a woman in her late 80's. She had a bad heart condition. She became acutely emotionally disturbed, as old people will. She was paranoid and psychotic. We gave her electric shock treatments, even though she was a bad physical risk. But she came through. She improved so much that the following spring, when there was a party being given for senior citizens at the Statler-Hilton Hotel in Los Angeles, she was well enough and had recovered so much that she went as the delegate from the Jewish Home representing the elderly citizens from that group.

Now, these are the kinds of things that we can do if we have the money to take care of these people. We have the skills and we have the know-how, and we have the people that can give these treatments if finances are available.

Now, this is not a plea for bigger and better charity. The American people are entitled to something better than that. We must recognize the need of our older citizens to live in dignity and self-respect. They are the ones who have in their prime brought our society to the zenith of its present prosperity. They are now entitled to status, social insurance in the form of adequate pensions, health care, and the good things of life which they have so richly earned.

We need have no worry or false sympathy for the burden on the younger generation who will keep the American production plants operating to provide a rich life for both young and old. The younger generation has acquired a rich inheritance from the old which will amply provide for both.

With reference to private insurance, let me say this. I personally have a lot of private insurance in case of sickness or accident. I am close to 65. At age 70 all my insurance is going to be canceled—not voluntarily, by myself, but by compulsion. The insurance companies who are engaged in the so-called free private enterprise of selling insurance are going to cancel my insurance because by that time I will be considered to be a poor medical risk. Now, the American people are entitled to something better than insurance policies which are canceled just at the time they are probably going to need them the most. If this is the American private enterprise, then something should be done about it.

I understand that New York State has a law that if an individual has carried insurance for a number of years, sick and accident, it may not be canceled, he may not be discriminated against by reason of age.

Thank you; and now I would like my two associates to state briefly their experiences in the particular field in which they are engaged.

(The material referred to previously follows:)

[Reprinted from Sept. 7, 1961, issue of the bulletin of the Los Angeles County Medical Association]

#### THE CASE FOR THE KING-ANDERSON BILL

The Kerr-Mills law \* \* \* requires beneficiaries to submit to the demeaning loss of dignity involved in a means test \* \* \*.

By Isidore W. Ruskin, M.D.

#### FEAR OF REPRISAL SEEN IN MEDICAL CARE STAND

"Fear of reprisal from organized medical groups is responsible for the failure of many doctors to publicly declare themselves in favor of legislation which would place medical care for the aged under the social security system, a local physician said Monday \* \* \*." This was the lead paragraph in a story by Harry Nelson, medical editor, Los Angeles Times, August 1.

The article then continued, stating that a group of Los Angeles doctors of medicine, including myself, had organized an ad hoc "Southern California Committee for Health Care for the Aged Through Social Security." They support the King-Anderson bill (H.R. 4222) now before Congress. The AMA, State, and county medical associations have officially endorsed, and lobbied for the Kerr-Mills law, already enacted by Congress and now operative in some States. It was recently enacted into California law through enabling legislation just signed by the Governor.

I was one of the ad hoc committee members interviewed by telephone by the Times medical editor, and I authorized him to quote me without anonymity. The lead paragraph above is not attributed to me.

The committee, including myself, received a number of requests from TV, radio, and other news media for interviews. We have also been requested to speak before political clubs and other organizations. I communicated with the LACMA Council for information regarding procedure for such interviews and appearances and received from Ian Macdonald, M.D., secretary-treasurer of the association, a copy of the LACMA press code, which does not give the modus operandi as to political and socioeconomic issues. However, doubling as editor of the LACMA Bulletin, Dr. Macdonald sent a follow-up letter which stated, in part:

"I shall assure you, also, the administration of the LACMA has no slightest desire to interfere with the right of free speech by any of its members, providing

Editor's note: Formation of the Southern California Committee for Health Care for the Aged Through Social Security, an organization whose nucleus of members includes Los Angeles physicians who support passage of the King-Anderson medical elder-care bill (H.R. 4222), was reported in the last issue (August 17) of the Bulletin. Readers will remember the editor's letter addressed to Dr. Ruskin, which said in part: "\* \* \* it has been our policy to air opposing views in the Bulletin when responsibly stated, and this will be an invitation to you, or any of your associates in this matter, to submit your views for publication." The accompanying article by Dr. Ruskin expresses the point of view of the committee.

it does not break the rules established by the council, and more important, assuming that such expression is consistent with ethical considerations and good taste.

"It is my conviction that the membership fears the King-Anderson bill by a large majority as a first step toward the ultimate and complete socialization of medicine in the United States. And speaking for myself, I am entirely sure that in the United States especially, socialization would result in the degradation of medical practice with the added penalty of still another powerful Federal bureaucracy of self-perpetuating order. Nevertheless, you may know that it has been our policy to air opposing views in the Bulletin when responsibility stated, and this will be an invitation to you or any of your associates in this matter, to submit your views for publication, preferably limited to 750 to 1,000 words."

I appreciate and accept Dr. Macdonald's invitation to publish this in the LACMA Bulletin. Needless to say, however, I completely disagree with his condemnatory opinion of the King bill, and with his prophetic pessimism as to the dire effects resulting therefrom on medical practice. We, doctors, will still be here with our medical skills and our humanity. As to the polemics in regard to the words "socialism" and "socialization" (or for that matter "John Bircher"), they are not germane to this issue. However, I respectfully refer the reader to Pope John XXIII's encyclical, "Mater et Magister," for further discussion on this point.

The following statement expresses my own reasons for supporting the King-Anderson bill. Some of the sources and even some of the content are from official legislative documents which were made available to me as a committee member. If this statement is lengthy, it is because a factual presentation of necessity requires more detail than propaganda clichés and slogans.

#### THE CASE FOR THE KING-ANDERSON BILL

Ever since Listerine, abetted by Madison Avenue, contrived the slogan "That Four Out of Five Have"—either halitosis or fallen arches, it doesn't matter which—anyone who has anything to sell, teach, propagandize, or just plain brain or hogwash, resorts to a barrage of statistics as the first play to confuse and overcome resistance. With this foreboding and forewarning, we, nevertheless, have sufficient faith in our Government and its institutions to accept the official Government data, which are semantically statistical.

The 1957 survey of aged, old-age, and survivors insurance beneficiaries, showed that older people (65 and over) had 2½ times as much medical needs and hospital days as the younger people. One out of every eight old people were hospitalized; 50 percent of reporting married couples had total medical bills of over \$700 for the year; among nonmarried hospitalized beneficiaries, 50 percent had medical costs of over \$500. Medical costs since 1957 have gone up 14 percent, hospital rates have gone up 20 percent; 50 percent of aged OASI couples had incomes of less than \$2,200 per year, \$1,100 per person; and half the unmarried had incomes of less than \$1,000. Of a total medical bill of \$25 billion for all the American people in 1960, only 18 percent, about 4½ billion, was covered by insurance. (The more affluent have the better medical insurance coverage and the very poor aged the more inadequate, if any). In several States in which the Kerr-Mills bill (AMA supported) is already operative, it provided average payment in November 1960 for some sample States, as follows: Massachusetts, \$191.44 per recipient (11,647 recipients) and for West Virginia, \$29.15 per recipient (46 recipients). Sample principal benefits: Kentucky, acute or emergency care only; Massachusetts, comprehensive care without statutory limitations.

I am opposed to the Kerr-Mills law because it is utterly inadequate. I dislike it even more because of the provision which requires beneficiaries to submit to the demeaning loss of dignity involved in a means test, less subtly referred to as a pauper's oath.

I am in favor of the King-Anderson bill because it is progressive social legislation. Its beneficiaries would continue in a state of dignity, like any other purchaser of medical care. It would not introduce any change in the pure medical practice. As far as the doctor of medicine, the physician, is concerned it leaves him by his own choice, as officially alleged by the AMA, in his status quo ante.

The proposed program is hospital oriented because that is the facility that provides the best of modern diagnostic and medical treatment throughout the county. In paying hospitals, it would follow practices (in large part based upon recommendations of the American Hospital Association) already well estab-



lished and accepted by the hospitals in their dealings with the Blue Cross, the States, and other Federal programs. In brief, payment would cover the cost of all services, drugs and supplies which hospitals customarily furnish for the care of patients except the services of personal physicians and private-duty nurses, and luxury items furnished at the request of the patient. (A similar approach would be used for reimbursement of nursing homes.)

The forms and the procedures to be used for payment would be much like those used by most Blue Cross organizations. Thus, the hospitals would not be burdened with processes foreign to their present practices. Dealings with hospitals and other providers of services would be largely locally administered.

It is alleged that there are 2½ million aged, 65 and over, who are not under social security or Railroad Retirement Act and therefore would have no protection. Of these 2½ million not directly protected as above, one-fourth million are under Federal staff requirement programs; one-half million are under veterans compensation or veterans pension; 1¼ million aged persons will be on the public assistance rolls; one-half million are not provided for but some of these will be eligible under the AMA-endorsed Kerr-Mills law. These figures deal with the situation as it will be when the new plan goes into effect. Within a comparatively short time, practically all the aged will have social security protection (except doctors of medicine and migrant workers).

There is nothing in this bill that would in any way conflict with the established practices for providing health care. Health benefits would be provided without interfering with the patient's free choice of physician or facilities and without altering the present form or organization of medical practice; care that a beneficiary would receive, and the institution or facility providing such care, would be a matter strictly determined by the beneficiary, his physician, and the providers of services (hospitals, convalescent homes, etc.). The proposed legislation specifically provides that no supervisory or control would be exercised over the administration or operation of participating institutions or agencies. By providing other than the physician's payments, it would facilitate the patient's financial ability to pay the physician's fee in the present usual and ordinary manner.

The bill, Health Insurance Benefits Act of 1961, would provide payment in the case of an aged beneficiary, for—

1. Inpatient hospital services (i.e., all those customarily furnished by a hospital for its patients) subject to—

(a) A limit of 90 days for each illness;

(b) A deductible amount (paid by patient) of \$10 a day for up to 9 days (minimum deductible, \$20; maximum, \$90).

2. Skilled nursing home services, if required, after transfer from hospital up to 180 days;

3. Outpatient hospital diagnostic services, as required, subject to \$20 deductible amount for each diagnostic study;

4. Home health services, up to 240 visits during a calendar year; includes intermittent nursing care and therapy.

Admittedly, there are some deficiencies in this health program. No provision is made for payment of drugs except when patients are in hospitals, nor for dentists' and physicians' services. Considering the greatest needs of beneficiaries, the best services and the simplest administration, the group of services provided in this bill is the best program.

Under this program, medical care would be provided for some who may not need it for financial reasons, such as: aged persons with income of \$50,000 or more who, however, represent only three-tenths of 1 percent of total OASDI eligibles, and those with \$10,000 or more who represent only 3 percent of eligibles. (They don't have to accept this care if they want to make their own private arrangements.)

It is true that much health care is now provided free to those who need care they cannot pay for. Public assistance agencies and private charitable organizations do this to the extent that they can with the funds available. Many physicians and institutions are generous in reducing charges or providing care at no cost. Relatives and friends of older people frequently pay medical expenses. Many older people who are sorely in need of medical care do not get it because they are too proud to accept charity. Those whose care is paid for by assistance agencies, public or private, receive such care after the humiliating experience of proving they are in want—the demeaning, dignity-destroying means test. Many of the expenses that are paid by relatives and friends are paid at great cost to the well-being of the children and grandchildren of the

elderly ill. Families go without things they need and go into debt to pay hospital and other health care costs for elderly relatives. We must prevent dependency, not just deal with it after it has arisen, and then only at the price of humiliation and deprivation for other family members, and on a catch-as-catch-can basis.

The bill provides safeguards against overutilization or abuse of the program.

1. The attending physician must certify and periodically recertify that services are required for medical treatment and diagnosis.

2. The institution (hospital or nursing home) must periodically review the further need for services.

3. There are initial deductible costs which the patient must pay himself and definitive statutory limitations in the act itself.

Also, we in the medical association can help prevent abuses and facilitate the smooth functioning of elder care through integration with hospital utilization committees.

My personal philosophy validating my support of the King-Anderson bill is as considerably and sincerely determined as that which motivates Dr. Ian MacDonald and those others who agree with him. My philosophy is derived from my life experience and interests. I remember being sensitive and poor.

Man's eternal search for the Fountain of Youth has brought about improved standards of living and medical care. However, instead of a renewal of youth, these have led inevitably to increased longevity at old age and to the problem of senescence.

Our society is not friendly to old folks. It is a youth-, work-, and money-oriented society and our technological revolution has accelerated their obsolescence and displacement. These senior citizens (a phony but euphonious label) would much prefer to continue working, paying their own way, and being independent. Our expanding urban culture seems to have no room for them and even "over the hill" has become a new suburb for ulcerating junior executives and some not so junior. It is idle to talk of returning to the good old days, when we lived an agrarian life. It is like rolling back the Asian and African revolutions.

I have as patients working men and women, the retired and aged, who need medical care and who confess fears and anxieties at being ill, disabled, and objects of charity. Many wish that they could be dead instead, and some of these are in the mounting numbers of suicides.

The worth of any society can best be determined by its attitude toward the weak, aged, and helpless. Measured by these criteria, ours is not a shining example of the good society. The Russian Nobelist, Boris Pasternak, in his "Dr. Zhivago," has his gentle and courageous doctor of medicine say, "Man does not die like a dog in the ditch, he dies with dignity and in bed." In the twilight of his life, we should also help him to maintain his dignity, not demean it.

And finally, as a personal ethic and identification with those aged, infirm, ill, and needy, human beings all, there echoes in my mind John Donne's "and therefore never send to know for whom the bell tolls; it tolls for thee"—and me.

Senator ENGLE. We would like to hear from you, Dr. Assali and Dr. Mishell, briefly. I call to your attention that we have seven witnesses yet to come on, and, as previously announced, this committee, in order to meet obligations in other cities, must necessarily adjourn at 4:30. We want to hear everybody we can; so, if you can, be brief, and we will try to be brief in our questions or comments.

**STATEMENT OF NICHOLAS ASSALI, PROFESSOR OF OBSTETRICS AND GYNECOLOGY, UNIVERSITY OF CALIFORNIA; DIRECTOR OF RESEARCH OF THE U.S. PUBLIC HEALTH PROGRAM, UNIVERSITY OF CALIFORNIA**

Dr. ASSALI. My name is Nicholas Assali. I am professor of obstetrics and gynecology at the University of California, and at the same time I am director of research of the U.S. public health program instituted at the University of California.

I just want to briefly say that the last 20 years have witnessed more progress in medical technology than the two centuries before put

together. This evidently has resulted in more laboratory procedures, more radiographic, electrocardiographic, electroencephalographic techniques, which have rendered possible the diagnosis and treatment of certain diseases that in the past could not be detected.

These diagnostic tools have not been made available in their full benefit for our elderly citizens, because they are very expensive. Doctors in many instances, when they are faced with these diagnostic tools and their cost, try to cut corners and eliminate necessary tests in order to keep the cost of medical treatment for our older citizens at a minimum. Accurate diagnosis and careful followup of any chronic illness which affects our citizens requires modern tools and modern diagnosis, but in the presence of their expensive cost these have been eliminated from our armamentarium of taking care of our elderly citizens.

I believe that Federal assistance to the problem of medical care for the elderly citizen through social security will make these modern miracle tools more available to the physician and his patient. The result cannot help but be beneficial for both. To the patient the benefit is derived from having all the modern medical methods applied to the diagnosis and treatment of his illness without worries about cost and possibilities to pay. To the doctor the benefit is derived from the knowledge that he can request freely all the laboratory procedures that he needs for his diagnosis and treatment without exhausting financially the patient and the knowledge that the patient's ability to pay his fees will continue to be in good shape and not impaired.

The question has been raised that any Federal assistance to the medical care for our citizens will place medicine under Federal control and in the hands of Government bureaucracy. I do not believe this is true at all. My associates and I receive close to a quarter of a million dollars a year for medical research in our field. Medical schools and universities receive at the present time close to 70 percent of their total budgets from Federal funds. The great majority of investigators in the mental research field in universities are paid from Federal grants. Yet I challenge any university president, dean, or professor to come and state whether the Federal Government tells him how to conduct his research, whom to employ, and what kind of research program he should follow and spend his money upon.

Another question that has been raised is that we have the best standard of health, and why change. We have a good standard of health, but not in all respects. We are far behind in certain areas of medical care, and we should correct them; and I believe only when the cost worry is taken from the mind of the physician that we can cover most of our citizens with the best medical care possible.

Thank you, Mr. Chairman.

Senator ENGLE. Thank you very much for your statement, Dr. Assali.

Now, Dr. Mishell, do you have a further statement to make?

#### STATEMENT OF DANIEL R. MISHELL, M.D.

Dr. MISHELL. I would like to make a short report, Senator Engle. I have been a practicing physician for 40 years. It is evident that there is an increasing need for care for people 65 years and over. In my daily practice I see many cases in need of surgical attention, some

of whom, in the older age group, have malignant tumors which require prolonged and expensive hospital care.

Today, with our modern technical skills, better anesthesia, and better laboratory facilities, expensive and prolonged surgery can be offered to patients who in the past were considered poor surgical risks. However, these newer advances, many of which save or prolong life, also carry an increased cost for their hospital care. Unfortunately a great many of these older patients have no adequate hospital insurance coverage. The immediate problem confronting the attending surgeon in private practice is how the hospital charges are to be met. Many of these patients either must be referred to a charitable clinic or rely upon their meager savings or depend upon their children to guarantee payment to a private hospital upon admission. Sometimes their children meet these responsibilities at great cost to their own children. I can give many instances of these situations.

Recently I saw a woman suffering from cancer. She had worked for 35 years, supporting an aged father. The firm for which she was employed unfortunately canceled the group hospital insurance policy and she was left with no insurance coverage. Her sole resources were about \$500. She wished private care but obviously her lifetime savings could not cover the cost of multiple operations, deep X-ray therapy, and so forth. This patient, who maintained herself and her father for many years, had to be referred to a charitable clinic, and this increased her well-justified anxiety.

Now, I have several other cases, but I just want to state one of a resident physician with a 4-year training course at a university whose father suddenly went blind due to a bilateral detached retina. His hospital and surgical expenses amounted to \$4,000. The son was confronted with the necessity of terminating his residency and going into general practice in order to pay the bills his father's illness had incurred. The young doctor had been opposed to the King-Anderson bill. Now he ardently advocates its passage, because he has been exposed to the reality rather than just the theory.

I could relate many other similar case histories. I am convinced that the King-Anderson bill would provide many patients with the means to pay for hospital care and utilize physicians of their own choosing. These people could retain their dignity instead of feeling pauperized because of their need to accept charity.

We as physicians can, and always will, render medical care to people at whatever modest fees they can afford to pay, but we cannot help them cope with the tremendous rise in hospital costs, a rise which is bound to continue.

I support the King-Anderson bill, because it would benefit physicians as well as patients. It would maintain the free choice of physicians and hospitals and also increase the quality of medical care by making adequate diagnostic facilities available to all older people covered by social security regardless of their economic status.

Senator ENGLE. Thank you very much, Dr. Ruskin, Dr. Assali, and Dr. Mishell. This is a distinguished panel of physicians. We certainly appreciate not only the position that you have taken, the correctness of it, but your courage in coming before this committee and your courage to take it. Thank you very much.

Senator RANDOLPH. Mr. Chairman, I join in the correctness of your commendation this afternoon. I realize that the discussion of the three practitioners of medicine, whether in the form of surgeons, physicians, psychiatrists, or the many facets in which they work with people, has centered about their actual day-by-day experience. This helps the members of the committee.

Senator ENGLE. Thank you very much, gentleman. We appreciate your appearing here today.

Our next witness is Col. Oliver P. Strickland, divisional commander, Greater Los Angeles Division, Volunteers of America.

Colonel Strickland, we are very happy to hear from you at this time.

**STATEMENT OF COL. OLIVER P. STRICKLAND, DIVISIONAL COMMANDER, GREATER LOS ANGELES DIVISION, VOLUNTEERS OF AMERICA**

Colonel STRICKLAND. Senator Engle, Senator Randolph, I appreciate the opportunity that you have extended us to come here this afternoon and speak for the Volunteers of America.

On the basis of 65 years of experience in social service and human relationships the Volunteers of America would like to urge the Senate Special Committee on Aging to give serious and sympathetic consideration to certain intangible but absolutely vital factors.

In dealing with the manifold problems of the underprivileged, the handicapped, or the homeless in all age brackets and circumstances, we have seen through the intervening years dramatic demonstrations of the truth that men and women "cannot live by bread alone."

We know from our thousands of case stories that adequate diet, comfortable housing, and material security, although essential in themselves, are not enough to make life pleasant and meaningful for people in the sunset years of their earthly journey. The loss of loved ones, the retirement from employment, the restrictions on physical activities and association with friends call for community intervention to provide facilities for social convalescence.

Elderly folk, like the younger generations, feel keenly the need for companionship, for group undertakings and for wholesome recreation. Their minds and souls instinctively grope for projects and activities that generate the "spiritual and intellectual vitamins" of everyday living. Constant and constructive associations with their fellow men and women provide for the elderly, as they do for others, the "morale maintenance" so necessary in days of reduced physical energies and efforts.

No one can be lonelier than an elderly person with nothing to do. For the aging, variety and activity is indeed the spice of life. New and interesting things to do must be available in any intelligent program.

A thumbnail sketch and description of one of such projects is our Volunteers of America "Sunset Club" now operating under our general supervision in the Long Beach area.

This group, started 9 years ago, today has a membership of approximately 1,600 men and women. It embraces 16 separate interest groups, conducts periodic dance parties at some of which the group

members host and dance with groups of blind people who are brought to these parties by friends and relatives. It stages picnics, has an active and talented harmonica band and in many helpful and unique ways widens the spiritual and moral horizons of its members. The volunteers are confident this committee, if it finds our recommendations appropriate, can do much to encourage and extend this type of enlightened humanitarianism.

A list of these "vital intangibles" is long and varied. Much has been said and written by experts in their respective fields. This committee undoubtedly has a great deal of such material available to it and has already given considerable thought and study to the subject.

