PROBLEMS OF THE AGING

HEARINGS

BEFORE THE

SUBCOMMITTEE ON FEDERAL AND STATE ACTIVITIES

OF THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

EIGHTY-SEVENTH CONGRESS

FIRST SESSION

Part 9.—Honolulu, Hawaii

NOVEMBER 27, 1961

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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.
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PROBLEMS OF THE AGING

MONDAY, NOVEMBER 27, 1961

U.S. SENATE,
SUBCOMMITTEE ON FEDERAL AND STATE ACTIVITIES
OF THE SPECIAL COMMITTEE ON AGING,
Honolulu, Hawaii.

The subcommittee convened at 10 a.m. in the banquet hall of Ala Moana Center, Honolulu, Hawaii, Senator Oren E. Long, chairman of the subcommittee, presiding.

Present: U.S. Senator Oren E. Long of Hawaii; U.S. Senator Wayne E. Morse of Oregon; U.S. Senator Hiram L. Fong of Hawaii; U.S. Congressman Daniel K. Inouye, of Hawaii.

Committee staff members present: William G. Reidy, staff director; Miss Dorothy McCamman, professional staff member; John Guy Miller, counsel for the minority.

Senator LONG (presiding). The meeting will come to order.

First of all, I wish to express my appreciation and the appreciation of Senator Morse, my colleague, and of others who are participating, for this splendid turnout this morning.

This is an official hearing of a subcommittee of the U.S. Senate Special Committee on Aging. It is one of a series of hearings being held by similar subcommittees in some 30 communities throughout the United States. This hearing and those which will be held on the other islands are, I think, most important to the people of our State. Our subcommittees are making a continuous record to turn back to our colleagues in Washington.

It is, I think, very important that they get a true picture of what we in Hawaii find to be the problems of our senior citizens and what we have found to date to be the best ways of coping with those problems. Even more important is the fact that we in Hawaii may have something unique to contribute to the Congress of the United States on problems of the aged and the aging.

Most States have aging populations. Problems of the aging have been thrust upon them without any forewarning, and our committee has found those problems in many instances to be very disturbing. We in the islands however, have a relatively young population. The problems of the aging that have confronted our sister States will not confront us for perhaps another score of years.

Perhaps of even greater importance is the possibility—and I would not hesitate to say even the probability—that because of the varied cultural patterns existing in our State, our people are in a position to explain to the rest of our great country how one should order the relation between generations so that what they call the "problems of the aging" just do not come into existence. Perhaps they can learn from our heritage of family closeness and responsibility of one for

the other; and perhaps, too, we may learn from these hearings the importance of keeping strong the ties that bind the generations one to another.

The record which we make here in Honolulu, in Lihue, in Wailuku, and in Hilo has another kind of importance to us. Our Federal laws are made in Washington by men of good will who base the legislation they enact on the knowledge they have of the particular problem involved. If that knowledge is based upon the problem as it appears in Miami, New York, Pittsburgh, Detroit, and San Francisco, it may take a form not designed to meet the needs of these wonderful islands of ours. However, if the legislators in Washington take advantage of the kind of information which our committee is now trying to collect, if that information comes not only from the metropolitan areas I have mentioned but also from such communities as Senator Morse's cities of Eugene and Portland or from Pocatello and Boise, from Las Vegas and Spokane, and, in addition, from Hawaii, then I think we can rest assured that whatever legislation is devised in Washington will almost certainly be such as will meet the needs of our own people, as well as those of the teeming millions of the great metropolitan centers. It will be our fault if it does not.

It is for these reasons that I hope these hearings will truly reflect the experience and thinking of our island people with respect to the many faceted problems of the aging. Fortunately, we have here in Honolulu and on the neighbor islands men and women with considerable experience in coping with problems of this kind. They are so numerous that time may not permit our hearing from each of them. In any case, and whether or not we are able to take oral testimony from everyone, the contributions of all will appear in full in the printed record of our hearings.

In this connection, I should like to announce at this time that if there is anyone in the islands who has not been scheduled to testify but who has some idea or observation which he or she thinks will be of value to the committee, he or she is invited to send such a statement in writing to us within the next 30 days. It, too, will be set forth in the printed record of these hearings.