Mindful of time limitations confronting the committee, the Volunteers of America gratefully accepts the committee's kind invitation to file supplemental data for the record and will attempt to document by statistical material and additional references some of our testimony here today. We feel that the interest and dedication of this committee to this important subject is one of the most gratifying and promising endeavors of our time.

Senator ENGLE. Thank you very much, Colonel Strickland. Without objection the supplemental material, if you desire it, may be presented to the committee and made part of the record.

We know that men cannot live by bread alone and that the services rendered by your kind of committee are vital services to people in their elder years. Thank you for your appearance and for your testimony.

The next witness is Mrs. Charles M. Broderick, the owner and administrator of the Broadway Home for the Aged in San Diego.

**STATEMENT OF MRS. CHARLES M. BRODERICK, COORDINATOR, THERAPEUTIC ACTIVITIES PROJECT, REGIONAL VICE PRESIDENT**

Mrs. BRODERICK. Senator Engle, Senator Randolph, though I do have the Broadway Home for the Aged in San Diego, I am also speaking as an officer of the California Association of Nursing Homes, Sanitariums, Rest Homes, and Homes for the Aged, Inc.

In California, because of the shortage of trained or experienced personnel, it is difficult to give the highest quality of nursing care to our sick and aged. Some endeavors to alleviate this dangerous shortage have become an important function of the California Association of Nursing Homes, Sanitariums, Rest Homes and Homes for the Aged, Inc.

This concern resulted in the formation of the Joint Council To Improve the Health Care of the Aged. Representatives on the council are from the California Medical Association, California Hospital Association, California State Dental Association, Southern California State Dental Association, and the California Nursing Home Association.

Under the direction of the joint council and with the cooperation of the State departments of employment, education, and public health, and the California League of Nursing, a course is being designed in preemployment training for nurses' aids.

The various local chapters of the California Nursing Home Association throughout the State have worked with State departments of education and licensing, and other local agencies, holding classes of training from which are emerging geriatric nurses and senior home aids.

Funds from the U.S. Public Health Service general health grant enabled Dr. John D. Gerletti, professor of public administration; Dr. C. C. Crawford, emeritus professor of education, of the University of Southern California; and Donovan J. Perkins, business manager of the attending staff association, Rancho Los Amigos, Los Angeles, with the cooperation of the California Nursing Home Association, to compile a manual, "Nursing Home Administration." Written in a nontechnical language, the book is designed to facilitate the establishment and teaching of courses and institutes in colleges and adult programs. One class is now in progress at Modesto Junior College. Others are being formed.

Recognition of the vital need to develop educational material, coordinate programs, survey needs for additional programs, and support ongoing projects, resulted in a request from the California Nursing Home Association for the formation of an educational development committee. This committee is composed of representatives from the State departments of education, public health, social welfare, and mental hygiene, Joint Council To Improve the Health Care of the Aged, private and State colleges, and the California Nursing Home Association. Others will be added as needed. A staff person will be required to effectively coordinate and implement the purpose of this committee. As yet, no financing has been found.

The first accomplishment of the Joint Council To Improve the Health Care of the Aged was to bring into being an accreditation program of nursing homes and related facilities. Effective September 8, 1961, the California Commission for the Accreditation of Nursing Homes and Related Facilities began functioning. This is a tremendous step forward in an attempt to upgrade services to the sick and aged. This program will coordinate with the national accreditation program of the American Nursing Home Association.

Another area of great concern, which remains yet unsolved, is the group suffering from a mental disease. Because of language in the Federal Social Security Act, with its subsequent amendments, these persons are not eligible for benefits from Federal funds. I would suggest that a study be made on this very complex problem.

The patients and guests in the homes in San Diego and Imperial Counties are the recipients of a very wonderful and unique program made possible through National Mental Health Act funds—therapeutic activities project.

There is total community involvement by the use of volunteers, church groups, Girl Scout and Brownie troops, and senior citizens themselves, who go into the homes to provide entertainment and purposeful activity.

This program is under the sponsorship of the Sanitarium and Rest Home Association of San Diego County, Inc.

The recognition by the Grossmont Adult School of the need for training volunteers to participate in the project has resulted in a 10-week class. Further expansion of the use of volunteers has been

suggested by Grossmont Adult School by having a traveling teacher with volunteers moving from home to home. A teacher would be training volunteers on the job and the patients or guests would be purposefully using their leisure time. It is hoped that funds from our State will be allocated. Grossmont Adult School is willing to provide matching funds, thereby insuring, in part, continuation of the therapeutic activities project.

(A short history of therapeutic activities project follows:)

THERAPEUTIC ACTIVITIES PROJECT, SPONSORED BY THE SANITARIUM & REST HOME ASSOCIATION OF SAN DIEGO COUNTY, INC.

A project to enrich the leisure time of those persons residing in out-of-home care facilities is in progress under the auspices of the Sanitarium & Rest Home Association of San Diego County, Inc., a nonprofit group of administrators dedicated to the promotion of higher standards in the care of the sick and aged.

This is the first time an organized effort has been made to do something for older people living in nursing homes, mental hygiene homes, and homes for the aged; the first time a grant has been made for this kind of project; the first time a group of proprietary persons in an association is doing something on a demonstration basis, showing that with proper guidance and attention there can be lessening of regression, more active participation, and an overall sense of well-being of the persons for whom they care.

People working with the aged program in San Diego had felt for some time that there was a great need to fill a void that is unavoidably created when persons need to live outside their own homes. Through the foresight of staff within the department of public welfare, a committee was formed which included not only staff, but persons from other agencies and lay persons who had shown an interest in the well-being of the aged.

It was soon evident that because of much leisure time the greatest need was to bring into the homes activities geared to the abilities of those persons in the homes. It was realized this must be done without cost to the administrator or the resident. It was further recognized that there must be someone to coordinate community resources, volunteers, and the activities project.

With the support of the director of the department of public welfare, an application for funds was submitted in 1960 to the National Mental Health Act Fund. This application was approved, the funds set aside by the Department of Mental Hygiene. However, the board of supervisors refused acceptance on the basis that county funds might be required.

The Sanitarium & Rest Home Association then took the initiative for sponsorship of the therapeutic activities project. Their application was submitted and approved effective March 1, 1961, and subsequently June 1961-62.

At the end of 7 months many rewarding events are developing. Of the 259 homes in San Diego County with approximately 3,500 patient-guests, we have gone into 23 homes, providing activities for 670 people. The first and most spontaneous response from the community was from retired musicians, senior citizens themselves. They have now formed a working club of 20 to 25 members to perfect their talents in order to better serve. They also are engaged in recruiting additional entertainers.

Another development is the recognition by the Grossmont Adult School of the need for training volunteers to participate in this project. A 10-week class is in progress with an enrollment of 61. Further expansion of the use of volunteers has been suggested by Grossmont Adult School by having a traveling teacher with five to eight volunteers moving from home to home. The teacher would be training the volunteer on the job and the guests or patients would be engaged in purposeful activity. By using more than one teacher and rotating volunteers, each home would be exposed to the spectrum of activities.

A provision of the grant is that funds are issued on a diminishing basis, and the community is expected to be involved to the point where such an ongoing activities program will become an integral part of the community's services for the elderly. Funds to supplement this secondary program are available from a State level with Grossmont Adult School willing to provide matching funds, thereby insuring, in part, continuation of the therapeutic activities project.



The extent of community involvement is shown by the 105 volunteers already participating, and several hundred Girl Scout and Brownie troops, church groups, college students, and senior citizens themselves offering their services and talents.

How could anything but success result from such wonderful cooperation. How much fuller will be the lives of those benefiting from this program, the recipient and the giver.

Mrs. BRODERICK. Though the care of the aged has been criticized for being below par, I feel that California's homes are to be commended. Every effort is being made to continually improved methods of care and general raising of standards. Those of us dealing directly with the health problems of the aged are attempting to meet some of the needs by the programs outlined.

The California Association of Nursing Homes, Sanitariums, Rest Homes & Homes for the Aged, Inc., is grateful to have the opportunity of demonstrating that, by preventive measures and constant alertness to new opportunities, the lives of those aged who must live in out-of-home care facilities can become more meaningful and a greater degree of normal living maintained.

Senator ENGLE. Thank you very much, Mrs. Broderick, for that very, very fine statement; and on behalf of the committee I want to express our sympathy to you for your personal loss in your family. recently.

Mrs. BRODERICK. Thank you.

Senator ENGLE. Our next witness is Mr. Foster J. Pratt, president of the Santa Barbara Chapter of the American Association of Retired Persons.

We will be glad to hear you, and we welcome your testimony at this time.

#### **STATEMENT OF FOSTER J. PRATT, PRESIDENT, SANTA BARBARA CHAPTER, AMERICAN ASSOCIATION OF RETIRED PERSONS**

Mr. PRATT. Senator Clair Engle, chairman, and Senator Jennings Randolph, I am Foster J. Pratt, of 222 Vista del Mar, Santa Barbara. I am speaking as president of the Santa Barbara Chapter of the American Association of Retired Persons.

Dr. Ethel Percy Andrus, our national president, participated in the White House Conference held this spring in Washington, D.C. We believe the Department of Health, Education, and Welfare should be provided with sufficient funds to follow through with a positive program.

We favor the Anderson-King bill for the medical care for the aged, with two modifications: (1) The elimination of its compulsory feature, and (2) provision for the inclusion of older persons not currently covered by social security.

This second proposal points to a weak spot between Federal and State laws. An older worker who retired before social security was established for his employment is unable to get benefits of social security even though the workers from his establishment are presently covered.

Another gap between the Federal and State laws is the residence law. The removal of State residence laws would permit residents of other States to come to California to live with children, relatives or

friends and still be eligible for the benefits of old-age security. The Federal Government should reimburse the State for the additional costs.

We believe the levels of assistance and standards of service to the general relief should be upgraded. Thus, to permit oldsters under 65, or otherwise not eligible, for old-age security to get the same standard of benefits and service; e.g., an older worker under 65 who is partially disabled is not eligible to obtain medical care. Another example is the older worker under 62 who is partially disabled so that he cannot earn sufficient to provide for his necessities, is now unable to obtain a disability pension under the old-age security.

We find the older person, who though well qualified, lost his job through no fault of his, is not adequately assisted in getting another job. The employment service of the Labor Department is doing a sincere job in attempting to solve this problem. Employers have to be educated in hiring the over-40 group of citizens. However, we believe more stress can be given to retraining and placement. The Labor Department officials should be well grounded in psychology to assist the elder ones in their period of trouble. The older person is frustrated by the difficulties he encounters when he tries to find a job to support himself.

In closing I should like to state our belief that while there is a role for government and private organizations, the individual must accept his fair share of the responsibility.

Our motto is that our unswerving aim is to help push out the horizons of aging citizens and to help them to realize that in their declining years they can be, and should be, as fruitful and happy as ever. Thank you, gentlemen.

Senator ENGLE. Thank you very much, Mr. Pratt, for this excellent statement.

Senator RANDOLPH. Mr. Pratt, am I seeing and hearing the man that I knew 20 or 25 years ago?

Mr. PRATT. I believe so, Senator. I think we used to meet in connection with the civil service employees in Washington, D.C.

Senator RANDOLPH. Well, you retained your vigor and your alertness, and I am delighted to hear you today.

Mr. PRATT. And I don't see that you are looking 1 day older than you did at that time. Thank you.

Senator ENGLE. The next witness is Mrs. Marion Hall, Paradise Senior Citizens Association of Paradise, Calif.

I am glad to see you come from the district I had the privilege and honor of representing in the House of Representatives for nearly 16 years. Only recently I had the pleasure of being in Chico; I'm sorry though I couldn't get up on the ridge to that beautiful area you call appropriately Paradise. We are glad to have your testimony at this time.

#### STATEMENT OF MRS. MARION HALL, PARADISE SENIOR CITIZENS ASSOCIATION, PARADISE, CALIF.

Mrs. HALL. Senator Engle, Senator Randolph, I am Marion Hall, a senior citizen, speaking for myself and for the Paradise Senior Citizens Association. This association was organized 7 years ago. It is an association of 350 members, and because we work closely with such

a large group we feel that we know a few of their names. Through our group we try to give each member a chance for happiness through the three essentials: something to do, someone to love, and something to hope for.

The population of Paradise is 11,000; 41.4 percent are 55 years and over, 26.6 percent are 65 years and over.

Our purpose is to integrate older citizens into the community and to maintain the dignity of each individual. Our association is self-supporting and self-governing.

We have implemented a community committee on aging since our participation in the Governor's conference and the White House Conference on Aging. This committee is currently making a study of the needs of seniors in our area.

We feel that older people, whose incomes are inadequate to meet the cost of long illnesses and who are not eligible for social welfare, need some assistance from Federal funds. Since transportation is a big problem in a rural community some assistance here would be a factor in keeping older people in circulation.

Senility, from which no one recovers, is often caused by neglect. Communities need field advisers to assist in organizing senior groups and in developing projects such as housing, visiting nurse, homemaker, and friendly visitors' service. Therefore we recommend that the State citizens' advisory committees on aging be expanded. Leadership training for voluntary leaders in the field of aging is especially needed by rural senior groups. Colleges need to include more training in aging for professional workers in the field of recreation, health, education, and welfare.

Thank you for allowing me, representing a volunteer group, to speak today. And we hope you can come to our area, Senator Engle, the next time you are in California.

Senator ENGLE. Thank you very much for being here. I believe you have the distinction of coming the longest distance of anyone to testify, save and except those, of course, of the committee, who testified somewhat themselves. Please express my best wishes to the members of your organization in Paradise.

Mrs. HALL. Thank you.

Senator ENGLE. The next witness is Prof. Dorothy O'Brien, Department of Recreation Education, Los Angeles State College.

Professor, you have a prepared text?

Professor O'BRIEN. Yes; I do. I think it is in the folder there.

Senator ENGLE. Thank you very much. We are glad to have you with us, and we look forward to your testimony.

#### STATEMENT OF PROF. DOROTHY O'BRIEN, DEPARTMENT OF RECREATION EDUCATION, LOS ANGELES STATE COLLEGE

Professor O'BRIEN. Senator Engle, Senator Randolph.

Mrs. Hall, I am happy to follow you, because you mentioned the words "leadership training."

I come to you as a representative of a community source who has been working for the last 21½ years with the Los Angeles County Senior Citizens' Association in providing leadership training. Our belief has been that the way to learn about leadership training for

senior citizens is to work with them, and that's exactly what we have been doing. We have had several conferences, several meetings, as you can tell by the folder, and we are bringing up some ideas and providing the seniors with the means of understanding that a great deal of their club leadership will come from within the group.

We have enjoyed it, and thank you.

Senator ENGLE. Thank you very much for that statement; and the report which you have submitted, entitled "Leadership of Senior Citizens Clubs," will be made a part of the record immediately following your extemporaneous remarks.

(The report mentioned previously follows:)

#### LEADERSHIP OF SENIOR CITIZEN CLUBS

The Recreation Education Department of Los Angeles State College is primarily concerned with education for leisure and leadership for leisure. Our philosophy is that senior citizen leadership for leisure must come from and involve the senior citizens themselves. This philosophy has been developed during the past 3 years through a series of meetings and conferences held cooperatively with the Senior Citizen Association of Los Angeles County, Inc.

Leisure education should be one of the most important considerations of our present times, and it is particularly pertinent to retired senior citizens who have leisure and free time. This implies a choice and a freedom. Their full and wise use of leisure will help shape the future course of civilization and our culture.

Older people are not a separate segment of the population, they are citizens who happened to have been born before 1900. The changes that have occurred during their lifetime are greater than the total of changes that have occurred since the beginning of recorded time. During all this necessarily rapid adjustment to change they have been living, growing, doing for themselves, and accumulating a wealth of experience and knowledge.

In order to have a true understanding of the leisure-time interests of our older citizens, meetings, conferences, and discussions must be held with them and by them, instead of just for them, and about their problems. We must use their knowledge and wisdom gained through the years, and encourage them to use their own abilities to determine and direct their wise use of leisure.

Our philosophy that senior citizen leadership for leisure must come from and involve the senior citizens themselves was developed in cooperation with the Senior Citizen Association of Los Angeles County, Inc.

The interest of the Recreation Education Department of Los Angeles State College in leisure-time activities for senior citizens was initiated in the spring of 1959. Mrs. Marjorie Borchardt, the president of the Senior Citizen Association of Los Angeles County, Inc., was invited to speak to a class entitled, "Recreation for Special Groups." As an outgrowth of this experience several events have occurred cooperatively with the Recreation Education Department of Los Angeles State College and the Senior Citizen Association.

During the summer of 1959, we published in mimeographed form their pamphlet "Looking for It," which had been written by senior citizens. It included information on how to start a club, objectives, duties of the officers, and other important topics. This material had been gathered from their experiences.

In November 1959, there was a conference entitled, "Senior Citizen Confab on Leisure." It was sponsored by Los Angeles State College and held on our campus, but the planning and choice of topics was done with and by the association members because of our belief that senior citizens themselves could indicate their wishes in the matter of recreation. The program was set up with opportunities for the delegates to meet in small groups and discuss such topics as welcoming new members, bus trips, television education, programing, writing articles for publication, community service, and others. This meeting was attended by approximately 400 men and women. The findings were published in a pamphlet, "Recommendations and Reports" from the group discussions. (This pamphlet has been requested and sent all over the United States.)

A series of leadership meetings with a Senior Citizen Association club was coordinated by our staff in November 1960. The purpose of these meetings was to further the understanding and recognition of the leadership and followership

qualities, techniques, and opportunities within their club structure. The success of this smaller venture led to a request for a similar meeting to be conducted on a larger scale, and a meeting was planned for May 1961.

On May 6, "Looking Ahead—A Town Hall Committee Meeting" of 100 representatives of the Senior Citizen Association of Los Angeles County, Inc., was sponsored by the recreation education department of Los Angeles State College. Three topics for discussion were chosen by the pilot group, "Planning the Future of the Association," "Developing Potential Leadership Within Groups," and "Exploring Possibilities for Senior Citizen Camping." These three topics were subdivided into three pertinent statements per topic, and discussed at nine round table meetings. The delegates to this meeting represented a cross-section of within-the-group leaders of the Senior Citizen Association clubs of Los Angeles County, Inc. The only professional leaders present were graduate students in recreation education, Los Angeles State College, who acted in the capacity of recorders.

The results of this meeting are being compiled by the association and when completed will be printed in mimeographed form, and entitled, "Looking Ahead." Sometime in the future the Senior Citizen Association of Los Angeles County, Inc., in cooperation with Los Angeles State College will publish a third handbook, entitled, "This Is It."

Information was gained from these conferences and meetings on which we can make some conjectures as to the kind and amount of leadership training most important to the successful operation of senior citizen clubs. We hope to further test our premise soon, and to put our beliefs into practice on a larger scale with assistance made possible by the Farr bill.

Our belief is and has been that the greatest need in the area of recreation and leisure-time activities for older people appears to be research with them, in order to ascertain the kind and amount of leadership which is most successful with older groups, and to develop knowledge, methods, and principles of member-leadership of senior citizen club groups. We are gaining an understanding of leisure-time interest of our older citizens, by holding meetings and conferences with them, and we shall encourage them to use and share with us their knowledge, abilities, and wisdom in determining and directing the use of leisure wisely and well.

The next witness is Mr. Leo J. Voege of the International Association of Machinists.

Mr. Voege, we are delighted to have you here and to have you speak for the International Association of Machinists. I understand that my old friend, John Snider, couldn't make it.

Mr. VOEGE. That is right, Senator.

#### STATEMENT OF LEO J. VOEGE, OF THE INTERNATIONAL ASSOCIATION OF MACHINISTS

Mr. VOEGE. Thank you for the opportunity of being here. It has been quite an intelligent hearing, and with all of the testimony that has been given here today why should a measure such as the King-Anderson bill meet with opposition from any fair-thinking American? That is something that I would like to elaborate on.

To begin with, in the Machinists Union specifically, and all other labor unions in general, it has ever been the aim to promote the type of legislation that this hearing is involved in. Union people are vitally interested in this type of benefit, for the reason that there are so many of them. The group that I am representing this afternoon in the United States comprises more than a million, and in California alone there are 152,000, and I would say that two-fifths of the California membership are right here in the Los Angeles area.

Senator Randolph said earlier in the hearing that this legislation would be difficult. Basically that might be a statement of considera-

tion. But is it difficult? Is it difficult if the voice of the people is heard?

And in connection with that I wish to mention a little experiment which we conducted with a small group of, say, 22,000 of the total membership in California. Senator Engle, you were the recipient of one of our letters. The entire Los Angeles delegation in Congress was written to. And the reply comes like this—and that was why I say is it difficult—out of the 15 Representations in California, we, in response to those letters, received 13 that were favorable to it. That's encouraging, and I do hope that that will react throughout the rest of your hearings that you are conducting throughout the country.

Senator RANDOLPH. Let me interrupt the witness. Now, if there is such an intense interest in this subject matter why is this auditorium not filled this afternoon?

Mr. VOEGE. Well, Senator Randolph, that is a good question. Your speaker McLain dwelt on that somewhat.

Senator ENGLE. I think that occurred before the Senator returned. He was tied up on the phone.

It was explained, Senator, that we are so far out that the elderly people who would like to be here would have to change buses about three times, whereas if we had held this meeting downtown we would have had 2,000 people. We knew that we would have to have an auditorium that would hold 2,000 people, and we couldn't find one that was available for this date that would hold 2,000 people, so we got so far out that we couldn't get them here.

I'm sure that Senator Randolph wasn't here when that explanation was made by Mr. McLain when he testified.

Mr. VOEGE. Well, I don't wish to challenge the Senator by any manner or means, but I do think I am correct in the statements that I made, that the people are wanting this type of legislation. All of the testimony, as I said a moment ago, that has been given here this afternoon, should be proof conclusive to you gentlemen of the sentiment of the people. They represented thousands. I represent a smaller group.

However, in our group, let me say this, that we range from 20 to 78 years. The average is probably around 40. Now then, the younger group that comprises our organization is likewise in favor of this legislation. So the question is, is this good for us, are the ways and means to provide it adequate, is the participation equal?—I think it is, as far as it can possibly be. As time goes on corrections and amendments can be made, but a start definitely is imperative. And that is my appeal to you legislators, that, come January, this legislation gets up on the docket and it becomes recognized and becomes enacted.

Thank you very kindly.

Senator ENGLE. Thank you very much for your statement. Please give my best regards to Mr. John Snider.

Mr. VOEGE. Yes, sir.

Senator ENGLE. The next witness is Mrs. Steven Hecton, owner-administrator of the Douglas Sanitarium in Pasadena.

Is Mrs. Steven Hecton present?<sup>1</sup> If not, we will proceed to hear from those members of the audience who have selected numbers, in accordance with the instructions, in the front of the auditorium.

<sup>1</sup> Mrs. Hecton's statement appears in the appendix on p. 519.

And will you undertake to limit yourselves, if you can, to 2 minutes, in order that all can be heard? Senator Randolph is going to have to leave very shortly, and in my case our proceedings will have to end at 4:30.

Who has No. 1?

Dr. DRIPPS. I do, Dr. C. W. Dripps.

**STATEMENT OF DR. C. W. DRIPPS, LOS ANGELES, CALIF., HIGHLAND PARK DERMATOLOGY GROUP**

Dr. DRIPPS. Senator Engle and Senator Randolph, I am Dr. C. W. Dripps, 5211½ Marmion Way, Los Angeles.

I brought no figures, I brought no data, I brought no paper. I brought myself.

I have been working for elderly citizens for 9 years in different parts of Los Angeles. You can print all the books you want, you can print all the papers you want; they know in Washington, they know here at Sacramento, what the older people need and what they ought to have. They have been worn out making their money for corporations. Now they think, some people do, they should be shelved. No. They made the country; they made the cities; they even made your politics; and if you don't keep the old people healthy, wealthy, and mentally wise, you will put them all under the sod.

They're getting too numerous for the other man to overlook them. I have been working hard. I got no compensation. I'm 85 years of age, and I'm sick. I came here with the shingles.

All you and I can do is remember, you are your brother's keeper, and when you fail to take care of him you will pay.

Senator ENGLE. Thank you very much for that statement.

Who has No. 2?

**STATEMENT OF CLIFFORD S. LeCAIN, SANTA MONICA, CALIF.**

Mr. LeCAIN. Senator Engle, my name is Clifford LeCain. I am legislative chairman of the Senior Citizens Association of Los Angeles County, Inc. Our association is comprised of members on all economic levels, and, if I may say, all political affiliations.

I believe that this is the first time that any Government agency or members of any committee have actually tried to learn the views of the senior citizen himself. Too often we have had to sit in the audience while other age groups tried to tell us how we should spend the remaining years of our lives.

The following statistics will give some indication of the practical needs of older retired people. These figures were secured from groups at various income levels. Those in the comparable low income group answered questions regarding medical insurance and housing as follows:

"Are you covered by medical insurance?" "Yes," 30 percent.

"Are you partly covered by medical insurance?" "Yes," 10 percent.

"Are you not covered by medical insurance?" Sixty percent.

"Would you be in favor of a senior citizens clinic for periodic physical examinations?" "Yes," 100 percent.

"Is your present housing adequate?" "Yes," 10 percent.

"Would you prefer living in a private senior citizens housing project?" "Yes," 90 percent.

"Would you prefer housing in a Government senior citizens project?" "Yes," 5 percent.

The somewhat higher income group answered another series of questions, as follows:

"Do you have adequate medical insurance?" "Yes," 36 percent.

"Do you favor medical aid under social security?" "Yes," 70 percent.

"Do you think the establishment of clinics for senior citizens where they could have at least a semiannual checkup at a low rate of cost would be a helpful preventive measure?" "Yes," 90 percent.

"Are you satisfied with your present housing?" "Yes," 74 percent.

"Would you like to rent a low-cost senior citizens apartment?" "Yes," 35 percent.

"Would you like to buy into a senior citizen apartment?" "Yes," 11 percent.

"Do you own your own home?" "Yes," 36 percent.

"If you own your own home is it completely paid for?" "Yes," 85 percent.

"Would you like a full-time job?" "Yes," 7 percent.

"Would you like a part-time job?" "Yes," 25 percent.

"Are you interested in volunteer work?" "Yes," 28 percent.

"Are you now drawing social security payments?" "Yes," 67 percent.

"Do you have an income from some other form of retirement?" "Yes," 54 percent.

"Is your income adequate for your needs?" "Yes," 51 percent.

"Do you feel that the Government has a responsibility for helping solve the problems confronting older people?" "Yes," 70 percent.

If one is to believe all the statements that you read and hear about persons retiring at 65 years of age you would come to the conclusion that such an individual is through with all life's activities and is of no more use to his community or his nation except to amuse himself with the playing of cards or shuffleboard. The senior citizen often has personal characteristics that are lacking in other age groups, such as patience, tolerance, kindness, and consideration of others. Surely these attributes are of some use to the Nation and to the community.

Seemingly the general impression of other age groups is that when an older person retires from a wage-paying job he must be considered a burden and a responsibility to his country for the rest of his life. In his early years the senior citizen had the responsibility of making a living for his family, therefore had very little time to devote to service of his community; and now, when he does have spare time for community service, he is told that he should spend his time fishing and playing cards.

The Senior Citizens Association of Los Angeles County believes that our Government, on all levels, Federal, State, and local, should seek out ways to use this source of human power that is contained in a growing population of older people. They further believe that if older people enjoy reasonably good health, with a decent economic existence, we can in time of disaster or any major trouble in our Na-



tion be an extra source of power for the Nation to draw on. On the other hand, an older group of citizens in poor health and forced to live on a low economic level would just be an added burden in a time of national peril.

The pronouncement of our President in saying that we should think of what we can do for our country is taken seriously by our senior citizens, and we want to be in condition, both mentally and physically, to serve our country in whatever way we can be used. Thank you.

Senator ENGLE. Thank you very much.

Who has No. 3?

**STATEMENT OF JAMES R. LARRIMORE, GLENDALE, CALIF.**

Mr. LARRIMORE. My name is James R. Larrimore. I live at 121 South Kenwood, in Glendale.

Senator Engle and Senator Randolph, I am not going to overstep your time. It will be impossible, Senators, for me to tell you all the problems that I have gone through in my time, and I am going to devote the most of that to write to you two gentlemen and tell you what I think should be. But there is one thing that I will say here and now, that some of these people who are professing that they have done all that has been done for the senior citizens, they had better wake up, because I was in the fight before they were born, so that I think that they had better step back and think over something.

I thank you, Senators, very much.

Senator ENGLE. Senator Randolph?

Senator RANDOLPH. The gentleman who has just spoken is approaching 90 years of age, and I think that the vigor he retains today is in part due to the fact that he lived a considerable portion of his years in West Virginia.

Mr. LARRIMORE. Yes.

Senator ENGLE. They grow them tough in West Virginia, and I only hope that at 90 years of age I preserve the mental alertness and the physical vigor just demonstrated by our last speaker.

No. 4, please.

**STATEMENT OF MRS. JENNIE DICKENSEN, PRESIDENT, SANTA MONICA CHAPTER, AMERICAN ASSOCIATION OF RETIRED PERSONS, SANTA MONICA, CALIF.**

Mrs. DICKENSEN. I am Mrs. Jennie Dickensen. I am president of the Santa Monica chapter of the American Association of Retired Persons.

Today there has been quite a bit of evidence that the problem of the older citizen is a three-faceted problem: Housing, medical care, and employment, and I would like to present a little evidence that I think it is a two-faceted problem. I think housing and medical care is one problem, and employment is the second problem.

One of the greatest pieces of evidence we have happened just last Wednesday with the tremendous crowd out at Seal Beach, which I hope you will be able to see while you are here, at the Rossmore Leisure World. I have no stock in this company whatsoever. I am only interested as president of an organization. I have investigated it thoroughly. Last Wednesday they opened their sales, and they broke

what they say is a national record of having sold 288 apartments the first day on Wednesday, simply and primarily because in that project they are including medical care with the cost.

Now, there are many projects. They are mushrooming all over the country, low rental projects. That does not answer the problem. We have to have included in these projects in some way or another some sort of a medical program that will give people this peace of mind that they need desperately. While our Congress is investigating, like today, and our State is trying to legislate, what is happening? Innumerable organizations, contractors, promoters are mushrooming all over the country building these private enterprises. They are in many cases offering the world with a string around it to a lot of people. I hope they can produce it. Included in that are marvelous facilities for recreation. There are very, very few, outside of the church organizations, that are giving medical care. The one at Seal Beach gives that. That's the only one I know of.

Now, my purpose in being here is to ask you a question. Is there any way that one can find a guarantee of perpetuity of these promises of these services in these so-called package deals? In several instances I have gone to the usual channels of investigating. I have gone to the headquarters of the FHA, who are making these funds available for these projects. I have gone to banks, I have gone to better business bureaus. I have found plus answers, everything is fine up to this point. Supposing something happens to these foundations or organizations? Many of these older citizens are putting their lifetime savings into these projects. They have no way of knowing that this is going to go on, any more than we do in these cooperative apartments, that they are going to be able forever and ever to furnish all that they promise in services.

Isn't it time that we have some sort of committee which might investigate and put a stamp of approval on these enterprises that are taking the funds from the older people and promising these things, so that they may feel secure that they will not lose their money? That's the question I would like to ask you.

Senator ENGLE. I don't know any way of guaranteeing anything in perpetuity. But I would say this: That the Government doesn't start out any program and let it fall on its face, and we don't expect that to happen. I think that's the best answer I can give you at the present time, unless my colleague, Senator Randolph, wants to make some comment.

Mrs. DICKENSEN. Other than the FHA financing the majority of these projects. We assume, of course, that the FHA will always be there, but what about these other services that people are supposed to receive when they pay into these private projects? I'm speaking primarily of medical care, which is the biggest problem—that they are going to get certain medical care.

Let's go a step further, into the church-sponsored programs. They have medical care included. Now, of course, as long as the churches can support it, of course they will do this. But these private things that are mushrooming, that is the serious thing. They are taking money. They expect to do this, but are they going to be able, with the rising costs, to insure people's investment, the older person's investment, and promise medical care, and so on and so forth?

Senator ENGLE. I can't go into anything beyond what I have already said. It depends upon how good and how stable the organization is. And, of course, the Government agencies are going to take a good look at those organizations before they authorize a program. They are not going to start out with some outfit that doesn't look like it knows its business.

Now, there may be some failures along the way, there isn't any doubt about that, as there are in private organizations. There isn't any way to guarantee the perpetuity of it beyond what I say, and that is that the Government ordinarily doesn't get into these programs just for the fun of it and just temporarily. We intend to try to go forward with these programs over the long haul and permanently, otherwise they would be of no service to the elderly people we are trying to help.

Who has No. 5? We will be glad to hear from you.

Senator RANDOLPH. Mr. Chairman, as the next citizen is coming to the microphone—would not the question be answered partially if the medical care programs are placed under social security?

Mrs. DICKENSEN. Yes, indeed. I'm thinking of the private projects, not the Government projects, Senator Randolph. I am thinking of all these mushrooming private projects that are cropping up all over California and, I believe, the United States.

Senator ENGLE. I know what you are talking about, and as far as they are concerned, as I say they are going to be just as good as the organization. But if they go in and get Federal money for the purpose of financing these projects, if they do get that kind of money, then the Federal Government is going to take a very close look at them.

No. 5, please.

#### STATEMENT OF MRS. CAROLINE RICHEY, LOS ANGELES, CALIF.

Mrs. RICHEY. I am Mrs. Caroline Richey, 934 South Lake Street, Los Angeles.

I would like to put in a plea for suitable housing for the very low income elderly. I have been a volunteer worker in politics and in welfare work, and I have often gone into the homes of these low-income elderly, not only in California but in some other States of recent years, and it is pitiful the way they live. They have a dark, dingy basement room perhaps, with very inferior plumbing. And I even know some of these very elderly people that go up on the third floor to live because it is cheaper rent there.

They don't seem to know what to do to help themselves. Many of them don't have any other income but just their pension, and they don't have anything, and the place they live in is just pathetic, and I think that something should be done to help these very, very poor elderly as to housing.

Now, I recently had the privilege of going through the Fresno Senior Citizens' place, and I will say that it is beautiful, and it is a wonderful place, and I'm sure that all who are privileged to live in it will be very happy. But on the other hand, it is really high priced for those of the elderly who are very poor.

I might have this suggestion that might help the older people, if something could be done, some sort of projects that clubs would take

hold of, or lodges, or some person, some sort of nonprofit corporation would take over to help these people—something with low interest rates. Many of these elderly people do not care to live in their present locality, and I think possibly there might be some buildings already built that might be taken, or there might be something where the ground is high priced that could be built several stories high. I find that elderly people really like to use elevators; they just enjoy them. And I think that where the ground is so high priced, that would be one answer to their problem. And, of course, the financing is the biggest one. But if that can be worked out I think that many of these elderly people could be happily housed, and I think their health would be better and they would be happier, and many of them could be kept out of the rest homes and, yes, the mental institutions, too.

Thank you.

Senator ENGLE. Thank you very much, Mrs. Richey.

Next, please.

#### STATEMENT OF REX THORPE, LONG BEACH, CALIF.

Mr. THORPE. Hon. Senator Engle, my name is Rex Thorpe, 236 Atlantic, Long Beach. I am speaking on behalf of the National League of Senior Citizens, of which I am honorary public relations chairman.

There are two bills on the national level that are coming up in January, medical aid and social security, and to raise the social security benefit. It has been proven in 1920 only 1 person out of 25 lived to be 65 years of age. This record was furnished me from Washington, D.C., last year. In 1960, 1 out of every 11 reached 65—in fact, it has been expanded to 70 years—and three-fifths of those people have incomes of less than \$1,000 a year, whether it's social security or whether it's a pension, or whatever you want to call it.

Now, there are millions of people that are caught in the grasp that I am, Senator. At the start of the Second World War I drew my check from the same building that you did back in Washington, D.C., when you were Congressman. I had to give up in 1957, when my mother died. Never got back. If I didn't have private outside social security I wouldn't have no check at all. Today my check will be only \$40 a month. How can anyone ever expect to live on that. I served my country, and I served her well. In other words, I worked just as hard, God knows, as anybody. I worked for two different branches. They wouldn't take me. But no social security. So today I'm just one of millions that's caught in this thing, \$40 a month.

I say make that amendment \$173 a month for the standard of living—a minimum. It has been proven that 65 countries have a better retirement than we have, and out of those 65 we are giving money to 34 of them. We are the richest country in the world. And I am not a Communist, because I worked with Martin Dies, and I think you agree he never had a Communist on his payroll.

Thank you.

Senator ENGLE. Thank you very much for that statement.

Next, please.

**STATEMENT OF REX MAINORD, LOS ANGELES, CALIF., UNITED  
AUTOMOBILE WORKERS**

Mr. MAINORD. My name is Rex Mainord. I'm here in behalf of the UAW Older Worker and Retired Member Department.

I should like to say at the outset that I made an effort to get a formal appearance before the committee and was unsuccessful. However, maybe that isn't too bad, since I would like to point out that UAW President Walter Reuther has already made a statement at length, in great detail, and well documented, formally before the committee, and I believe before the overall committee.

Senator ENGLE. I am advised that by some mischance the request didn't come through. I'm sure we would have been glad to hear you; and, of course, we will be glad to hear you now. You can proceed and make a statement, if you wish.

Mr. MAINORD. All right; thank you very much. It will be short.

First I would like to concur in the sentiment already expressed concerning the inadequacy of this place for a hearing such as this. I recognize that it is not close to public transportation. It is very difficult for people in the age bracket from whom you want to hear to get here. I know we didn't make any special effort to get the retired members of the UAW here because of that particular problem, although many of them are represented here today. I realize that this observation has been made already, but I just wanted to concur in it.

Secondly, I want to formally say that I know you are aware of the testimony that UAW President Reuther has already made before the overall committee, therefore what I have to say here today is merely supplementary.

Sometime 4, 5 months ago during this year I believe you were the recipient of a number of petitions circulated by our organization and sent to you, with the request that it not only be used for your own benefit but for the other Senator from this great State, and for the benefit of the congressional Representatives of the State of California, informing them of the position of hundreds, actually thousands, of UAW members, most of them retired, from the State of California, concerning medical, hospitalization, and health care. And it goes without saying that that sentiment still stands as contained in the petition already submitted to you.

Now, I would like to indicate to you that I represent the UAW international older workers and retirement department, and my statement is in regard to the health needs of those people that too often society in general treats as being too old to work but too young to die, and those are what we commonly call senior citizens. I speak from my experience in working with a continuously enlarging group of retired workers, retired members of our organization, a group that in just a few short years has grown from a mere handful to hundreds in the State of California, a group with the potential of several thousand in the immediate years ahead.

My remarks also include observations gleaned from working with many other organizations interested in the plight of people in this age bracket, organizations that are in position to know the health needs of literally thousands of senior citizens in this State. In the

main my observations refer to that economically regimented group of older people whose income is too little to sustain their health needs but too often considered too much for them to be eligible for some of the public assistance handouts and charitable givings that are tendered to them occasionally, a group with too much dignity and too much pride to be willing to submit to the kind of demoralizing means test that is required under the so-called Kerr-Mills bill that has already been passed by the U.S. Congress and signed into law.

This is the age group that finds upon retirement that the cost of private health insurance schemes and plans is too inflated, or unavailable, at the time of life when they are likely to stand in need of greater health care and protection than at any other time during their life. This is the period of life when the fear of ill health and disease is the most devastating, when the fear alone takes a tremendous toll on their health and resistance to disease. There are countless cases on record where so-called retired people have had their life's savings eaten up by medical and hospitalization costs. This is a group where too many too often find that after health needs are met, if indeed they are met at all, they have too little left over to take care of the other necessities of life, necessities that, were they able to provide for themselves, such as wholesome food, proper clothing, and adequate shelter, would help tremendously in meeting their health needs also. Thus they are forced into a vicious cycle of existence.

Now, regardless of how they may try, the well-financed public relations professionals who have been retained to attempt to scuttle health legislation such as we are requesting, cannot make the issue disappear. Older people have greater health care needs than do any other Americans. This is an inescapable fact. They have twice the chronic conditions, spend almost two and a half times as many days restricted to their beds, are limited in their activities by chronic conditions six times as often, visit physicians appreciably more, and spend two to three times as many days in the hospital as do people younger than they. They have to pay for more medical care when such service is rapidly increasing in cost, and they are less able to pay it.

The majority of older people have little or no health insurance at all, at least it's not adequate. What little they do have is grossly inadequate, to say the least. It typically provides far less protection than that available to those who have not yet retired.

The fact is that the inadequate financing stands in the way of health care for older people. We feel that too often too many doctors, too many insurance agencies and companies, are ganging up on the older people to prevent them from obtaining the proper and adequate medical care.

We think, in conclusion, Senator Engle, the easiest, most adequate answer to the health care problem for older people is to provide it through social security, as proposed in the modest—and I want to emphasize the word “modest”—King-Anderson bill, and approached, in the words of President Kennedy, “entirely in accordance with the traditional American system of placing responsibility on the employee and the employer rather than on the general taxpayers to help finance retirement and health.”

And as a final and concluding remark I would like to say, thank God that we have some doctors who have the courage and the conscience that the three had that appeared here this afternoon to testify in behalf of this kind of legislation, and that finally the so-called ranks of resistance of the American Medical Association apparently have been broken and that maybe we have some hope in the future of attaining this kind of legislation.

Senator ENGLE. Thank you, Mr. Mainord, for a very fine statement.

While the next speaker is coming to the microphone, Senator Randolph has a short statement to make.

Senator RANDOLPH. Mr. Mainord, you have reemphasized the expressions which were made by Walter Reuther before the House Ways and Means Committee. His presentation was one of the most effective heard by that body on the items to which you have referred. I congratulate you for being active in an organization which has his dedicated leadership. He was born in West Virginia.

Mr. MAINORD. Thank you very much, Senator. May I just say, that's why I didn't go into greater detail on the situation, because it had already been covered.

Senator ENGLE. Walter does a pretty good job.

Now, the next speaker.

#### STATEMENT OF ANIBAL GUTARRA, LOS ANGELES, CALIF.

Mr. GUTARRA. My name is Anibal Gutarra. I am a retiree for one of the oldest and most rich companies in the United States. After listening by the good, fine audience that we have today, the different statements and proposals, I like to be brief in announcing that lately I was in a hospital, and after paying the wonderful social security—I have been paying my dues, what I was supposed to be, my social security—and to my disappointment, when I was last July operated I have to pay over \$400. And I really don't know—I went to the so-called Blue Cross, and of course they shift me from one section to another. And one of the things that surprised me, that in the bills that they send me I have to pay for the anesthetics, and I have to pay for the assistant, and so forth.

May I explain, or speak about, that after all the fine things that we have heard through words, and of course notwithstanding the wonderful thing of what legislation is, I notice that it seems that, due to the wonderful age that we are approaching through the automation, there is nothing left but to act and have a form of social government, cutting the hours completely and giving the men 45 years of age what they are entitled to after 20 years. May I mention at this time that Mr. Edsel Ford at one time in one of his statements said that the man after 20 years of work should be pensioned. I really favor it now, because we are living in the wonderful age of the pushbutton and all these fine things.

I like to express at this time my appreciation for this fine opportunity of addressing the audience and expressing my opinion. I received from Senator Engle a communication some time ago, and, with my brother, we have the honor to answer your letter, Senator Engle; and I really feel very proud and really, well, privileged to have this oppor-

tunity to see you personally and explain to all my sentiments and my ideas, which are possible to be practical.

Senator ENGLE. Thank you very much.

**STATEMENT OF CHESTER WOOD, LONG BEACH, CALIF., REGIONAL DIRECTOR, NATIONAL LEAGUE OF SENIOR CITIZENS**

Mr. WOOD. Chester Wood, from Long Beach. Glad to see you out today, and I want to thank you for the patience that you gentlemen have shown this afternoon.

I will talk about liens. The Government doesn't take a lien on people's homes, the State doesn't take a lien on people's homes. And I've been working on liens for the last 3 months. The Government gives 46 percent to the aged of this State, the State gives 45 percent, and the counties give 9 percent. As an example of what they do—I've got laryngitis very bad, but I do want to get this over, how they take a lien on a person's home and make them a sitting duck for communism.