Now, before we begin, I should like to make one thing clear. This is a special committee of the Senate. That it is considered important is obvious in that it is the second largest committee in the Senate of the United States. But this committee is not concerned with any specific bill that may now be pending before Congress. I would ask our witnesses to keep this in mind. The Congress has committees which handle legislation in specific fields, but the Special Committee on Aging is not one of them. This committee does not concentrate on any one aspect of the aging problem. Its predecessor subcommittee has prepared and printed excellent reports on housing, on nursing homes, on income maintenance, on guaranteed income bonds, and on half a dozen other subjects that are of concern to elderly people. Each such report was written in terms of the whole of an elderly person's life and then referred to the appropriate legislative committee for its consideration. That and that alone is what we are here for—not to promote any particular piece of legislation. We are here to listen and to learn so that we may report back to the Congress on what the people of our Pacific islands think about any and all problems affecting the aging.

This afternoon we will interrupt the testimony of our technical experts and will have what we shall call a town meeting of senior citizens. It is my hope that the real experts on Oahu, the people who from personal experience know the situation that confronts older people, will speak for themselves and let us know what they think.

With that understood, and before introducing the Honorable William F. Quinn, Governor of Hawaii, who will be our first witness, I should like to say that, in addition to the members of the committee staff, we have the distinct honor and pleasure of having with us a man who is known to and beloved by all of us—a man who did much to help see to it that Hawaii became a State of the Union. Our good friend, Senator Morse, is here as a member of the special committee.

With us, too, we have the pleasure of having my colleagues, Senator Fong and Congressman Inouye. Although not members of our committee, they are esteemed and influential Members of the Congress.

Now, Senator Morse, if you wish to make a statement at this time, we will be delighted to hear you.

STATEMENT OF HON. WAYNE E. MORSE, OF OREGON

Senator MORSE. Senator Long, you have put it very well, as far as my part in these hearings is concerned, in your statement. I came to listen and to learn and to participate with you and our colleagues in putting democracy to work in these hearings.

I only want to say to you and to Senator Fong and Congressman Inouye that I appreciate very much the wonderful Hawaiian hospitality you have extended to me and to Mrs. Morse while we have been with you—and I am ready to hear the first witness. Thank you.

Senator LONG. We have looked forward to your coming, Senator, and we are delighted that you are here.

Senator Fong, we would be pleased to have a statement from you.

STATEMENT OF HON. HIRAM L. FONG, OF HAWAII

Senator FONG. Mr. Chairman, Senator Morse, Congressman Inouye, and members of the staff; first, may I express my sincere appreciation to you for your graciousness and courtesy in permitting me to participate in this town meeting for the State's senior citizens.

With your permission, Mr. Chairman, I will read my prepared statement, which is very brief for I know you are eager to begin taking the testimony of other witnesses present.

It may seem incongruous to some that Hawaii, a State with more than one-half of its population under age 24, should be concerned about problems of the aging. But, like everybody else, we are growing older with each tick of the clock and we are living longer. That, in itself, is not so startling. What is startling is how rapidly our over-65 group is enlarging.

Out of our total population of 632,000 some 29,000 persons are today age 65 or older. By 1970, just 9 years from now, it is estimated 49,000 persons in Hawaii will be in this age group.

Our experience will be repeated to a greater or lesser degree in every State of the Nation. It gives us fair warning that we should accelerate our efforts to meet the medical, the housing, the employment, the

recreational, and all the other needs of this rapidly growing segment of our population. We should step up our social progress.

Twentieth century America has made tremendous strides in scientific and technological fields. But the scientific and technological revolution that makes us the land of plenty, that permits more people to have more things than ever before in history, that gives us labor-saving devices, that allows us more leisure, that adds years to our life-span, has paradoxically resulted in human problems that already tax our ingenuity, our imagination, and our very best efforts to solve. The problems of the aging, to which we are devoting our attention this morning, are complex and far reaching, for we are not dealing with a homogeneous group but with a heterogeneous population.

Since the White House Conference on Aging last January, some progress at Federal, State, and local levels has been recorded. Congress liberalized the social security laws somewhat and amended the Housing Act to stimulate provision of suitable housing for the elderly. But it did not enact a Federal medical care plan for the aged, which was a great disappointment to me. If all those in the administration and in Congress who say they favor such a program will actively work for it in the next session of Congress, prospects for enactment will be brighter.

At the State and local levels, a great deal of credit is due our Governor, our State agencies, members and staff of our Hawaii State Commission on the Aging, and our many private, civic, religious, and philanthropic organizations in Hawaii. It is they who are helping to define the dimensions of the particular problems facing senior citizens in our islands. It is they who have proposed specific steps toward resolving these problems so that Hawaii's senior citizens may live in dignity and self-respect, secure in the knowledge that they will have food, clothing, shelter, and medical care sufficient unto their needs along with opportunities to lead useful, rewarding lives.

Mr. Chairman, human resources are our Nation's most valuable resources. We must intelligently cultivate, wisely conserve, and fully utilize these resources not alone for our Nation's immediate benefit, but for the benefit of future America. We in America comprise only 6 percent of the world's total population. To retain our freedom and our leadership in the world, we necessarily must make up in quality what we lack in quantity.