I had a friend who made 59 missions in World War II. He had a lovely wife and four children. He put her in the hospital, and she was in there 6 months, \$38 a day for a room and \$24 for incidentals. After being in there 6 months they called him and told him, after he told them that he didn't have any more money, that she was to be dismissed, that it was \$11,000.

Now she's got to go back again to the hospital, and the first thing that they will do when they get her back in there is take a lien on that home.

I think that the Congress of the United States and the Senate of the United States should look into that, and somehow the people of the State of California should get up in arms and get rid of this dictatorship by the county supervisors. Thank you very much.

Senator ENGLE. Thank you very much. Let me say that if we can pass the bill in which we have a contributory system of medical care for the elderly people we will get away from a lot of that lien business.

The next speaker, please.

**STATEMENT OF MRS. CARNAHAN, LOS ANGELES, CALIF.**

Mrs. CARNAHAN. Well, I'm Mrs. Carnahan, and I want to speak on this medical care program.

Recently we have had so many articles in the paper where they have misused these medical care funds, and it's very easy for them to do that; but it would be very easy for them not to do it if you would put in a few things, a paper or something, so that the people know what they can have and what they can't have. And also if the patient goes there he would have to bring a duplicate with him and give it to his worker the same as when he gets a prescription for vitamins and such things as that.

Now, I think you folks in the House of Representatives, or wherever you are, are to blame for these laws that are made. Now, you wouldn't begin to write your name on a check and hand it to somebody, and yet when these people go to the doctors that's exactly what they do, they give them a check for anything on this medical bill. You go in there and they hand you a slip and they say, "Well, write



your name here." You've never been interviewed or anything, they just say, "Write your name," and you write your name before they even look at you or see you. You never see that slip any more after that. It goes to the State, or whatever it goes, to the worker or whatever it is. You don't know what they put on there, you don't know how many visits you have been charged with. And then they will give you medicine for a few days, or a week, and they will say, "Come back in a week." Well, you haven't gotten any good out of what you did get, and you go back in a week, and they give you the same thing over and say, "Come back in another week." Now, that's a bunch of foolishness. You wouldn't run your business that way.

And so I think it's up to the legislators to correct these things, because a lot of this money is channeled into places where it shouldn't go. And you know that we have dishonest people in all things, in the medical profession as well as anything else.

Then I wanted to say something about these vitamins. Now, they will give you an order for vitamins—at least I think they will from what I've heard, I haven't had any—and they will say to you, "You go down here and get your vitamins." Well, I'm one of these people, I don't use all that drugstore stuff. And I'll tell you, I went into the drugstore one day. I wanted some flaxseed, and I wanted it real bad, because I had been sick. And I went into the drugstore in the neighborhood, they charged me \$1.19 for a pound of flaxseed. And I said to myself, "Well, that's kind of high, I never did pay that before."

So I went to my health store, and I got a pound of flaxseed for 35 cents. Now, you know health stores aren't cheap stores, if you ever do a lot of trading there. They're not cheap. But I buy natural vitamins, I don't buy a lot of this synthetic stuff you get in drugstores.

And so I went back—I had opened the box, and I went back there, and I said, "Look here," I said, "you've charged me \$1.19, and here is my pound for 35 cents from the health store."

"Oh, this is inspected."

I said, "Do you think that they don't have inspected stuff at the health foods stores? Generally you have to pay a few cents more there."

"Well," she said, "It's boxed."

I said, "You mean to tell me that the difference between 35 cents and \$1.19—that box cost that?" I says, "Haven't you made a mistake?"

So she went and looked it up in the book, and she says, "No, it's \$1.19. But," she says, "we will refund your money," and which they did.

Now, that's something that I think can be looked into.

Senator ENGLE. Mr. Kefauver has been looking at that pretty hard.

Mrs. CARNAHAN. We have to go to the drugstore. They will tell you where to go and what to do. Now, you folks, when you retire, you get your thousands of dollars.

Senator ENGLE. If we live we get it.

Mrs. CARNAHAN. They don't tell you where to go or how to spend it or anything else, and yet if we have a few hundred dollars in the bank and we get \$1 or \$2 interest, when they come around they deduct

that from the measly little \$90 or \$95, whatever it is they get, see? They deduct that interest that you get, when you're supposed to be allowed to have a bank account or have money to \$1,200, I think it is. Yet if you get \$2 or \$3 interest, they deduct that.

Well, that's all I have to say.

**Senator ENGLE.** Thank you very much for those comments.

Next speaker, please.

#### STATEMENT OF GERDA SERUNTINE, LOS ANGELES, CALIF.

**Mrs. SERUNTINE.** This is a request of a lady from Highland Park. She asked me if I would speak about these new clubs that are forming that are just for recreation for the elderly. She belongs to one in Highland Park, and it's taken some of our members away, and she was wondering whether we would send somebody from our headquarters. Well, that would be to be taken up at headquarters, I suppose. But that way it's hurting the membership in our organization, because a lot of them want to just have a good time, and they aren't thinking about the stomach. So that was the one request.

I forgot to give you my name. It's Gerda Seruntine. I live here in East Los Angeles, and I have been secretary-treasurer of the East Los Angeles club. Just within the last few months we lost our treasurer and vice president, then finally our hall was closed to us; so the members that are left that are loyal, they're joining up with the Montebello club and trying to do our little bit.

And I understand in Montebello, that they have one of those social clubs, too, and it's drawing members away from our organization. And those that don't know it, if they do like to play cards and dominoes or different games, they can go down to headquarters there. They have all those facilities down there for them, too.

And I think that's all.

**Senator ENGLE.** Thank you very much for that statement.

#### STATEMENT OF JOHN VAN DYKE, LOS ANGELES, CALIF.

**Mr. VAN DYKE.** My name is John Van Dyke, and my address is 1341 East 22d Street, Los Angeles, Calif. It is indeed a pleasure to be here today.

I'm permanently disabled, and I just did get \$100 a month. I don't think that's quite enough. But anyhow, thank God for that.

That's my saying to you all.

**Senator ENGLE.** Thank you very much for your statement. Next, please.

#### STATEMENT OF MAX WEINER, LOS ANGELES, CALIF.

**Mr. WEINER.** My name is Max Weiner, and I represent the West Side Jewish Community Center. I have close to 700.

**Senator ENGLE.** If you have a lengthy statement we will be glad to put it in the record.

**Mr. WEINER.** I have given the statement to the young lady there. I don't intend to read it all, but just a couple of items.

**Senator ENGLE.** We will be glad to put it in the record for you, and you can summarize. Go right ahead.

Mr. WEINER. An item in the Christian Science Monitor of January 25: "Horses can retire and have care, enjoy green pastures," reminded me of the year 1956, when the U.S. Army abolished the mule corps. Those that could they put to work, and the others, they let them loose in the national parks, forests, and deserts to live in freedom and feed in abundance.

Of course, the mules had no health problems; neither did they have any life savings.

The older citizens do have a health problem and very few of them have some life savings.

I'm skipping over, I'm getting down to the last point.

I am confident that were I to come before any assembly expounding the idea of farming out, let's say, the collection of income taxes and take it out of the Revenue Bureau, there would be not one dissenting vote on a motion to put me into the snakepit. The AMA is all for health insurance. The word "voluntary" has no meaning, because anybody may get ill, and no American wants to get on the dole, but not through an agency of our Government with 26 years of proven efficiency.

I'd like to remind them that failure to pay one insurance premium, even after continuous payments for 20 or 30 years, the policy is canceled. The social security has no cancellation clause.

As representative of senior citizens of the West Side Jewish Community Center in Los Angeles, with a roster of close to 700 members, I urge this subcommittee of the U.S. Senate, presided over this day by the Honorable Clair Engle, our California Senator, the Senate Ways and Means Committee, and the U.S. Senate to pass favorably on the King-Anderson bill and make this the law of our country and earn the gratitude of more than 180 million Americans, who made it the greatest in the world now, and the generations to come and follow in our footsteps.

Senator, I want to take this opportunity to thank you for the way you have treated my inquiries. I've gotten about half a dozen letters from you. And if it wasn't for the fact that your office was very efficient I wouldn't have been here today. I wrote to them and they sent me a letter telling me about it, and so forth. So thank you.

(The prepared statement of Mr. Weiner follows:)

#### PREPARED STATEMENT OF MAX WEINER

An item in the Christian Science Monitor (Jan. 25, 1961): Horses can retire and have care, enjoy green pastures—reminded me of the year 1956, when the U.S. Army abolished the Mule Corps. After a pompous parade and appropriate speeches the able were put to work and the old were turned loose in national parks, forests, and deserts to live in freedom and feed in abundance.

Of course they had no health problem. They also had no life savings.

The older citizens of our country do have a health problem and some few have some life savings. Our Congress started to wrestle with the health problem of our Nation early in this century and in 1917 the chance of solving it looked so good, that the AMA (who is always against anything that will benefit the general public) gave in and was making plans to work out details.

World War I killed it.

Beginning with the 75th Congress in 1938 every session struggled with the problem. The efforts of Senator Wagner and others in 1939 were nullified by World War II; 1949 saw former President Truman's attempt defeated by the AMA, who switched from opposition to Blue Cross as socialistic to its enthusiastic endorsement.

The President's Commission on the Health of the Nation in 1952 suggested comprehensive medical care benefits, in and out of hospitals, specifically stating that the plan should not involve a means test and tied it to social security.

The Forand bill, providing only hospital care for those 65-plus, left out medical care entirely, was again dubbed "socialistic" by the AMA and defeated by the threat of a White House veto. In its stead we got the Kerr-Mills monstrosity, which solves nothing. (U.S. News & World Report, Sept. 5, 1960.)

The King-Anderson bill now before Congress, has generated the kind of heated controversy this country has never seen before. An unholy troika: The AMA, the chamber of commerce, and the insurance industry, are arrogantly claiming the full custody of our country's freedoms, the AMA spearheading the most vicious agitation against this bill. On July 1 I wrote in part to the Honorable Thomas H. Kuchel, our other Senator from California: "Do I have to tell you about the destructive effect this requirement (the means test) has on the citizenry of our generation?"

"An all-embracing health measure, covering all 65's under social security as a right and not charity is the crying need of our time. Don't let the vicious, insidious propaganda of the AMA politicians for their own pecuniary interests mislead you . . . help stop the steady stream of our Nation's seniors knocking at the gates of the overcrowded inefficient mental institutions. Help stop the alarming rate of suicides of our age group. The health and welfare of 180 million Americans (the seniors being the weakest link in the chain) is at stake." Contrary to his previous habit, this letter, it seems, deserved no answer.

With "nearly half the physicians in the United States unable to treat their patients in a hospital" (Look, Jan. 17, 1961, by Ronald N. Berg), is that free choice of doctors? Doctor-patient relations. "War declared on medical overcharging in Los Angeles County," Dr. Edward H. Crane, president of Los Angeles County Medical Association declared in the Los Angeles Times (Dec. 14, 1960) and on September 10, 1961, the same paper prints in much smaller type: "400 complaints made against county doctors in the first 6 months of 1961."

A few more lines from Look (Jan. 17, 1961): "The most famous incident of such discrimination occurred in Washington more than 20 years ago . . . it resulted in the conviction of the AMA and the District of Columbia Medical Society for violating the Antitrust Act . . . upheld by the U.S. Supreme Court." Illuminating the reluctance of young people to choose medicine as a career, is it not?

"Medical care is available at all times for those who need it," fact or fiction? "Tomorrow never came" to Miss Peterson; about an hour later she was found dead of a heart attack on Holly Avenue. (News item in Los Angeles Times, July 7, 1960.)

"Hospital and medical bills vary with area, Mr. Samuel Tibbitts:" in 1960 the average hospital bill per day in Los Angeles was \$45.68. In New England the comparable figure was \$38.69. (Los Angeles Times, Sept. 10, 1961.) Mr. Chas. Neal, Jr., in the same paper of another date finds it hard to explain the "huge difference between areas in the charge for eyeglasses"—\$35 in Los Angeles against \$12.50 in Baltimore (my own experience), with an examination thrown in in Baltimore. Another of my experiences: \$279 for a 4-day stay, two to a room in a local proprietary hospital. No three-bed room available. And the doctor's bill—just short of a hundred. You, the AMA politicians, talk loudly of individual initiative, freedom, and responsibility and honesty. How many of these attributes do you possess?

Take a good look in a mirror. Since when have you been worried about the poor worker's high taxes? What responsibility do you assume on the chaotic hospital situation, when "25 percent are below par in the Nation and worse in our State"? What about their systems of accounting—\$167.52 for a 3-day stay with an ingrowing toe nail? Only 35 nonprofit hospitals out of 69 have doctors 24 hours a day and a lot less in others. And you oppose the King bill because the Government will control the hospitals, and you call it socialistic (Examiner, Dec. 6, 1960). My files are loaded with evidence on this subject, but it's time to examine freedom. "Fear of reprisal seen in medical care stand," is the headline in the Los Angeles Times of August 1, 1961, and thank you, Dr. Leonard W. Larsen for your generosity in . . . "admitting doctors' right to back (King) plan." (AP release from Washington, Los Angeles Times, Aug. 3, 1961.) And I, like a fool, always thought that freedom of conscience and speech is guaranteed by our Constitution and is one of the cornerstones of our American

\*All statements between these (\*) marks are culled from the Los Angeles Times.

way of life. Permit me now a moment or so to join my voice to that of Walter Lippmann (Los Angeles Times, June 18, 1960) : "For reasons which he has never explained, the President (Eisenhower) regards compulsory social security taxes as unsound, socialistic, and rather un-American; on the other hand he regards compulsory taxes to pay for doles based on a means test as somehow more voluntary, sounder, more worthy of a free society and more American. In order to save time, I'd like to list just a few references in opposition to Mr. Eisenhower's viewpoint."

First editorial, Life, April 25, 1960; Dr. James P. Dixon, Jr., in Goals for Americans, Congressional Library Card No. 60-53566, pages 249-255; Consumer Report, June 1960, pages 329 and 330; enough. Initiative is something you lack completely. Your vitriolic invectives against the King bill are not new; we the oldtimers still remember them from the middle thirties, when the social security legislation was on the agenda. Yes, we remember Alf Landon's platform concocted by the same unholy alliance. "Repeal this duress legislation, let experts do it, let private insurance take care, compulsory savings, robbing the workers of their earnings, reducing responsibility, killing initiative and un-American, un-American". These were the banner headlines blazoned on the front pages of the newspapers of that day. Back to responsibility, self-discipline is without a doubt an integral part of it. Dr. John G. Walsh, president of the American Academy of General Practice, is quoted in the Los Angeles Times, May 6, 1960, by Harry Nelson: "Medicine has broken into fragments of specialty groups, which are becoming more competitive on an economic basis rather than co-operative on a medical basis. . . . Because of the fragmentation of medicine . . . and because these groups are not pulling together in the interest of the patient, the public is beginning to feel it should take medical organization out of the hands of doctors and give it to the Government." There is more of it in the same vein; I will only give his concluding sentence: "To pretend that these disagreements are based upon anything but economic reasons is to dodge the issue \*ostrich style.\*"

"The greatest physician of his time, Sir William Osler, often used to say that the practice of medicine never should be a business; it should be a calling like the ministry; and a physician should be a dedicated, idealistic, kindly and generous man, who always did what he thought was best for his patient, and never was tempted to \*make work\* or order a needless operation, or run up a huge bill. But even 70 years ago, Osler had to admit that there were a few men in medicine who worked only for dollars, and were not a credit to their profession." (Los Angeles Times, Aug. 21, 1961.) A headline in the Los Angeles Times, October 5, 1961: "Surgeons' Spokesman Criticizes \*Fee Splits.\*" Dr. Robert S. Myers: "roughly half of all the operations in the United States are done by unqualified doctors . . . receiving part of the fee, usually 40 percent or 50 percent\*." The same paper, October 18, 1961: "Fee-Splitting Defended by California Doctors." Harry Nelson. "The counterattack was also taken up in New York . . ." \*Dr. Egeberg at a weekend doctors' conference: "Organized medicine's attitude toward social security makes older people think doctors don't care a damn about them." "Tighter rein urged on health insurance cost. (AP); A California legislator charged that some policies pay less than a dime on the premium dollar." "Tighter Controls Urged on Health Plans for Aged." By Louis Fleming. "Program Switch Urged for Health Insurance." switch from low premiums to adequate coverage. Dr. Bostick: The pressure for social security-type health insurance is symbolic of a need that is not being met adequately by existing insurance.\* "Socialized Medicine Held Costly Success" . . . Dr. William Hawksworth, as quoted by Harry Nelson, Los Angeles Times, September 16, 1961 . . . "The system works well, but it's an expensive luxury." "The public likes the security of being able to get good care without cost, except taxes, and most of the doctors accept it as part of a worldwide evolution."

Please note, that the statement quoted above is the only one about a foreign country.

I am confident that were I to come before any assembly expounding the idea of farming out, let's say the collection of income taxes and take it out of the Revenue Bureau, there would be not one dissenting vote on a motion to put me into the snake pit. The AMA is all for health insurance, the word "voluntary" has no meaning, because anybody may get ill and no American wants to get on the dole, but . . . not through an agency of our Government with 26 years of proven

\*All statements between these (\*) marks are culled from the Los Angeles Times.

efficiency. I'd like to remind them, that failure to pay one insurance premium, even after continuous payments for 20 or 30 years, the policy is canceled. The social security has no cancellation clause. As representative of senior citizens of the Westside Jewish Community Center in Los Angeles with a roster of close to 700 members, I urge this subcommittee of the U.S. Senate, presided over this day by the Honorable Clair Engle, our California Senator, the Senate Ways and Means Committee, and the U.S. Senate to pass favorably on the King-Anderson bill and make this the law of our country and earn the gratitude of more than 180 million Americans, who made it the greatest in the world now and the generations to come and follow in our footsteps.

Senator ENGLE. I thank you very much for your statement.

Now we have arrived at the time when we must necessarily adjourn this committee. Statements that are not made in the presence of a U.S. Senator cannot, except by unanimous consent, be made a part of the record. We are providing franked envelopes in the outer lobby, and those of you who wanted to speak or to say something particularly with reference to this committee and who have not had the opportunity to do so, will be permitted to write out your statements and mail them in to the committee or give them to the committee. The address will be provided for you. Without objection all of those statements will be made a part of the record.

I want to say that we have listened today to 37 witnesses, starting with the Governor of California, and I think we have moved with expedition. We have had an excellent hearing. The contribution made by all who appeared here has been an excellent contribution. We have had very well-prepared testimony from everyone who came before this committee.

I want to express my gratitude to those of you who came here to testify in connection with this problem of the elderly. I also want to thank all those of you interested in the problem of the elderly, though you didn't come here to testify, for coming this long distance to be here and to listen to this testimony.

Other hearings are going to be held throughout other parts of the United States. The purpose and the function of these hearings is to enable the Congress of the United States to act more intelligently with reference to the solution of these problems. And I would say that if all the hearings that we hold throughout other parts of the country are as constructive, are as well prepared, are as well thought out and can handle as many witnesses during the day as we have done this day, certainly the congressional committee will go back with adequate information to put together legislation that will provide a better and more dignified future and more healthy living for the elderly people of our country.

Thank you very much, and the committee stands adjourned.

(Whereupon, at 4:30 p.m., Tuesday, October 24, 1961, the committee recessed.)

## APPENDIX

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PREPARED STATEMENT OF MRS. IRENE HECTON, DOUGLAS SANITARIUM,  
1836 NORTH FAIR OAKS AVENUE, PASADENA, CALIF.

Honorable members of the committee, in reviewing progress within the last decade toward solving the multiplicity of problems and situational adjustments facing the older segment of our population, I take pride in our country's great strides in providing resources in the area of housing, medical care, recreation, research, and income maintenance. We have come far in recognizing the need for more adequate basic necessities for a comfortable survival even though it may be true that our growing concern with the problems of aging stems from an egotistical interest of most people in relation to their own future. Since several aspects of our modern way of life seems to militate against a satisfactory adjustment in advanced years there is increasing awareness in the middle-aged members of our population of life's more competitive character, quickness of pace, ostentatious consumption which tends to make savings inadequate if not impossible and provision for their own old age with its probable biological, psychological, and economic handicaps questionable particularly in view of the current taxload, the support of still minor children and assistance to aged parents. The burden on the working population is heavy and yet we must find a way to stimulate wiser planning for their own satisfying old age at a period in life when this is still feasible.

Adults in middle life must take stock of their ability to make adaptations to reality factors. Reinvestment of emotions in other people, other pursuits, and other life settings require new learning in order to make these adaptations to changes constructive ones for it is during this period when children grow up and leave home, when the wisdom gained through life experiences should be balancing the lessening of physical powers. We should be aware of the need to change values when physical powers yield to the values of mental powers.

Too many of us have not yet accepted old age as a useful phase of living on a par with other periods of our life; we plan for the aged and push them into a "groove." We believe we are making them comfortable when in reality we are making ourselves comfortable by believing we have solved some of their problems. We project our own rejection of old age and rely too much on palliative measures.

We recognize characteristics common to the group we call aged but have we taken cognizance that each individual is different. It is time to focus more on individual needs and it is in this sphere that social services are lagging behind progress on other fronts; perhaps justifiably so, as first things first and necessities such as shelter, food, clothing, and medical care are prerequisites to life enjoyment. However, man does not live by bread alone and the older adult finds himself reevaluating his self-worth when he is no longer able to spend life working or rearing a family. He must find new ways of achieving satisfaction in roles other than the work role and new status other than being needed by spouse who may be gone or children who have major responsibilities elsewhere.

Society has not helped the individual to find a new role other than that of leisure time in recreational activities and we find many lonely old people who do not know what to do with themselves nor with the time that hangs heavy with uselessness. Many give up and succumb to physical deterioration, others flit from recreation center to recreation center vainly seeking a useful rightful place in the community and not finding it. The community has not yet found a way to give the status the aged citizens are seeking. On the other hand the older citizens have accepted what has been given to them financially without a reciprocal feeling of responsibility to contribute further of their talents to the community without financial remuneration for services. In too many instances it has been difficult to involve them in community services as volunteers or as

having a voice in community affairs. For example, it is most difficult to get them to the polls at election times.

Families have not yet found a way to provide satisfying roles for grandparents and great-grandparents and the three or four generations are now in process of experiencing personal interrelationships that are mutually beneficial even though not living under one roof. The recent tremendous changes in our way of life have created physical and emotional environmental changes in family relationships which in turn have created changes in the adjustment of the elder members of the family whose childhood patterns with their own elders no longer serve as familiar roles and they must adapt to a new as yet unsatisfying one in too many situations.

Many older individuals must find other than family satisfying human relationships as a means of achieving happiness and well-being. For those who do find this, the gradual adjustment to physical decline is less traumatic. But too many older people lack the capacity to do this on their own due to the constrained existence of their previous years. For too many the preoccupation of uselessness, facing personal death as a certainty, a constructive way of living during these older years seems an impossibility. How to reach and help all these individuals is a monumental task facing all of us. Far too many wait until major crises before seeking help.

My own major concerns at the moment are those aged individuals who are not only lonely but alone and at the mercy of anyone who sees a mercenary gain. There are those proud, independent souls who have made their own decisions and cared for themselves an entire life long who at the time of crisis become completely dependent physically or mentally; they have not been able to reverse their pattern to allow themselves to make wise provision for the emergency other than in financial protections in the way of savings. Only to find that their funds and disbursement of them for their own welfare because the responsibility of whomever gets there first. In too many situations the funds are not used to provide the best care possible and in too many instances the very independent nature of the individual has created in relatives disinterest in him or her other than a monetary one.

There is the instance of the retired schoolteacher, 67, left a widow; struck with Parkinson's disease whose brother-in-law was appointed guardian. He placed her in a private mental institution much against her will; she ran away taking the only funds she had available—a private savings account in her own name of which her brother-in-law had no knowledge. All her husband's assets were now in possession of the brother-in-law. She took a bus to California although she had no living relatives here. When she arrived in California she knew no one. Confused and ill, she rode local buses all day long trying to decide where to settle. On one bus she met a Salvation Army volunteer who befriended her and found a home for her. This friend took her money, deposited it in a bank and carefully disbursed her funds for doctor, medicines, and personal supplies until her death 2 years later. Her body she had willed to a university.

There is the case of the spinster 70 whose father had left her and her sister a considerable estate. She unfortunately suffered a stroke resulting in inability to use limbs, right arm and hand and left her incapable of speech. The sister took guardianship, placed her in a nursing home which after a couple of years changed ownership and the new owners asked for removal for nonpayment of her bill. She was sent to the county hospital and replaced in a less pretentious modest low-cost facility. Here it was discovered that she had excellent control of mental powers, a strong desire to improve her condition. Soon she was out of bed, walking in a walker, writing her wishes on a slate, gained control of bowel and bladder, showed real pleasure and interest in music and reading. When the rental fee of \$8 a month for use of a walker appeared on the bill, her sister appeared at the nursing home with an ambulance brought all the way from San Diego to remove the patient. The patient refused to leave; inasmuch as the sister had guardianship the patient was forced to leave although she insisted she would ride only in the car with the family. The brother-in-law asked for a sedative for her to make her amenable saying that in the other nursing home she had been restrained to bed all the time and this was easier. They refused to let her sit in the front seat but did spread a blanket on the back seat of the car for her and drove away. They obviously felt because she could not communicate in the normal way that she was mentally not competent.



There is the case of a man whose funds in a savings account drew the attention of a bank clerk when a "friend" of the client asked to withdraw a substantial amount. He had a note from the elderly man saying he wished the funds released to this individual to further this person's artistic talents. The bank clerk having taken a liking for the old man visited and found he was living in squalor. The artistic friend's mistress was supposedly providing for the old man's physical comforts in the way of cleaning his room and giving food. The bank clerk was unable to find any responsible relatives and his efforts to locate a responsible community agency resulted in guardianship given to the woman who was already caring for him.

Then there was the elderly gentleman who in an emergency collapsed on a sidewalk was taken to county hospital where he had to remain until a public guardian could be appointed because he had lost the use of his hands and could no longer write checks to pay for medicines and care.

My second major concern at the moment is the need for a more realistic approach to planning for the ill aged person on the part of families and communities. Family members are wrought with emotional conflicts of guilt, over identification, childhood unresolved parental resentments and financial stresses which affect their choice of plan and influence strongly the decision to keep an ill person in a home situation not conducive to his or their welfare, or to place an ill person in a setting that does not really meet his needs. Very often ill persons are placed in boarding homes because this setting is more familiar, more attractively acceptable to the family and their own prestige relationships with contemporaries or because it is more financially possible although their medical needs are not met in this setting and the chances for restorative recovery is seriously impaired. Also too often ill persons are placed in medical settings which they outgrow but for lack of followup remain in this setting too long thus being deprived of a more normal way of life.

In addition to the inability to realistically assess the needs of the older person in accordance with his financial, physical, and emotional limitations since families tend to see their loved ones in their former state of health and status, there is as yet not sufficiently knowledgeable use of community resources with real understanding of what each can offer. What each family is really seeking without realization is to restore the aged person to his former status quo and has not yet accepted well the dependency, the physical and possibly mental deterioration because these are painful and burdensome. Real help is needed by an overwhelmingly large number of families in resolving these conflicts.

I am respectfully submitting these humble opinions and observations acquired from my past and present experiences with older people and their families in my professional capacities.

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PREPARED STATEMENT OF JANET J. LEVY, EXECUTIVE DIRECTOR.  
LITTLE HOUSE, 800 MIDDLE AVENUE, MENLO PARK, CALIF.

Chairman McNamara and committee members, both as special consultant to the Citizens' Advisory Committee on Aging and as executive director of Little House, senior activity center in Menlo Park, it has been suggested that I contact you to state the needs for the expending of Federal effort for the furtherance of programs for the aging.

In preparing the survey and directory of California "Community Leisure-Time Activities for Older People." I visited over 500 individual programs throughout the 58 California counties. Although there are differences of interest and activity, there is a general need for encouragement and support from State and Federal resources. In many communities where the need for senior programs has been recognized there are either existing facilities or volunteer organizations which might be utilized in the development of activities and programs. However, the lack of direction and coordination often prevents the development of a local center or group. In many instances the support and approval of a governmental agency may be the sole stimulant necessary to further these activities.

In my work at Little House I have the daily opportunity of observing the effects of a comprehensively planned program for persons over 50 from all levels of economic, social, educational, and cultural backgrounds. The preventive aspects of an all-inclusive schedule within a center not only affords the

individual a new way of life, but the community prospers from the many advantages gained through the services and activities of a healthy older population. I believe it can be readily proven that there is a definite decline in the ratio of mental illness with planned senior activities. Since mental illness has been recognized as a grave national problem it behooves your committee to take as many preventive steps as possible, consistent with its "charter."

Another grave problem facing communities in other States as well as California is that of the retired military personnel, as observed in San Diego and Monterey, Calif. These retired men in their forties and early fifties present a dual problem in that they have long periods of leisure time, or offer themselves at a reduced rate to the local labor market, with a subsequent adverse effect upon the local economy. A partial remedy for this problem is the provision for an adequate leisure-time program and the conditioning of these people for this type of activity prior to their retirement.

Evidence of the validity of the above may be seen in practice at Community House, Bakersfield, Calif., Pasadena and San Francisco senior centers, as well as the aforementioned Little House in Menlo Park.

I hope this information will prove to be of benefit and interest to your committee and will form a portion of whatever legislative action you may recommend.

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BOARD OF SUPERVISORS, COUNTY OF LOS ANGELES,  
383 HALL OF ADMINISTRATION,  
*Los Angeles, Calif., October 26, 1961.*

HON. CLAIR ENGLE,  
*U.S. Senator,  
Senate Office Building,  
Washington, D.C.*

DEAR SENATOR ENGLE: At its meeting of October 24, 1961, at the suggestion of Chairman Ernest E. Debs, the Board of Supervisors of Los Angeles County adopted an order requesting that an expression of its support of the plan to enable workers to add to their social security payments during their working years in order to pay for their hospital needs after retirement be conveyed to you, as chairman of the Senate Subcommittee on Aging.

Very truly yours,

GORDON T. NESVIG.

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4610 WEST MYRTLE, *September 9, 1961.*

HON. CLAIR ENGLE,  
*U.S. Senate, Washington, D.C.*

DEAR SENATOR ENGLE: Many of our citizens are trading hard premium dollars for nickels in medical benefits.

It is hoped that your subcommittee will point up these low-benefit, high-expense companies. Even the "responsible, old-line" carriers have poor records, especially in individual (nongroup) coverage, which is all that is available to most of the old folks and a good deal of the young folks.

Over a recent 4-year period (1955-58), in California, only 44 cents out of every premium dollar was returned in actual benefits (all carriers, individual policies). Some pay out less than 10 cents on the dollar.

It is doubtful whether our old folks, with low incomes and much medical need, can stand to pay this high overhead (salesmen's commissions, profits, advertising). Much of this overhead would be eliminated largely under a social security medical care plan, and the APA thinks it is high time we got one.

Hundreds of old folks (and young folks), have written us for advice on health insurance. They don't seem to have any protection from the dubious operators in the business. And even the highly respected, well-known carriers can't fill the needs economically.

We will be glad to help your subcommittee in any way we can.

Sincerely,

JOSEPH A. KING.

*All health insurance—California business—Year ending Dec. 31, 1959*

Name of carrier	Direct premiums received	Direct losses paid	Percent of total premiums paid out in medical benefits
Westland.....	\$2,853,313	\$1,077,455	37.0
Family Life.....	133,898	9,160	7.0
Industrial Life.....	198,823	39,243	20.0
Massachusetts Indemnity & Life.....	1,233,935	389,507	31.0
Midland National Life.....	191,758	15,518	8.0
Monarch Life.....	1,875,726	837,336	44.0
Old Security Life.....	96,186	9,793	10.0
Stuyvesant Life.....	406,290	35,830	9.0
Volunteer State Life.....	1,359,596	282,234	20.0
Beneficial Standard.....	7,970,616	2,958,908	32.0
Reserve Life.....	8,206,595	4,102,989	50.0
Credit Life.....	278,223	4,901	1.7

NOTE.—Although the figures are for all health insurance business (group, accident and health, noncancellable, and medical and hospital), most of these companies did little "group" business in California, specializing in individual policies. The exception on this list is Volunteer State Life, which sold group policies only in California in 1959.

Source: 92d Annual Report of the Insurance Commissioner of the State of California (for the year ended Dec. 31, 1959). See table No. 4, p. 114, ff., and table No. 14, p. 158, ff.

[Reprinted from the Californian]

THE HEALTH HUCKSTERS: A CALIFORNIA SCANDAL

(By Joseph A. King<sup>1</sup>)

PART I: PROFITEERING HOSPITALS AND KNIFE-HAPPY DOCTORS

A scandal of major proportions, a story of how hospital profiteers and insurance racketeers are milking the consumer of millions of dollars, driving up medical costs, and threatening his right to good medical care, is buried deep in the appendix of a California Assembly Interim Committee report prepared by Ronald Brooks Cameron of Whittier.<sup>2</sup>

Given skimpy 1-day, one-column treatment in a few California newspapers and completely ignored by others, the Cameron report tells about health hucksters like Dr. Frederick Gruneck of Los Angeles, a man who knows how to make a quick million on a nonprofit hospital. It tells of insurance racketeers like the Westland Life Insurance Co., that pay out more in salesmen's commissions than in medical benefits to their policyholders. It tells of profitmaking "nonprofit" hospitals, unethical doctors, lack of hospital planning, a shortage of accredited hospitals, and an oversupply of small hospitals. It tells how this combination has made California the highest-cost hospital area in the country. The nationwide average cost in a three-bed ward in 1958 was \$15.91, while it was \$21.50 in Los Angeles and \$23.12 in San Francisco.

But the most chilling conclusion of the Cameron report is that California is a dangerous place for one to be if he is sick. Or even if he is healthy, for that matter. Scalpel-happy physicians abound. Profiteering hospitals raid the patient's pocketbook and the insurance company's treasury with utter disregard for medicine or man.

It is a bizarre and depressing story, but one which medical consumers interested in their purse—and in their pulse—should know about. So, let us begin with the Cameron report's account of Dr. Frederick Gruneck of Los Angeles, whom many people in the town of Ojai, Calif., wish they had never seen.

<sup>1</sup> Joseph King is president of the American Patients Association and instructor of English at College of the Sequoias, Visalia, Calif. This is pt. 1 of a 2-part article dealing with racketeers in the medical, hospital, and accident insurance business. Many of the facts in pt. 1 are from the Cameron report.

<sup>2</sup> California Assembly Interim Committee Reports, 1959-61, vol. 15, No. 24, December 1960, pp. 95-130.

When Dr. Frederick Gruneck set his sights on Ojai in 1958, he had already established a reputation as one who knew how to make a quick buck on a hospital. As majority stockholder of the Northridge Hospital in the San Fernando Valley, Gruneck shared considerably in the profit of \$45 per patient day on an average charge of \$70. The Northridge Hospital sold out to a nonprofit corporation with a profit of \$127,000 on an investment of about \$500,000. The nonprofit corporation then contracted with Dr. Gruneck (as part of the deal) to serve as "administrator" for \$1,000 a month for 12 years, and as a "consultant" for the next 10 years at \$900 a month. In the event of the 60-year-old Dr. Gruneck's death, the entire contract is to be paid into the estate, for a total of \$252,000 profit. Grand total profit so far, \$379,000.

But Dr. Gruneck is not one to miss a chance of exploiting his Hippocratic oath for all it is worth. He did not stop with a mere \$379,000 profit. The nonprofit corporation leased back the Northridge Hospital pharmacy and gift shop—with a \$13,000-per-month volume of business—to a corporation headed by, you guessed it, the good Dr. Gruneck. And the owners of the land, of which (you guessed it again) Dr. Gruneck was the majority stockholder, netted a profit of \$217,435 (200 percent) on the sale to the nonprofit corporation.

Dr. Gruneck then invaded Ojai—with stethoscope, fat bank roll, and new plans for building a 25-bed hospital. He ignored citizens of that town who were debating whether to establish a hospital tax district. In the midst of the debate and before the tax district advocates could secure financing, the good physician from Los Angeles announced his plans for building the 25-bed proprietary hospital. The announcement ended any chance of the community's obtaining Government funds to help with the construction. Availability of such funds (Hill-Burton Act) depends upon the number of existing hospital beds in the community. But Dr. Gruneck prevailed, despite the protests of the leading citizens, most of Ojai's physicians, the Ojai Valley News, and Gordon Cumming, chief of the bureau of hospitals. Dr. Cumming was quoted by the Ojai Valley News of December 11, 1958, as saying:

"The residents should not consider building a hospital until the area can afford at least a 50-bed hospital. An institution must be at least that size to afford the expensive equipment used in modern medical research."

Two town meetings were held in Ojai in December of 1958 to discuss the threat posed by Dr. Gruneck. Despite the obvious desire of the townspeople to develop their district nonprofit hospital, it was only a short while after the meetings that the wishes of the townspeople were ignored. Dr. Frederick Gruneck, owner of two highly profitable proprietary hospitals in the City of the Angels, began construction of a hospital. Every form of exposure was used, including help from Blue Cross, the chief of the bureau of hospitals, and other well-known people in the field. The efforts failed. There was no way in which the hospital building could be stopped.

#### NONPROFIT IS PROFIT

In the Newspeak of the Ministry of Love in George Orwell's "Nineteen Eighty Four," love is hate and freedom is slavery and peace is war. In California hospitalese, medicine is money and nonprofit is profit. Or so the Cameron report indicates. The story only begins with Dr. Gruneck. He is just one of many who have found the land of milk and honey in nonprofit hospitals.

The profiteering is all beautifully legal. Investment brochures cited by Assemblyman Cameron brag about the big money to be made on the pain and suffering of fellow man. A brochure for Anaheim Memorial Hospital indicated a projected income of \$1,092,018. Cameron says that \$500,000 was put up by the investors. In 5 years they will have recovered their investment and paid off a large part of the loans made to buy the land and build the hospital. This is supposedly a nonprofit operation.

Another of many examples cited by Cameron of complete disregard for the consumer's pocketbook—as well as community desires and needs—is the Martin Luther Hospital in Anaheim. The gold seekers who built this hospital did so over protests of some segments of the community that there were many unoccupied beds in the existing hospitals in the area which were running only 60 to 70 percent occupancy. The hospital profiteers ignored the protests, built the hospital, then turned it over to a nonprofit corporation established by two small Lutheran churches. The nonprofit corporation agreed to pay excessive rent, \$500,000 a year, to the investors. (Assemblyman Cameron reports that there may be a fundraising drive in the community. But some community leaders, he says, will oppose such flagrant and profitable cynicism.)

The Cameron report goes on to cite example after example of the rape of the consumer's purse by the hospital buccaneers. His documentation is thorough. A Culver City Hospital report shows a net income in one quarter of \$41,115, with a gross income of only \$265,300. A sales brochure prepared by the American Hospital Management Corporation for Morningside Hospital in Los Angeles, 86 beds, showed a projected income of \$1,084,136, and a projected net profit of \$129,888. The total cost of this hospital was estimated at \$900,000, of which the investors reportedly put up \$300,000. A sales brochure for Bon Aire Hospital, 39 beds, predicted an annual profit of \$91,500, with the value of the hospital estimated at \$400,000! The operating profit would pay for the hospital in less than 5 years.

Investment in hospitals, Cameron claims, can be more profitable than investment in oil, even when the well is a gusher. He was unable to find a single dry hole among the proprietary general hospitals of southern California; 25 to 30 percent of capital investment per year is considered by shrewd investors to be minimum profit. His evidence points to the half truth that skyrocketing hospital costs are due to expensive new techniques, machines, services, and maintenance.

The other half of the truth involves the hospital profiteering that Cameron documents so thoroughly. It involves also the wasteful duplication of services that stems from the inability of the public to plan, coordinate, and control the expansion and new construction of hospitals. Some of Cameron's findings:

There is nothing to prevent a hospital's purchasing equipment for its own use without regard to the needs—and the purses—of the community.

According to Mark Berke, director of the Mt. Zion Hospital and Medical Center in San Francisco, in a 1958 speech, five hospitals in San Francisco were approved for open heart surgery. Others were planning to install the necessary expensive equipment, even though three such installations would be sufficient. San Francisco hospitals have six electroencephalographs. Only one or two are fully used. Several hospitals are considering installing cobalt bomb units at a cost of \$60,000 each. Only one is needed.

The planning of facilities on a coordinated basis is one of the most fertile areas for reduction of costs. Unfortunately it is one of the most difficult to achieve. It involves the autonomy of individual boards of directors, medical staffs, and hospital administrations. Each with its vested interests, its own philosophy, and its own desires.

Governor Brown's Committee on the Study of Medical Aid and Health in California, his advisory hospital council, and Cameron's own investigations all indicate that a lack of planning has resulted in too many beds in certain areas. This leads to abuse and high costs.

Voluntary planning, endorsed by organized medicine, has not worked. Cameron proposes legislation to give the public, through a State agency, control of construction and expansion of hospitals in California. His proposal is resisted by the California Hospital Association and the California Medical Association.

A voluntary plan adopted for both the Los Angeles-Orange County and San Diego metropolitan areas pointed out that no hospitals of less than 150 beds should be built in either area. The plan was blissfully and legally ignored by the hospital profiteers. Ninety general hospitals were built in Los Angeles from 1950 to 1959. All but 17 were under 150 beds. In San Diego, seven or eight new hospitals are being planned, or are under construction. All, says Cameron, are under 70 beds. The Governor's advisory council predicts that 160 new hospitals will be built in Los Angeles by 1975, with all but 14 being under 100 beds.

Ray Everett Brown, director of the Chicago clinics and hospitals, and a past president of the American Hospital Association, estimates that an unoccupied bed costs about 80 percent of the amount that it costs to maintain an occupied bed. He further estimates that more bed-days were lost in 1958 because of non-occupancy than were paid for by all Blue Cross plans. Mr. Brown advocates franchising of hospitals and stricter licensing through governmental action. Otherwise there is no stopping the upward spiral of hospital costs.

Overlapping, competitive hospitals lead to unnecessary hospitalization of patients. A lawsuit was filed in 1957 in Los Angeles against the board of directors of a Los Angeles hospital (not named by Cameron) by a doctor who alleged that he was removed from the staff because he did not bring his "quota" of patients to the hospital.

A 1958 Los Angeles County Federation of Labor AFL-CIO report charged that kickbacks were made to doctors by some hospitals.

In some hospitals in Los Angeles, according to a 1959 series in the Los Angeles Mirror News, the patient who enters with a broken toe may get a GI series, chest X-ray, urinalysis, EKG, or other unnecessary tests.

#### THE DANGER TO LIFE

Hospital profiteering, waste, fraud, and flagrant disregard of the consumer's needs and purse do not make up the whole story contained in the Cameron report. Not only is the consumer's purse raped, but his very life has been placed on the sacrificial altar of greed.

Now, to say that our lives are being threatened by the practices of many physicians and investors is to accuse our fellow men of being evil persons indeed. If not in intent, at least in practice. But the charge must be made. The evidence is in the Cameron report. That the California press has only skimmed the surface of this story (almost always omitting the names of profiteering doctors, investors, and insurance companies) is hard for some observers to understand. That these same newspapers can devote lavish amounts of space to corruption in labor and in government (always citing the personalities by exact name) and to the popular syndicated doctor who gives kindly free diagnosis by mail to those who prefer it that way, forces Assemblyman Cameron to wonder if our newspapers are really interested in the public interest.

Doubt as to the integrity of California's hospitals was first called to the public's attention in 1958 in the famous Blum report. This report on the practices of 10 large hospitals was prepared by Richard Blum, Ph. D. of Stanford, for the California Medical Association. To this day, very little of the Blum report has been released by the CMA. To this day, the CMA keeps it securely under lock and key. It is unavailable even to top-ranking medical authorities. Assemblyman Cameron, therefore, had access only to the released portion. But even that little bit indicated that barbarism and cynicism were riding high in the "noblest profession." The story of two surgeons having a fist fight over a patient on the operating table until one was floored, the story of the dying patient who was refused admission to a hospital because a doctor did not like his health plan (supposedly Kaiser), and others of a similar nature, caused James E. Smits, president of the Hospital Council of Southern California, to be quoted by the Los Angeles Times on August 28, 1958, as follows: "I see no reason why the survey should be an indictment of the hospitals, as we have no control over the doctors." This has caused Assemblyman Cameron to wonder who does have control over the activities of doctors in the hospitals, if the hospitals themselves do not.

By virtue of his State-issued license, any physician can do just about anything he pleases with the human body. If he violates his Hippocratic Oath or engages in malpractice, he is secure in the knowledge that his fellow physicians will not testify against him in the event of a court action. It is a gentlemen's agreement. And so the physician may perform in many hospitals surgical operations and other procedures for which he is not especially trained. He may write prescriptions which do no good at best and are positively harmful at worst. He may subject the patient to expensive procedures which do nothing but empty his purse or the insurance company's treasury. Some evidence in the Cameron report, much of which indicates that the problem is not restricted to California:

#### UNTRAINED SURGEONS

Paul R. Hawley, M.D., director of the American College of Surgeons, was quoted by Medical Economics on July 6, 1959, as saying that 50 percent of our surgery is done by untrained surgeons and further that our health plans do nothing about the quality of care. The New York Times quoted Hawley as saying: "Inadequately trained doctors were doing an increasing amount of surgery because every insured patient was a paying patient."

#### UNNECESSARY SURGERY

Even the Journal of the American Medical Association, neanderthal in economic matters, but usually quite sound in strictly medical matters, played tattle-tale on the pseudosurgeons in their midst. The March 29, 1952, Journal carried an article by Edward H. Daseler, M.D., which stated:

"It is obvious to me, after practicing surgery in the Southwest for 2 years, that huge numbers of perfectly normal, undiseased inflamed organs, e.g., ap-

pendixes, uteri, fallopian tubes, ovaries, and even gall bladders, are being removed for one reason only: extirpation of the customary fee from the pocket-book of the unwary patient or his relatives."

POOR LABORATORY SUPERVISION

In 1960, the American College of Pathologists warned doctors that 78 percent of the hospitals of under 100 beds had inadequate laboratory supervision.

INABILITY TO MEET STANDARDS

Dr. Kenneth E. Babcock, Director of the Joint Commission on Accreditation of Hospitals (a purely private agency—no hospital need apply for accreditation), reported that in 1959, 1,000 out of 4,000 major hospitals inspected failed to meet standards of good hospitalization. During the year, 223 accredited hospitals had taken a turn for the worse. Of the 1,000 mentioned, 400 were refused accreditation, 600 put on probation. In addition there were 2,000 hospitals that were not accredited or that were under 25 beds and were not inspected. Dr. Babcock goes on to report that in one hospital 600 out of every 1,000 operations were abortions. In another, 380 uteri were removed, of which 300 were unnecessary. James C. Doyle, M.D., assistant professor of gynecology at the University of Southern California, earlier made a similar study of hysterectomies performed in southern California hospitals, with similar results.

NO WAY TO STOP UNETHICAL PRACTICES

Since the actions of the Joint Commission on Accreditation are voluntary, those hospitals and doctors who want to practice in an unethical way continue to do so.

MOST HOSPITALS NOT ACCREDITED

Twenty-nine and three-tenths percent of California's nonprofit hospitals and 79 percent of the proprietary hospitals are not accredited. Estimates indicate that California will continue to have more of the small hospitals. These are usually proprietary and generally not interested in accreditation.

FAILURE OF VOLUNTARY WAY

The Joint Committee on Accreditation (the doctors' own organization) has done a conscientious job of trying to elevate standards. But it has no control at this time over almost one-half of the hospitals in the United States. It has not succeeded in protecting the consumer from the unethical and incompetent doctor.

SITUATION WORSE IN CALIFORNIA

In California, the situation is worse than in the country as a whole. Cameron's figures:

*Percentages of accredited hospitals in California*

Type of hospital	Number	Percent accredited
State.....	2	100.0
City-county.....	51	52.9
District.....	48	35.4
Nonprofit.....	181	70.7
Proprietary.....	161	21.0

PROFIT HOSPITALS MEET NO STANDARDS

A Los Angeles County Federation of Labor, AFL-CIO, study conducted in 1958 revealed that many profitmaking hospitals met no standards at all.

HOSPITALS WITHOUT DOCTORS

In southern California, in 1958, only 36 out of 84 proprietary hospitals had a doctor on duty 24 hours a day. In nonprofit hospitals, only 35 out of 69 had doctors on duty 24 hours a day. How many deaths have occurred because no

physician has been on duty. Cameron cannot estimate. The situation, he says, is analogous to classrooms without teachers. George Schecter, formerly administrator of the American Hospital in Los Angeles, proposes that every hospital have a licensed physician or surgeon on duty 24 hours a day.

#### WITHHOLDING OF RECORDS

The American Patients Association and other consumer organizations have proposed, Cameron says, that hospitals be required by law to have an independent pathologist review all tissue slides, and that patients' medical records be microfilmed and made available to the patient or his representative. One of the most frequent complaints received by Cameron has been the inability of patients to secure their own medical records. They appear to be readily available to everyone else, including insurance personnel.

#### DISHONEST REPORTING

That there is need for honesty in examining tissue removed in surgery is testified by Drs. Myers and Stephenson, reported in the December 25, 1954, issue of the *Journal of the American Medical Association*:

"Not all surgical tissues are diagnosed honestly. Some surgeons are reluctant to accept 'normal tissue' as an accurate diagnosis. Some pathologists are coerced into attempting to report some pathological process in every specimen. Some physicians are unwilling to criticize the surgery of a colleague. The decisions of the tissue committee are sometimes not recorded properly, making it difficult or impossible to evaluate the surgery later."

If these difficulties exist in accredited hospitals, Cameron says, conditions are worse in the nonaccredited ones. He cites Richard Blum's recommendation that hospitals should be obliged by law to make minutes of their staff meetings. Blum believes that these minutes should be available to the public. A lay person should be invited to sit in as an observer on committee meetings. Blum proposes an accreditation system to be operated by a State agency, with renewal each year of the accreditation status. Any doctor found to violate hospital rules would be reviewed continually. If there was no improvement, then his work would be restricted. He could be reinstated only with approval of the accreditation team. Small hospitals, Blum believes, should be limited to emergency work, diagnostic procedures, and minor operations.

Assemblyman Cameron's proposals for reform have been placed before this session of the California Legislature in Sacramento. It is a mild program. He proposes a compulsory master plan for hospitals to eliminate needless duplication. He would allow the State boards of medical and osteopathic examiners to set up medical practice standards for hospitals. He would require hospitals to publish a price list for all services and not base the charge on the available health insurance. He would provide that all hospital financial records be uniformly kept and an annual report on them be submitted to the State department of public health. He would repeal a law which required that information on hospitals cannot be disclosed—even to the legislature.

The need for this legislation in the interest of the consumer is obvious to Cameron and to consumer groups. Nevertheless, it is being opposed with all the force of the rich and powerful California Medical Association.

Cameron told this writer last September that he had to conduct his investigation without funds because the chairman of the insurance and finance interim committee—Democratic Assemblyman Thomas Rees—feared CMA reprisal in his Beverly Hills district if he showed signs of actively supporting an investigation. Cameron says that 70,000 letters were sent out by the organized doctors last fall in an effort to defeat him in Whittier. And now, he says, the CMA has carried its fight to the bars and banquet halls and hotel suites of Sacramento. Ben H. Read, an old hand at lobbying for the CMA, reported spending \$2,704 to influence legislation during January of this year. Of this amount, \$1,895 was paid directly by the California Medical Association to Sacramento's Hotel Senator.

In the latter part of February, CMA-lobbyist Read was the host to a lunch for members of the assembly public health committee. Cameron claims that the fate of his bill to force hospitals to open their records was decided at this lunch. But he has promised to continue his fight to protect the consumer dollar—and the consumer heartbeat. He believes that society has certain rights and one of them is to know exactly what is going on in our hospitals. He believes that



society should have the right to provide good and economical and safe medical care for itself. He says that society goes to great lengths to protect its money, even to the extent of the Federal Government insuring bank deposits. Why shouldn't it go to equal lengths in protecting flesh and blood? he asks. Is life of less importance than money?

PART II: THE MEDICAL INSURANCE RACKET—THE RAPE OF THE PREMIUM DOLLAR

The story of the rape of the consumer purse and threat to his heartbeat does not end with the California hospital profiteers and unethical physicians. Also buried in the Cameron report are the facts on medical insurance profiteers. The report tells how they, too, are freely driving up medical costs and draining the consumer purse.

The treatment given this story by the California press is hard to understand. This writer has been unable to find specific mention of the names of the insurance racketeers unmasked in the Cameron report in any of the newspapers of San Francisco and Los Angeles. The public should have these names. How else, Assemblyman Ronald Brooks Cameron asks, can the individual protect himself from the fast-talking salesman representing an insurance company that returns to its policyholders less than 10 cents on every dollar collected in premiums?

The insurance salesman basks in the holy image of the insurance industry's own creation. He pictures himself as a defender of the American way. He is the bulwark against socialized medicine. He is the promoter of a good, clean, and economical way of protecting Americans from financial disaster caused by illness.

The Cameron report points to the lie in the self-image. The truth is the commercial medical insurance business is the most deceiving business operation devised by man. It is wasteful and inflationary. It appears to be without conscience.

The truth is that the share of the premium dollar taken from the trusting individual policyholder and earmarked for benefit payments is sometimes less than the salesman's commission. In most cases, it is less than operating expenses. Some figures on four companies which do a large business in California:

*Hospital and medical individual policies only<sup>1</sup> (1958 only)*

	Estimated premium	Percent paid in benefits	Salesmen's commission percentage
Monarch Life.....	\$2,754,557.37	44.5	36.9
Westland Life.....	3,318,701.81	41.5	44.1
Beneficial Standard.....	13,587,559.74	42.4	16.3
Constitution Life.....	8,520,000.00	50.0	23.0

<sup>1</sup> Figures are for all business of the carrier, not just that done in California.

Source: Annual financial statements, California State Department of Insurance.

These four companies, Cameron says, have been the target of a great number of complaints. A typical complaint comes from the policyholder who finds out for the first time of the conditions that are excluded when he files a claim. One of the most flagrant cases cited in the Cameron report involved a 69-year-old woman who had a policy since 1956. In 1958 she was approached by a salesman for Westland Life Insurance Co. who convinced her, after a long sales talk, that she should drop a policy of Constitution Life Insurance Co. and take Westland, which he alleged was much better and only slightly more expensive. In 1960 she was operated on for a hernia and her claim was refused on the ground that the condition had existed prior to taking out the policy. In reviewing this complaint it was found that the policy was only slightly better and that the premium was much higher. But more important, her Constitution policy would have covered the operation and paid a total of about \$400. A complaint has been filed with the insurance commissioner by her own doctor, who states that the condition was not preexisting.

"To date," Cameron says, "the claim has not been paid."

You should not be led to believe that the four companies cited in the table above are exceptions to the milk-the-purse rule of the commercial insurance companies. Cameron states that the average return in benefits on the premium

dollar for all health insurance business transacted in California, all individual policies, is only 44.6 percent. When you consider the fact that the Social Security Administration—which is a Federal Government insurance agency—pays back in benefits over 98 cents on every dollar collected, it is easy to understand the opposition of the insurance lobby in Washington to proposals for financing medical care for old folks through the social security mechanism.

Only rarely, Cameron says, is the consumer share of the premium dollar (on individual policies) more than the operating expenses of the carrier. Some figures:

*Hospital and medical individual policies only<sup>1</sup>—(4-year period, 1955-58)*

	<i>Percent of total premiums paid in benefits</i>
American National.....	36.1
Business Men's Insurance.....	45.0
California Life.....	37.2
California Standard.....	29.8
Connecticut General.....	39.6
Indemnity Insurance Co. of America.....	6.8
Mutual Life (New York), 1958 only.....	24.5
New York Life.....	39.7
North American Life.....	26.4
Pacific Mutual.....	37.8
Provident Life and Accident.....	48.9
Security Life and Accident.....	28.2
Washington National.....	43.3

<sup>1</sup> Figures for all business of the carrier, not just that done in California.

Operating costs exceed benefits in every case cited in the above table. You will note that the Indemnity Insurance Co. of America paid back only 6.8 percent of the premiums collected. The figure is not a printer's error. Fact after fact in the Cameron report points to how very little the consumer is getting on his medical insurance dollar. Just how many policies would be sold—and how many would be canceled—by the poor policyholder if the figures cited by Cameron were widely known, it is impossible to estimate. That the California newspapers have ignored or suppressed these facts is a reflection on our free press. The newspapers have not acted in the public interest. They have not told their readers that policyholders would do better putting their hardearned cash in the bank instead of investing in dubious health insurance schemes.

Cameron's figures are not guesses. Some were taken from statistics compiled for Governor Brown's Committee on the Study of Medical Aid and Health in California. Some figures (on group insurance) are available in the file of the insurance commissioner for the State of California.

The facts cited so far are for individual and medical policies. An even worse picture is found in accident and health policies, with one company, Stuyvesant Life, paying out only 3½ percent in benefits during the 4-year period of 1955-58:

*Accident and health insurance individual policies only<sup>1</sup>—4-year period, 1955-58*

	<i>Percent of total premiums paid in benefits</i>
American Casualty.....	29.3
Continental Casualty.....	37.2
Federal Life and Casualty.....	13.0
Fireman's Fund.....	34.2
Hearthstone.....	19.6
Indemnity Insurance Co. of North America.....	23.1
For 1958 only.....	12.4
Stuyvesant Life.....	3.5

<sup>1</sup> Figures for all business of the carrier, not just that done in California.

The truth is that even greater profits are reaped by the insurance companies than are indicated by these tables. When the insurance company takes the customer's dollar, it invests the dollar. It makes a profit on this investment. The tables do not reflect this investment income. Since Stuyvesant Life returns

only 3½ cents on the premium dollar, it is not an exaggeration to say that this company actually returns less than nothing of the hard-earned money of its policyholders!

Some other companies cited by Cameron, with figures for noncancelable individual policies:

	<i>Percent</i>
National Life & Accident.....	16.7
Continental Assurance.....	23.6
Union Mutual.....	18.2
Massachusetts Casualty.....	12.4
John Hancock.....	15.9

"It is no wonder," Cameron says, "that there is widespread dissatisfaction with individual insurance policies."

With such a small amount of the premium dollar returned to the policyholder in the way of benefits, Cameron charges that the result has been misrepresentation of policies, cancellations when coverage is most needed, overselling, refusal of coverage to many persons, and limitations and restrictions through health statements and preexisting condition clauses that are misunderstood.

Cameron recommends legislation to protect the consumer from misrepresentation and gouging. One possible way to drive the racketeers out of the business, he says, would be a legal requirement for the grading of policies in relation to benefits. The Governor's Committee on the Study of Medical Aid and Health in California has made the same recommendation. Policies would be graded A if the company has paid in the previous year or averaged over a 5-year period 75 percent claims ratio, B if between 65 and 75 percent, C if between 50 and 65 percent, and D if below 50 percent. For new companies, a projected expense and commission schedule would have to be considered in grading the policies. The legislation proposed by Cameron would require insurers to refund part of the premium if benefits fall below minimum standards.

Another Cameron measure would block cancellation of policies held by persons who develop major illnesses, or who become aged and therefore poor risks. Complaints have been received, the Cameron report says, from persons who say that policies they have held for many years have been canceled arbitrarily by the insurance carriers. The cancellations invariably come at a time when the insured person is suddenly taken sick. He is then quickly notified that his policy would be canceled on the 1st of the following month (the next renewal date). To restrict such unethical practice, Cameron proposes that insurance carriers be required to write only noncancelable types of health insurance.

"If a company is required to write only noncancelable types of health insurance," he says, "it is hoped that many of the misrepresentations made in the past will be eliminated."

Another frequent complaint of the policyholder is the "exclusions" listed in small print. "I have health insurance," medical writer Richard Carter joked. "If a giraffe bites me, I get \$50, if my wife is not pregnant." Cameron believes there is some truth in the joke. So he proposes that illnesses excluded from the benefits be listed prominently on the face of the policy, in type of at least the same size and style as that with which benefits are listed, and on the same page. The same goes for all sales brochures.

GROUP POLICIES

So far only policies sold on an individual basis have been discussed. The group insurance picture is better. While the average return in benefits for individual health insurance is 44.6 percent, the average for group insurance is 75.9 percent for all business done in California, 1955-58. But even in the group business the range is wide.

*Group insurance (all health insurance), California business only, 1955-58*

	<i>Percent of premiums paid in benefits</i>
Industrial Life.....	5.3
Fidelity Life & Income.....	14.4
Manhattan Life.....	21.7
National Casualty.....	54.8

The reader should be certain that the figure for Industrial Life is not a printer's error. This company returned barely a nickel out of every dollar

collected for group insurance sold in California during the 4-year period, 1955-58.

What these insurance companies have been doing and how much profits they have been reaping after the year 1958 is almost impossible to find out. Up to 1958 a provision in the Rees-Doyle Disclosure Act provided that duplicate copies of the Federal disclosure form be filed with the Insurance Commissioner of California. This provision was discontinued. And now group policyholders, trustees, and welfare fund officials can find out next to nothing concerning the operations of other policyholders and insurance companies. Trustees are often unaware as to what administrative costs, expenses, and commissions of insurance companies and other operational costs are reasonable and customary.

A glaring case, concerning the Metropolitan Casualty Co. (now out of the group health insurance field) and the Los Angeles Hotel & Restaurant Owners & Culinary Workers fund, could not be exposed if it happened today. In this case, a 15-percent commission was paid to a broker in 1953, resulting in a payment of about \$49,000 on a premium of slightly over \$300,000. The usual commission on this type of policy would be from 1 to 3 percent, probably not in excess of \$5,000. In this instance, the trustees of the fund disclaimed any responsibility through a letter to the insurance commissioner, pointing out that they knew nothing of this agreement, and that it had resulted only in loss for the company since the benefits paid had exceeded premiums earned. (But few losses occur in this group business, Cameron says, if investment income is counted.)

Cameron says the excessive commission paid by Metropolitan Casualty Co. was revealed to the trustees of the fund only when the insurance company filing was made necessary by the Rees-Doyle provisions. Similar information, he says, is on file in Washington. But the expense of securing it when needed is almost insurmountable, except in the most serious cases. Cameron proposes that a duplicate copy of the Federal reports be filed with the State department of insurance.

Some more figures for group insurance carriers cited in the Cameron report:

*Group insurance (all health insurance) <sup>1</sup>, 4-year period, 1955-58*

	<i>Percent of premiums paid in benefits</i>
American National.....	70
Business Men's Assurance.....	65.8
Washington National.....	69.9
Mutual Life (New York).....	99.1
Firemen's Fund.....	74.6
American Casualty.....	70.9
Continental Casualty.....	64.4
Indemnity Insurance Co. of North America.....	54.6

<sup>1</sup> All business of the carrier, not just that done in California.

Cameron notes that some group carriers may return 80 to 95 percent of the cash collected from the policyholders. At the same time, he says, you cannot judge the efficiency of commercial health insurance just by a look at the percentage of premium returns. Although a company may return 90 percent in medical benefits, this is not proof that all is rosy for the consumer. There is plenty of evidence that commercial health insurance—by giving an incentive to the physician and the hospital to base their charges not on what the patient can afford to pay, but on what the insurance company can pay—has driven up medical costs in California and elsewhere.

Figures compiled by Governor Brown's Committee on the Study of Medical Aid and Health in California, cited by Cameron, indicate that medical expenditures in 1959 were 111 percent of the 1939 Consumer's Price Index, and hospital expenditures were 329 percent of the 1939 index.

A survey of the Consumer's Price Index illustrates how medical-care costs have risen in comparison to the overall cost of living during 1947-59, the period of greatest health insurance growth:

	1947	1959
All items.....	95.5	123.7
Medical care.....	94.9	148.6

The increase in medical care costs during this period was 50 percent greater than for all items. Californians have been especially victimized by this inflation. In California the difference in hospital costs is even greater, Cameron says, when it is considered that in 1959 the average daily cost for hospitalization in all general hospitals in the United States was \$28.17, whereas the average in Los Angeles has been estimated at \$50, with some hospitals averaging as much as \$70.

The Cameron report does not give a complete picture of the rise in hospital and medical costs and their relationship to the increase in prepaid care. But some evidence in the report points to a fatal flaw in the whole commercial health insurance scheme. That flaw is this: losses are more important than benefits, profits are more important than people.

#### INSURANCE COMPANIES NOT TOTALLY TO BLAME

The rapid rise in medical costs and insurance premiums, Cameron says, is not wholly the fault of the insurance companies. That the doctors and hospitals must share the responsibility is suggested by some facts:

The administrator of the Motion Picture Health and Welfare Fund (Ted Ellsworth, who helped Cameron with his study) in 1956 issued a report indicating that by increasing benefits for the administration of anesthesia by 25 percent, its insured members realized only an 11-percent gain because of increased doctors' fees.

The Medical Claims Bureau of Los Angeles reported charges of \$1,000 for a hernia, \$800 for a hysterectomy, \$150 for a cystoscopy. Dr. Robert Kimbro, in Medical Economics, reported charges of \$1,800 for removal of an eye and \$1,000 for a thyroidectomy; and he estimated that under major medical insurance, doctors' charges were 20 to 25 percent higher than private patient fees.

In a survey made for the San Francisco Labor Council in 1954, E. Richard Weinerman, M.D., of El Cerrito, Calif., estimated that 50 percent of the premium dollar went to expenses or unnecessary services.

Jerome Pollack, program consultant for the Social Security Department of the United Auto Workers, AFL-CIO, in 1956 reported that a UAW program, in which benefits were raised 26 percent, yielded only a 9-percent gain to the worker because of increased medical fees.

The Health Information Foundation, in a 1958 study, found that 14 percent of insured persons were hospitalized each year, only 9 percent of the uninsured, and that the percent of patients having surgery was almost double for insured patients.

The Health Insurance Council, in a survey for 1955, found the cost of medical care for a family to be \$145 per year if insured, \$62 if not insured.

An official report of the Medical Services Committee of the Los Angeles County Medical Association, in 1959, stated:

"With the creation of these funds to provide a degree of protection against medical indigency, there developed in some physicians a subversion of motives wherein the welfare of the patient becomes secondary to the financial welfare of the physician. \* \* \* Our committee has so far received records which reveal the most flagrant abuses, overcharging, overuse, and fraudulent practices, but too often have felt frustrated in making adequate disposition of these cases due to lack of policy as formulated and approved by the council of this society."

The insurance companies are powerless to stop the unethical doctors and hospitals who are raiding their funds. Many insurance carriers and welfare fund officials in Los Angeles, Cameron says, consider it a waste of time to file a complaint with the Los Angeles Medical Association regarding a complaint against one of its members. He has heard from many people who claim that the Los Angeles Medical Society has ignored their complaints.

Rollin Waterson, a medical economist for the California Medical Association, stated at a union conference in San Francisco:

"The more insurance coverage you buy, the more utilization you have, the more X-rays are taken, the more lab work is done. \* \* \* You say it has to stop and I agree with you."

In a report to the Los Angeles County Federation of Labor, AFL-CIO, in 1958, a union hospital committee told of a case at a North Hollywood hospital (unnamed by Cameron) which it had visited because of a complaint from the Teamsters Union. A charge of \$167.52 for 3 days' hospitalization for an ingrowing toenail was reported. The average daily charge in this hospital was admitted to be \$55 to \$57. The owner of the hospital, a Medical Doctor, ad-

mitted that this type of surgery could be done in his own office. When asked why the hospital did not deny such doctors staff privileges, he stated that they would merely go to another hospital, and his occupancy would drop.

The Health Plan Consultant's Committee, AFL-CIO, submitted a bill of particulars to the Hospital Council of Southern California showing variations of as much as 300 percent for identical items.

Voluntary policing by the doctors doesn't work. The doctors' Hospital Council of Southern California set up some Guiding Principles to receive complaints, hear them, and make adjustments in fees if called for. The Guiding Principles are strictly voluntary; they have been ignored, they have not worked. In one instance cited by Cameron a welfare fund submitted a complaint against the Valley Hospital in Van Nuys. This hospital promptly refused to abide by the council's decision and took the patient to a small claims court. About 50 hospitals in Los Angeles which has subscribed to the Guiding Principles were recently visited to determine if the charging schedules were readily available. In most cases, Cameron says, the clerks either knew nothing about the Guiding Principles or referred the investigators to the hospital council. In only two cases did they make the schedules available. The Guiding Principles, effective since July 1, 1959, still have not made the pricing methods of hospitals easily accessible or understandable to the public. Cameron also found that the worst hospitals either do not subscribe to the Guiding Principles or pay no attention to them.

So, Cameron concludes that existing health insurance—including group policies—is not the answer to a thrifty public's prayer. The truth is, if the percentage paid in benefits is high for some companies selling group insurance, the rise in the cost of premiums has been continuous—and it is far out of proportion to the general rise in the cost of living.

#### BLUE PLANS NOT THE ANSWER

Even the nonprofit health plans—Blue Cross and Blue Shield—do not provide the answer to the problem of skyrocketing costs. Beginning April 1, 1960, Northern California Blue Cross individual subscribers from Fresno to the Oregon border will have had their rates increased by 24 percent. In a March 1, 1961, statement to the Blue Cross Board of Directors, J. Philo Nelson, executive director of the service, said that hospital bills have risen 8.8 percent in northern California in the last year. He reported that the per diem hospital bill has jumped from an average of \$33.46 a day to an average of \$42.12 a day, an increase of 26 percent.

"Our rates are tied to hospital costs," the Blue Cross spokesman said. "They will continue to go up as long as hospital rates rise."

The Cameron report figures indicate that Blue Cross-Blue Shield programs in California consistently pay back a higher percentage of the premium dollar in medical benefits than do the commercial carriers. His figures show that the Blue Cross ratio of benefits to premiums is 94 percent for group policies (as compared to 75.9 percent for commercial carriers in California); 89 percent for individual policies (as compared to 44.6 percent for commercial carriers in California), and over 100 percent on group conversions. Nationally, Blue Cross pays back in benefits 97.4 percent of premiums on all policies. In California, commercial insurance pays back in benefits 66.7 percent of premiums, all policies.

But even the efficient Blue Cross operation, the Cameron report indicates, cannot control the pricing policies of the individual doctors and hospitals. The Blue Cross rates, along with the commercial insurance rates, rise as the unregulated doctors and hospitals inflate the medical economy. And the unregulated commercial carriers dig into the prime risks in the ranks of the Blue Cross subscribers. This leaves Blue Cross more and more topheavy with oldsters—who have the greatest medical needs.

Now, Ronald Brooks Cameron, Democratic assemblyman from Whittier, Calif., is a conservative. His proposals in this session of the legislature in Sacramento are an attempt to save commercial health insurance and the Blue plans at a time when more and more Americans are becoming aware that socialized medicine has worked well in 59 civilized countries, has provided a sound economic base for medicine, and eliminated a family's fear of financial disaster caused by sudden illness. That the chamber of commerce, the California Medical Association, and the insurance industry—all longtime foes of socialized medicine—are lobbying mightily in Sacramento against the man who proposes to save private in-

surance is hard to understand. Unless it is another example of Jenkinson's law: Everybody's crazy.

Cameron's legislative program for insurance, like his program for hospitals, is mild. He would set minimum standards for insurance policies "to get some of the racketeers out of the business." He suggests that no company returning less than 50 percent in benefits be allowed to operate in California. He would make all health insurance policies noncancelable. He would require all policies be convertible so a person leaving a group insurance plan can get an individual policy with the same benefits at the same, or slightly higher, rate. He would require a full premium refund if a person cancels a health policy within 10 days after receiving it, so the salesman cannot cheat. He would allow a person to receive benefits from health insurance equal only to his total economic loss. So much for the heart of the program. Nothing bold, nothing revolutionary, yet the insurance lobby and doctors' lobby are waging mighty war against the man who proposes to save them from what they fear the most.

If the lobbyists for medicine and insurance succeed, Cameron says, the consumer will be the loser. His plan, if adopted, would save "absolutely" 25 to 30 percent of the cost of health insurance plans, he says. It would help, he says, 80 percent or 12 million residents of California get more out of their health insurance dollar.

Although Governor Brown is supporting the program and although the Democrats control both houses of the legislature, Cameron's program faces tough sledding. The insurance and doctors' lobbies are rich and powerful.

"I am continually amazed," said Cameron in March 1961 in a Los Angeles speech, "at the raw power of organized medicine in our society and of medicine's ability to marshal this power at what it considers to be a time of need."

The chamber of commerce and organized medicine have never been famous, among professional economists, for their economic wisdom. So, many observers are not surprised by their efforts to torpedo legislation in the interests of good business and good medicine. The stalwarts of standpatism, Cameron believes, think that they are making a choice for the status quo as opposed to the Cameron program. But the choice they are really making is that of socialized medicine. As private insurance continues in its failure to provide full and economical coverage to all our citizens, and as unregulated doctors and hospitals continue to inflate the medical economy, socialized medicine begins to look more and more attractive to Americans.

As big medicine and big insurance try to close the door on Ronald Brooks Cameron, they unwittingly open the door to what they fear the most—the dragon of socialized medicine.

The knight of medicine then mounts his steed. His suit of armor is bad economics. His motive is self-interest. His shield is public ignorance. His mace is cliché. Toward every suspect windmill he charges, believing the dragon socialism to be hiding therein.

#### PEOPLE DIE NEEDLESSLY

(The following is a copy of one of many hundreds of letters received at national headquarters of the APA during the past few weeks, all pointing to the urgent need for new thinking on the problem of medical care and fees.)

SACRAMENTO, CALIF., *January 6, 1960.*

Mr. JOSEPH A. KING,  
National President, American Patients Association,  
Visalia, Calif.

DEAR MR. KING: It was most gratifying, the item about APA in today's Sacramento Bee.

Having undergone several major operations including a craniotomy, coupled with the fact my husband has multiple sclerosis, I am an expert conversant on the sinful medical fees for those chronically ill. Last year our medical bills totaled \$1,500, for seven doctors. Three hundred dollars of this was a fair surgical fee; \$160 was for hospitalization insurance; but let us calculate that seven doctors each received \$175 from each two people who called on them last year. From 300 to 500 different patients per year at this figure would place their income in the \$50,000 to \$90,000 bracket.

Patients need good doctors but they also need to feel the doctor is their friend, in order to really heal emotionally. This they cannot realize when the sting of "high charge" hits them. Many people die needlessly because they cannot pay these charges and will not humiliate themselves begging.

I believe we must have a change and have talked for a long time about forming an APA. However, I've been too busy trying to exist and keep my ailing husband on his feet through giving sound nutrition and exercises.

I have had several years' public experience prior to the beginning of all my surgical bouts in 1953. I am 52 and quite a "platformer" against medical gods. I would like to help the APA grow to national status. At any rate I want to be kept posted on the association's program and become a paid member if financially feasible.

Sincerely yours,

Mrs. \_\_\_\_\_

P.S.—I might add that for the past 7 years we have had Federal audit because of the unbelievably high medical deductions.

DOCTOR BILLS BANKRUPT INSURANCE COMPANY

SACRAMENTO, *January 12, 1960.*

To: J. A. King, APA President.

DEAR MR. KING: I am in sympathy with your statements made to the Bee and over KGO San Francisco not long ago. I have spent 14 years selling health and accident and hospital insurance, representing many different companies. I also worked as an insurance adjuster in San Francisco.

Health insurance plans are seldom adequate. The reason is the cost of a good policy is higher than most persons could or would pay, so limited policies are sold, because no others can be sold in volume.

I worked for an insurance company that went bankrupt selling a \$25 deductible policy, paying all doctors' bills up to \$500. The doctors really clobbered us, and we were paying out \$2 in claims for every dollar we collected in premiums.

It is common knowledge to most insurance salesmen that the medical charges are based on how much insurance is carried. Often the charge is based on double whatever the policy pays. A person with no insurance may pay say \$200 for an operation, while another person with a surgical policy paying only \$150 for the same operation will be charged \$300. So he might as well not have a policy.

I, personally, as a hospitalization insurance salesman, carry big hospital insurance, but no doctor benefits, on the assumption that my doctor bill would only be increased by the amount paid by my policy, whereas a hospital room is so much per day, regardless.

The above does not apply to all doctors, of course, but the average doctor in northern California makes over \$5,000 per month, so they have told me, and it is difficult for folks making \$250 or \$350 a month to afford services. Even the plumber is getting in the same class today.

My stepmother is a Christian Scientist, so has no doctor bills. I suggest that the Nation go Christian Science and no M.D.'s will be necessary.

Eventually the United States of America will have fully prepaid medicine, surgery, dentistry, etc., and it is up to fellows like you to hasten the day when we join other civilized countries like England and Sweden.

Sincerely,

Mr. \_\_\_\_\_

EXCERPTS FROM SOME LETTERS RECEIVED

I am so interested, as many, many people are forced to neglect going to see a doctor when they should because of the price charged and if they do and a prescription is given they neglect having it filled, as they cannot afford it.—WHR, Fort Bragg, Calif.

I am a retired government worker. I am 73 and have a slight heart ailment which don't bother me much but medicine runs about \$30 per month and the doctor bill between \$10 and \$20 so you see I am interested in anything that would help to reduce cost. I will be glad to help APA all I can.—FMP, St. Louis, Mo.

Am definitely interested. When definite plans are formulated, please advise.—RK, Bayonne, N.J.

Am very interested in your activities. Please send me information. Good luck.—WT, Brooklyn, N.Y.

Can't afford a doctor any more. Am 65 years old. Thanks for what you are doing to help us.—MG, St. Louis, Mo.



My husband and I and numerous friends read with much interest your letter in the December 17 San Francisco Chronicle. We would be most grateful to be kept advised.—MW, Berkeley, Calif.

It wouldn't surprise me if the medical associations tried to put you out of business. They have made laws before to promote their own best interests. Millions are happy that you have started this. Millions will join.—NPP, St. Louis, Mo.

Something definitely should be done in America for old folks who need more treatment and have only small pensions.—EDM, Flushing, Long Island, N.Y.

Suffering should not be subject to the profit motive of individual enterprise, when the best care of all patients is the main consideration. The present system of hospitals in America, of segregated care according to social and economic means is clearly undemocratic. When hospitals are administered like the school system, for the equal of opportunity of all, we will benefit greatly, certainly.—RH, Fresno, Calif.

If you are able to get something going in your area, let me know what lines you are following and I will try to be of assistance to you here in Bakersfield.—JF, Bakersfield, Calif.

I am a medical patient who needs your organization.—HS, Westphalia, Mo.

Read the item in the St. Louis Post-Dispatch about APA and wrote to my Congresswoman and also to the two U.S. Senators from Missouri about your badly needed organization.—TEP, St. Louis, Mo.

#### EXCERPTS FROM SOME LETTERS TO APA

If you're serious, hell, yes, I'm with you 100 percent. The doctors and their henchmen, the drug manufacturers, are financially ruining us.—PHF, Paradise, Calif.

I think our present system, which frankly puts profit ahead of humanity, positively indecent. Every human being ought to be entitled to the best possible medical care and education, and anything I might help to do to hasten that day, well, I shall do.—SLW, Oakland, Calif.

Congratulations on sentiments expressed in your letter to the San Francisco Chronicle. Such an organization as yours is vitally needed. Having had a long and catastrophically expensive illness, this subject is very important to me.—MJ, San Mateo, Calif.

Your letter to the St. Louis Post-Dispatch interested me and I would like to help.—MG, St. Louis, Mo.

I am a member of the California Teachers Association. I feel that many CTA members would be interested if they were properly informed, as would members of other similar groups.—RSC, Tulare, Calif.

We are interested in your American Patients Association which we read about in the San Francisco papers. There is a great need for a sound, comprehensive, prepaid medical and dental plan. The various plans—Blue Cross, union funds, Kaiser plan, etc.—all only stand in the way of a sound national plan. Even worse are the special funds for cancer, polio, etc.—again they stand in the way of really adequate medical research.—M and JM, San Francisco, Calif.

I am thoroughly in accord with your program (postcard from California legislator).

The American Patients Association sounds good. Doctors seem to feel that they should charge all the patients can possibly pay.—DLB, San Antonio, Tex.

The president of the above group of senior citizens would be interested in hearing from you. She hopes to go as a delegate to the White House Conference on Aging in January 1961.—FR, New York City.

I read your letter in the New York Post and am with you all the way. It is about time that the people of this country had a little to say about how they are being gouged.—HG, Los Angeles. (I have brothers still living in Scotland who visit me, and when they see and hear how we are treated by the doctors and dentists, they are absolutely shocked.)

Would like to hear from you as I am much interested and think that American Patients Association is a necessary thing.—FW, San Francisco.

It's about time we patients took a stand against the high cost of medical care. Congratulations to Tulare County.—PWD, Oakland, Calif.

Please enroll me as a member of your organization and send me any literature you have. We have needed you and your APA for a long time. God bless you.—**MBR**, Alameda, Calif.

My wife recently had a cataract operation on one eye and the doctor's charge for this operation was five times more than Blue Shield paid us. Any help I can give APA in St. Louis?—**HOW**, St. Louis.

Here in San Francisco a 5-minute doctor's call is \$7.50, too much for everybody.—**IVS**, San Mateo, Calif.

You'll have trouble with people who have holy fear of any change being "socialized medicine." Why not call yourself the "Stars and Stripes Security Plan"?—**FBH**, San Francisco.

Your work to help the patients of America interests me. I am the editor of a small co-op paper.—**IDF**, Brooklyn, N.Y.

I am interested in your organization described in your letter to the New York Post. How may I join with you?—**NLN**, Jamaica, N.Y.

I am interested in your group and its objects as doctors seem interested in prolonging life so they can get bigger fees from patients on fixed incomes.—**FR**, New York City.

Clients of mine express interest in your association as outlined in your letter to the Post.—**BJ**, attorney, New York City.

I want to congratulate you for your wonderful idea. In our rich country with very advanced medicine, a big segment of our people, especially the middle income group, are deprived of that progress. I'm ready to join with you, anytime.—**MB**, New York City.

The APA, working for the interest of the health of all people, is the most sensible idea I've seen in print. I will be most happy to help with the organization.—**EHL**, Tulare, Calif.

I have contacts with many organizations in the bay area. Will you be willing to speak to them? I can arrange speaking dates. Many doctors will be our good, if secret, friends.—**FC**, El Cerrito.

One of my reasons for leaving Visalia, Calif., was because of the high cost of medicine. Now I am closer to Oakland and the Kaiser plan.—**VL**, Fresno, Calif.

Doctors who are raking in more than \$20,000 per year on maternity fees alone, at a local hospital, decided this was not enough. They have raised their fees again, from \$150 to \$165.—**HH**, Visalia, Calif.

617 WEST SEVENTH STREET,  
September 13, 1961.

HON. CLAIR ENGLE,  
*U. S. Senator from California, Senate Office Building, Washington, D.C.*

DEAR SENATOR ENGLE: There has just come the mimeographed announcement of the field hearing of your Subcommittee on Aging on October 24 at Los Angeles.

If the schedule permits, I should like to present a very serious problem of people upward of 65, and more particularly those upward of 70, on the matter of automobile public liability insurance.

On all sides I hear complaints from clients and friends who have "committed the crime" of attaining the age of 65, that public liability coverage of \$100,000 or \$200,000 per person and \$200,000 to \$300,000 or \$500,000 per occurrence, is arbitrarily reduced to \$5,000 and \$10,000 respectively, even though they have perfect driving records, and never incurred a loss for insurance companies to pay and even though as individuals they are more alert and careful drivers than many people of 50.

This absurd notion that old age and decrepitude are wholly chronological with no differentiated consideration of the individual comes into glaringly vivid contrast with the unlimited coverage afforded men and women in middle age brackets who drink three or five or more highballs or cocktails and then get out and drive—unlimited coverage until some horrendous accident. One of the most unfortunate political results in self-defensive bloc voting, probably lead by demagogues, lies as a potential in the 15 percent of people over 65 who still feel that they are entitled to be dealt with as individuals and not merely herded in consequence as though everyone over 65 must necessarily be decrepit.

Those who operate casualty insurance companies would shriek State socialism if insurance became a function of the several States, but unless they have at least the amount of civic sagacity which would warn them that if 15 percent of the voting power is a bloc of people who feel they are being unfairly treated and discriminated against, they will bring about just this result.

Even in the highly hazardous group of college-or-shortly-after showoff driving by young males there may be a rate-up, but at least there is coverage provided.

Soundly exercised business judgment can, it seems to me, obviate this instance of bloc voting, which is undesirable, and no less avoidable.

Perhaps putting this letter in the record at Los Angeles may serve the same purpose as an appearance.

Sincerely yours,

LINDSTROM, ROBINSON & LOVELL.

FAIRMONT HOTEL, SAN FRANCISCO, CALIF.,

September 14, 1961.

HON. CLAIR ENGLE,

Senate Office Building, Washington, D.C.

DEAR CONGRESSMAN ENGLE: I received a notice that you are holding a meeting in Los Angeles in October for the purpose of finding some means to take care of the older people. As you are a Congressman from California, and as I have lived in San Francisco all my life and have spent a great deal of my time doing civic and charitable work, I feel that I am well qualified when I say that various committees have been formed for the purpose of trying to help the older citizens. I am most interested in the welfare of our older citizens, and I think for the past 6 years I have demonstrated my interest in their welfare, but I am getting a little tired of hearing about all of the various organizations and committees that are being formulated in Washington for this purpose.

I would like to say at this time that we have had an organization here in San Francisco for the past 6 years known as Careers Unlimited for Women. The purpose of this organization was to try to find jobs for older women. This is a strictly volunteer organization and we do not charge either the employer or the employee for this service. Mr. Benjamin Swig, the owner of the Fairmont Hotel, who I am sure you know very well, is the president of Careers and has given us free rent in his hotel for the past 6 years. He also gave us the first money with which to start the organization. We have one paid woman who receives \$100 a month and we are naturally obliged to pay for our telephones, printing, stationery, postage, and a few other incidentals. Aside from that, this is all of the expenses that we have in operating this office. We are most fortunate in having about 10 or 12 outstanding civic-minded women who devote 5 days a week around the clock on a strictly volunteer basis, and I also direct the organization on a strictly volunteer basis.

In the past 6 years we have placed over 3,600 women in good jobs all the way from 40 years of age up to and including 70 years of age. It was a terrific fight during the first 2 years in trying to convince employers that older women were as capable of filling jobs such as stenographers, bookkeepers, general office workers, sales people, receptionists, domestic help, nurses, in fact, every type of position that a woman is capable of filling.

The many firms who refused to employ older people are now using our service and have testified that they were wrong by not employing older people. I have many letters from big firms who tell us that these older people do a much better job than most of the young people, mainly because it has always been so hard for an older person to get a job, and once they are able to secure employment they are much more reliable because they know how hard it was for them to be gainfully employed. I have been told by many employers that there is less absenteeism with older people.

I continually read in the newspapers and hear over television and radio of the large sums of money that is being spent by the Government in building homes for the mentally ill. A great number of our outstanding doctors have told me that mental illness could be reduced by 60 percent if these people were allowed to make their own way in the world rather than worry themselves into mental sickness because of the fact that they cannot take care of themselves. I am very proud to say that the biggest proportion of our American citizens do not want charity, but through no fault of theirs they are forced to accept social security, unemployment insurance, and even old-age pensions; and you know, as well as I do, that these highly intelligent capable women cannot take care of themselves on the small amount of money that is given to them through these various agencies. In other words, you, as a Senator of the State of California, know that if we are at any time to be able to reduce our tax burden, this is one way that I am sure these people, if gainfully employed, would be able to pay their share of taxes such as local, State, and Federal, and when they are able to earn a decent living wage, they are allowed to buy some of the good things of

life which they so richly deserve, and then they are not compelled, through no fault of theirs, to live off the tax rolls. In other words, they then become taxpayers.

I know this is a very long letter and a man as busy as you are with the affairs of the Nation probably will not even have time to read it, but I am sure that as a Californian you have read the newspapers over the years and have seen exactly what they think of this organization of ours. We are the first of its kind in the Nation. I sent a letter some time ago to the Secretary of Labor in Washington, D.C., and received an answer from one of his assistants. I also sent a letter way back on January 12 to President Kennedy but have never received an answer.

The life insurance companies have said that in the past 20 years, due to the various types of new drugs and the great advance in surgery, the life of women has been extended about 13 years greater than before, and for the men, around 8 or 9 years. If these people are to enjoy longer life, I am afraid they have nothing to look forward to when there is discrimination against age. I think that some of our big firms, by forcing retirement at 60 and 65, have found themselves in a bad position, mainly because it takes time to train people and as we all know, there is no substitute for experience. I feel that older people, working in various types of business, when they reach the retirement age, should be allowed to take a physical examination and if they are in fine physical condition and mentally alert, they should be given the choice to either retire or to continue work.

We have a very small operation, but if organizations similar to ours were created throughout the Nation in all metropolitan cities, I am sure that we would be able to take care of our older citizens and in return they would create a greater buying power which would be good for our economy.

I am sure that there are quite a few of your colleagues who know me and could very easily tell you of the work I have done over the years on a strictly volunteer basis in my beloved city. In 1941 up to and including 1946, during World War II, when I had the distinct privilege and honor to work with the U.S. Treasury Department as a dollar-a-year man, first as associate administrator, then as coordinator of payroll savings plan, U.S. Treasury, and later as chairman for fraternal and service organizations in northern California, I was responsible for the sale of \$800 million worth of war bonds. I am sure that if you take the time to check this statement you will find my record with the U.S. Treasury Department. The only reason I am calling this to your attention is to let you know that I have served my country with the best of my ability and I have been the head of many organizations and charitable drives that have been put on from time to time. This I am very proud of because at no time, whether I was working with the U.S. Government or with local and State governments, did I receive or ask for one penny for my service. My great love and devotion to this great country of ours, and the privilege of being a citizen of this country makes me feel very humble in the small amount that I have been able to contribute with the privilege of living in the greatest country in the world.

I hope that you will accept this letter in the spirit that prompts me in writing it to you; knowing that you have always been a devoted public servant, I feel that you would like to know of organizations such as ours, and I would appreciate any suggestions that you may be willing to give us for the benefit of the organization.

Sincerely,

CHARLES ROSENTHAL,  
*Executive Director.*

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PREPARED STATEMENT OF MRS. DAVID S. COMFORT, PRESIDENT, CITY OF COMMERCE SENIOR CITIZENS CLUB

Members of the City of Commerce Senior Citizens Club are very much concerned with the need for more facilities for senior citizens.

We urge the Senate subcommittee to take appropriate steps toward this goal.

I would like to cite the role of the City of Commerce Recreation and Parks Department regarding senior citizens. They have organized a club, meeting weekly. We have social activities and also have use of the recently purchased city bus for trips throughout the area.

1814 CIELITO AVENUE, MONTEREY, PARK, CALIF.,

October 24, 1961.

DEAR SENATOR: Our names are Harry and Goldie Drobman (Mr. and Mrs., aged 68 and 65).

We reside at 1814 Cielito Avenue, Monterey Park, Calif.

Harry is a retired house painter, receiving \$116 monthly social security. Fortunately, he is covered under the senior members health plan of Painters' District Council No. 36, which benefits do not apply to the spouse.

Goldie is a retired legal secretary, receiving \$87.51 monthly county retirement and \$55.20 social security. Again fortunately, she is insured in the Kaiser (Permanente) health plan, having in 1947 left private employment to obtain work where a health plan was in effect. After paying premiums for several years, Goldie found she could not receive any medical aid after 3 months, since her physician had inadvertently listed three separate ailments in his report, one of which, arthritis, covered everything from lumbago, sacroiliac strain, etc., to sciatica. Were it not for the peace of mind resulting from her hospital coverage, Goldie would probably become a mental case just from worrying about her partially detached retina, afraid to stir for fear "the curtain would come down." In addition, while her Blue Cross was in effect, Goldie paid the difference between the doctor's fee and his reimbursement from that group.

Therefore, we concur most heartily in everything that was said in favor of a health plan under social security, as well as the inclusion of other aged not fortunate enough to have enough credits for that purpose. We are devoted admirers of George McLain, and stand behind him 100 percent. We consider him one of the great heroes of this century.

We thank you for your unfailing courtesy and patience, as well as attention. You never once left your seat. We are fortunate that you are on this committee, and are proud that you are a celebrated member of the Democratic Party.

Most sincerely yours,

HARRY AND GOLDIE DROBMAN,

1773 NORTH ROOSEVELT AVENUE, ALTADENA, CALIF.,

October 24, 1961.

DEAR SENATOR: Here is what I would have said at the hearing of your subcommittee of the Special Committee on Aging if there had been time for everyone to speak:

In long-range planning, the most important help to future senior citizens should lie in the field of helping him to help himself. The issuance of Federal income bonds, in limited amounts, which were protected against loss of principal and against rise in the cost of living would tremendously encourage workers to save throughout their active life. When purchased, such bonds would carry a moderate rate of interest as of that date, say 5 percent, and would also carry the official cost-of-living index then current. As the Cost-of-Living rose thereafter, the percent of interest paid would rise in proportion, as is done in many union wage contracts.

When the worker retired, the interest rate would be doubled at that time, and still continue to be geared to the cost-of-living or if the bond owner died, the interest rate would be doubled at the time of death (if he were still actively employed up to the time of death or permanent disablement) and the payments would continue through the life of his widow, or during the minority of his younger children.

These bonds would be uncashable as to principal, thus protecting the owner from unwise alternate investments and from unscrupulous raiders. The Government would have the use of many billions of savings, which would never have to be repaid. The worker would have a chance to invest in a sure income for his retirement, and the cost would be less than under many of the aid schemes now under serious consideration.

Under the above plan, the senior citizen would administer his own funds, pay his own rent, hire his own doctor, thereby retaining his independence of children and of government aid per se. Surely this would contribute immensely to his retention of his self-respect.

The above plan has so many long-range merits that it deserves study, even though many of its provisions might require revision, with provision of safeguards against abuse of the system, and with limitations of the amounts purchasable any 1 year of his preretirement life. Overall, the plan is fair, workable, attractive, and economically feasible.

LISLE J. MAXSON,

INTERNATIONAL ASSOCIATION OF MACHINISTS,  
214 SOUTH LOMA DRIVE, LOS ANGELES, CALIF.,  
November 21, 1961.

Hon. CLAIR ENGLE,  
*Special Committee on Aging,*  
*U.S. Senate, Washington, D.C.*

DEAR SENATOR ENGLE: I am writing you in reference to H.R. 4222, which many of our members here are vitally interested in. We urge you and your colleagues to do all in your power to assure its passage.

Please let us know if we can be of any assistance to you in any way.

Very truly yours,

RICHARD E. HARDEN,  
*Business Representative, District Lodge No. 94.*

2806 MIDVALE AVENUE, LOS ANGELES, CALIF.

Hon. Senator CLAIR ENGLE,  
*U.S. Senate, Washington, D.C.*

DEAR SIR: I learned through the Los Angeles Times that you would be interested to hear from social security pensioners how they get along with their income and what happens if one gets sick.

Now here is my case:

I am 69 years of age and get \$84 social security pension a month. Now I have another \$26 a month income from a second trust deed. Of course, even that is not enough to live on. So I go and work occasionally as extra cook at parties. Last time I got swollen feet and I had to go to the doctor.

The doctor's fee was \$10, the medicine was \$15.45 and I have to go back for shots and treatments once every week for about 6 weeks. I am not able to work right now and the doctor said that if the shots and treatment don't help I would have to go to the hospital for an operation.

Now God help me if that would be necessary. But I think I won't have to. Now you can very well see how badly we old people need a little help for medical treatments.

Thank you for listening but that's the truth. I gladly will send you the paid doctor bill and the bill from the drugstore to see for yourself that my statement is true.

Yours very sincerely,

PETER BACHMAYER.

226 IRVING AVENUE, GLENDALE, CALIF.,  
October 24, 1961.

STUDY GROUP ON PROBLEMS OF THE AGING GROUP,  
*Care of East Los Angeles Junior College.*

GENTLEMEN: Please add these two items to your research list:

1. Wives have no social security of their own. This particularly applies to a divorced woman or widow who might wish to remarry for companionship in her declining years. I understand that a woman must be not only the "legal widow" of a deceased man but must be residing with him at the time of his death. Remedy: The wife's share of the husband's social security is credited to her account yearly—the only fair way.

2. I understand that a widower pays no inheritance tax but a widow does. Please research.

Yours very truly,

Mrs. W. M. BROCKMAN.

339 EAST MOONEY DRIVE, MONTEREY PARK, CALIF.

DEAR SENATOR: Here is what I would have said at the hearing of your subcommittee of the Special Committee on Aging if there had been time for everyone to speak: I am in favor of the aged, the blind, and the disabled to pass the bill in Congress and in the Senate. I am for George McLain plan; take it out of the hands of the States and the county gestapo and snoopers; now I am on a disability pension. I was on State compensation but to save the insurance company money they put me on a handout in Los Angeles County. I am ruined for life. My age next birthday will be 59. I am much older, but I always reduced my age to hold a job 10 years, but years ago they did not have birth papers. I even got my social security number 10 years younger so now I have to be under the county gestapo; they can tell you what to eat, how much money you should

have, where you should live. I had a broken neck, a head injury, my arms and legs were injured at the Los Angeles County powerhouse.

I was pushed around for 20 on a handy out; right now I should have treatment for arthritis; now the doctor cut me down to three treatment a week; he got his orders from the county gestapo with all this trouble from year to year. I live in a neighborhood where a citizen cannot even rest in his cabin; dogs bark day and night; cannot go down to church without getting bit with a dog; the police tell me its the county to look into this dog problem, and the county gestapo will tell you its the city to move. I get \$106 a month. I cleaned up my cabin. I just cannot afford to move. The next move is a gun and start shooting every dog comes in sight; take the law in your own hands is wrong. I should be in a climate with arthritic condition. I only hoping and praying each day that you will in Washington pass the bill for \$173 at age 60. I always said we live in machine age. It should be 50 years I did shake your hand at East Side College in Los Angeles. I hope someday I could explain my troubles in person as an American of five generations. I am ashamed of the American handout to their own people. Billions for Europe, Asia, all over the world and the average American when aged, blind, or disabled are forgotten. I think the disabled should get the same amount to live on as the aged and blind. They have to pay rent and living is high.

Sincerely,

MICHAEL H. CARROLL.

121 SOUTH KENWOOD STREET, GLENDALE, CALIF.,

October 24, 1961.

DEAR SENATOR ENGLE: Here is what I would have said at the hearing of your subcommittee of the Special Committee on Aging if there had been time for everyone to speak:

First: Any ills which befall society, whether physical, political, economical, or welfare, we must first find the cause of the ills before we try to prescribe a cure.

"On November 8, 1904, I wrote President Theodore Roosevelt as follows: 'In 1850, the workers of the Nation retained for his own use 80 to 85 percent of the wealth he produced, because production was mainly with handtools and he could and did own them, therefore his production per man-hour was small, but now, through the genius and inventiveness of man we now have the machine age, where man produces many more units of wealth per man-hour than were possible or even dreamed of in 1850. Therefore, at the present time the workers are receiving only about 15 percent of the value of the wealth they produce, so, if the same ratio continues as above and no plan is adopted whereby there is a more equitable distribution of the wealth produced, we will have a complete economic breakdown between 1930 and 1935 and there will never be a sound and stable economy in this Nation until the purchasing power of the lower income people is raised so they can buy their share of the production of industry. In other words, the purchasing power of all "we the people" must balance with the productive power of industry."

"The business of the Nation has but one road to travel and that is the highway of the purchasing power of 'we the people'."

Now, Mr. Senator: You surely remember the debacle of 1929 and believe you me, deficit spending by our governments, both State and National, has been the only thing holding our economy together. There is a way out; and it is not fascism, nazism, Russianism, nor any other form of national feudalism, if we do not wait too long but the time is getting short.

First: We must change the present inadequate and expensive "social security law" to a pay-as-you-go social security insurance system, financed by a gross income tax, where every citizen pays on the same basis and everyone benefits the same. I believe the Blatnik bill, H.R. 7542, will do the trick.

Second: We must abolish our antiquated and dishonest tax system and adopt a pay-as-you-go gross income tax system patterned similar to Indiana and Hawaii's systems.

Third: All departments of our Government must use the preamble to our Constitution as a basis for our laws and decisions. Then and only then will they be just, honest, and impartial.

Fourth: The McNamara report shows that three-fifths of our senior citizens of 65 years or older are trying to live on \$1,000 or less per year. There are at least 9 million under 65 years who are in the same class. Therefore, in order to balance our economy these citizens' incomes must be raised whereby they can live

the much talked about "American Standard of Living." If we want to ward off another 1929 debacle, the economy must be balanced or we will follow the nations of the past, and, it is later than you think.

Fifth: Please always remember the consumers of a nation pay all costs including the profits and so-called philanthropies.

Sincerely,

JAMES R. LARIMORE.

2030 FAIR PARK AVENUE, LOS ANGELES, CALIF.,  
November 4, 1961.

DEAR SENATOR: Here is what I would have said at the hearing of your subcommittee of the Special Committee on Aging if there had been time for everyone to speak:

Now when we are trying to end one type of segregation—we are starting another—building small towns for senior citizens which not only segregate, but isolate them. Builders are permitted to build places for sale to people who should be renting, not buying, and using their money for unachieved dreams of travel and other enriching experiences.

Senior citizen housing should be where friends, facilities, and transportation are. A segregated, isolated senior is in prison. Seniors have their licenses to drive taken away, or are heavily penalized by insurance companies, then stuck out in the desert miles from family and friends, with no transportation or none they can use because of prohibitive cost.

As vice president of the Senior Citizens' Association of Los Angeles County, Inc., I am and have been working with seniors and am almost one myself, so feel I speak for a large number of seniors.

JANE EASTMAN.

POST OFFICE BOX 195, WOODLAND HILLS, CALIF.  
SUBCOMMITTEE ON FEDERAL-STATE ACTIVITIES IN THE FIELD OF THE AGING,  
U.S. Senate, Washington, D.C.

GENTLEMEN: A local report did not tell where to send this so I'm hoping it gets to you through channels.

The paper says Governor Brown claims the Federal Government has to do a great deal more for the aged.

May I make a point?

The desperate need is to build programs that encourage self-reliance and personal responsibility.

With due respect to the President's obsession with courage, his and your federalizing programs of cradle to grave control are making a nation of cowards and leeches of us.

There are several things that can be done:

1. Make savings going into certain "locked" accounts deductible for income tax purposes in the year in which saved, and taxable in the year they are used. Such an account would be closed out on the death of the owner, or his or his wife's if married, or the last child reaching age 21.

The locked accounts can be insurance, savings, investment groups, and the investment and take-out will be accounted for in the same way as payroll withholdings for tax purposes.

The effect will be to induce heavy personal savings for one's own future. It will be especially beneficial to the person who earns a big chunk, as a big-league baseball player, for a few years and loses much of his only chance to self-reliance because of massive income tax drains. It will tend to incite younger families to prudence, and thus, at retirement age, keep them off the public rolls.

2. Redesign the social security programs to inspire older people to get as much extra income as they can. The present law induces early retirement, when the great need of our Nation is ever-increasing productivity and services. This is the only road to great national living standards. It is silly for older people, given a chance to serve and thus benefit both from the income and from the psychological effect of being productive, to cut off their work at a certain point to keep from "losing" their social security.

3. Permit those who so desire, who have their own insurance and other personal security programs, to withdraw from the FICA program. If we are going to reward self-reliance, we want it to be true self-reliance. The fewer people



in the Federal program, who are otherwise covered by their own efforts, the lower the tax cost, and the greater the ability of the Government to help the remainder who are not otherwise able to help themselves.

4. Develop a "depreciation" program on private housing that will induce further cash saving. I'll not detail this one, here, but have it somewhat worked out to redevelop older areas, and especially to induce homeowners to have their homes paid off by the time of retirement so that they will have the most economical form of living quarters, rather than fighting for massive "low cost" senior housing. This is a poor substitute for prudence over a lifetime.

5. Start a program of encouraging senior free enterprises, so older citizens can make jobs and maintain their own security.

Gentlemen, there is nothing more dreadful than having to loaf and take charity when a man, or a woman, is in good health and mind, has certain skills and a willingness to learn others. Your State and Federal programs are not charity. They are slavements. They destroy men's souls in the name of compassion and should be kept to the utmost minimum rather than being enlarged.

6. Sound out, loudly and often, that the inflation spiral must be stopped. Unfortunately, the President has gotten rid of all conservative advisers in the field of economics, and is led by those who believe inflation is a good thing. The man himself studied his economic science in London in the most radical school outside of Harvard, and is totally unaware of the dreadful nature of inflation and its effect on the helpless older person who tried to stand on his own feet, but is destroyed by the Government's fumbling desire to be "helpful."

To stop inflation, we must take two steps. One is to cut Government as much as possible, primarily by measures such as I've outlined that induce self-responsibility for one's security.

The other is to hold wages stable. This will make you totally unpopular, and I doubt you have the courage even to discuss the matter openly, but stable wages will make more jobs, which is the only real answer to the older worker, bigotry, juvenile problems, and other such matters.

To sum up, the need is not for more Government "help," directly, but in areas which induce personal responsibility.

The most important need is for more jobmaking.

This means that almost every Government, business and labor action that reduces job opportunities is evil, if we must put a word to it.

Now then, the only real incentive to jobmaking is for men to be able to make, keep, and use money. You'd give our older citizens far more return by cutting hidden tax costs than by increasing them in order to pass them more money or help.

You must find ways that men can be induced to build jobs. This means taking the pressure off of profitmaking, and keeping.

Until you find ways to do this, you are wasting your time, and our money.

So I hope one or more of you can see this point. It is apparently rarely considered in the Senate. I do not hope to make any impression but the situation is too serious not to try.

May God guide you.

T. S. Booz, *Economist*.

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POST OFFICE BOX 195, WOODLAND HILLS, CALIF.,

October 23, 1961.

DEAR SENATOR: 1. People certainly should have their free choice of physicians to care for them, and any socialistic program will deny this.

2. There was no representative present at the hearing from Los Angeles County Medical Association, and none was invited as far as I can determine. The only medical personnel heard were from the "Ivory Tower" groups. It should be noted, however, that your hearing received very little or no publicity.

3. The greatest problems in aging are at local levels, in reference: Zoning laws, licensing agencies for out-of-home facilities, etc.

THORP A. KLUMPH, M.D.,

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525 PRINCETON CIRCLE, E. FULLERTON, CALIF.,

October 24, 1961.

DEAR SENATOR: Have been associated with the Highland Park gerontology, adult education, etc., for more than 8 years and active, also having been previously at Sacramento last October.

My desire is to see the olders gets old happily and healthy and enjoy life. I am 85.

10310 WILSEY AVENUE, TUJUNGA, CALIF.,  
September 13, 1961.

Senator ENGLE,  
Sacramento, Calif.

DEAR SIR: I am writing to you since you are conducting the hearings of a subcommittee on the aging about a matter that causes some worry and distress among some of the senior citizens. If the ruling in Los Angeles County and city could be changed on requiring the senior citizens from having to have a garage or carport on their property when they do not own or drive a car some would like to make an attached garage into a room but cannot if they do not have room for a carport. It seems so foolish when they do not even possess a car. Could a ruling or exception be made to clear up this trouble?

Why is a garage or carport required on every lot when the people don't use them when they have them? Thank you.

Mrs. FLORENCE E. THOMAS.

210 EAST BROADWAY, WHITTIER, CALIF.

Dear SENATOR: You will be somewhat surprised, if you pass H.R. 4222 as written. Why? I belong to Senior Citizens of Jackson, Mich., also of Whittier.

By talking to a great many of them, I find at least 75 percent of them could not take advantage of such a bill. Why? Because any one receiving \$150 or less a month could not have \$90 taken out of their check, also \$20 for an examination, is too much; \$10 would be enough. My understanding of that bill is some one would have the privilege of taking the amount required out of check before the recipient could get it.

What would one have to live on? The bill should have a stated amount that could be charged to the aged. I had to go to a specialist here for my eyes. When he knew of my financial circumstances he charged me \$1.50. Another time the wife and I went to a regular physician for a general checkup. His regular price for such a check was \$12 a piece, but he charged us \$14 for both.

We still have a few human beings left in this world.

Please take those loopholes out of the bill and make it more liberal.

Please show this to Pat McNamara and use it as you see fit. Thank you.

SYLVESTER D. WARE.

MY DEAR MR. ENGLE: Thank you so much for answering and heeding my voluminous letters. Well, I feel we need the good old town meeting to thresh matters out. There is a "Spit and Argue Club" in Long Beach. They get the candidates down to "brass taxes."

They have started many recreational centers. However, there should be a place to practice an instrument, sing for one's self, an automat washer, ironing, and cleaning facilities. It costs a great deal for women to keep clothes cleaned and repaired.

As for old men it is pitiful. Their clothes cost so much to get a button sewed on. Some sewing machines where women could fix clothes. In New York City, it is under the recreational department. They have sports, crafts, entertainments, etc. Also, a sort of small hospital. They advertise special nursing service to homes; I never knew of anyone to have such a nurse? Have you? Chicago has one, low prices paid.

Now, I know of one case. A certain old lady was so elated to get old-age pension. She had been on relief 26 years. You know people feel they are going to live forever. After she broke her hip, she went to hospital, then to rest home. She said food was so terrible. She signed herself out of rest home. By walking, etc., she increased her physical inability to walk but she went to a hotel room to live. No, sir; no rest homes for her. She was an American citizen.

She fell again. She had managed to walk to a nearby restaurant and get errand service to bring in groceries. She had a sick spell. Was rushed to General Hospital and then to a rest home. Her room was standing with rent paid. She was at rest home 4 days and never ate a particle of food. Her bed was not changed. The manager of rest home demanded her to sign over her whole month's check to her. Said she could make her her legal guardian. The patient did so, at request of her welfare counselor.

She went back to her room but was charged \$20 per day. The manager was 6 months in paying her back. Now, this woman was behind on rent, etc., everything.

It seems to me if we had a nursing service where one could stay in one's room or a room in this building. Oftentimes, one may have a small ailment, not serious, but he cannot get out. The landlord doesn't want one—like this one—all of this fuss. She finally landed at Olive View. But, all this extra expense?