Therefore, it would not only be inhumane, but it would be a national folly to turn our backs on the maturity, the wisdom, the skills, the experience of that ever-growing portion of our senior citizens.

The problems of the aging are the problems of all of us, because the community, the State, and the Nation with its 180 million persons are affected directly or indirectly. It is clear the testimony this subcommittee is about to receive should be of tremendous interest not only to senior citizens of today but to those who will be the senior citizens of tomorrow. I shall follow the hearings closely, for I am certain the information and ideas presented by State officials and private citizens will be invaluable in charting our future course for Hawaii.

In concluding, Mr. Chairman, may I state that in the last session of Congress I cosponsored S. 937 with Senator Javits of New York, and other Republican Senators, providing for health insurance for

the older persons of our Nation on a program of matching funds between the Federal and State Governments. Thank you.

Senator LONG. Thank you, Senator, for your splendid statement.

Congressman Inouye, we would be pleased to hear from you.

STATEMENT OF HON. DANIEL K. INOUYE, A REPRESENTATIVE FROM THE STATE OF HAWAII

Congressman INOUYE. Thank you, Mr. Chairman, and thank you for this opportunity of participating in this morning's affair.

Hawaii has approximately 29,000 elderly people 65 years or older. In 10 years, that population is expected to increase 70 percent or about 49,000. The problems confronting the aged and their families are the same throughout the United States. Their No. 1 problem was clearly stated by President Kennedy: "* * * how to meet the cost of health care at a time when income is lowest and potential or actual disability at its highest."

There are almost 16 million Americans 65 years or older. Three out of five have incomes of less than $1,000 per year. The average old-age benefit is $74 a month. In Hawaii, 75 percent of the aging population receive benefits from the Government and for 16,000 of them the monthly benefit ranges between $35 to $120 a month. Yet, the aged have two to three times more illness than the rest of us. Three out of five have no health insurance protection. In 1959–60 the total medical expenses of the aged were estimated to be $4.2 billion. In that same year, the Federal Reserve Board survey showed that 29 percent had no bank accounts or savings bonds and 17 percent had less than $500 savings. But these statistics do not reveal the heart of the problem, namely, aged persons constantly face the threat that costly medical care will wipe out their savings and force them after a lifetime of independence to seek aid from their children or from public or private charity.

Adequate health insurance for the aged would meet the needs of millions who do not want charity but whose entire financial base and often that of their children could be shattered by extended hospital care.

The great majority of private insurance plans are not sufficient to meet the problems of the aged. Fortune magazine in its survey of retirement plans for 25 of the largest industrial corporations reported:

"There are some very stringent limitations on virtually all the industry plans. * * * Ordinarily, major medical policies available to active employees cannot be extended into retirement, even at an individual premium rate. A clause automatically canceling a dependent wife's benefits when a retired worker dies is almost universal. In some plans, medical expenses incurred by the retired worker are deducted from the face value of this company-sponsored life insurance."

The inadequacies of present insurance plans are not the fault of the insurance companies but due to the nature of the problem. The aged have higher medical costs, less money to pay for them, and they are poor health risks. They can only be properly insured by charging prohibitive premiums. I favor legislation to extend coverage of the Social Security Act to insure adequate medical care for the aged dur-

ing their retirement years. This is not a charity program. This plan is self-supporting. It is financed by increasing the social security contributions of individuals during their working years. The theory is simply to permit working people to contribute during their years of employment for adequate medical care when they become 65 years old. Furthermore, it upholds one of the major principles of the American Medical Association, freedom of choice of doctor or hospital.

The Kerr-Mills bill is complex and expensive. It assists those already on relief but it does not even make a dent in the problem of medical aid to the aged. Under this act, the aged sick must prove that they are unable to pay and have exhausted most of their assets. This degrades the self-supporting aged because it does not prevent financial bankruptcy. Carried to an extreme, it could make paupers out of an entire family. In Massachusetts, children of a patient are liable for repayment in full for the financial assistance granted.

The last White House Conference on Aging called by President Eisenhower gave overwhelming support to the thesis that medical care has become a basic human right, and not a service purchasable only by those with necessary private means. I have come to the same conclusion and feel that medical care can best be guaranteed not by charity but by methodical contributions of the insured during his working life.

Senator LONG. Thank you, Congressman Inouye.

We are honored this morning to have as our first witness the Governor of the State of Hawaii, the Honorable William F. Quinn.

STATEMENT OF HON. WILLIAM F. QUINN, GOVERNOR OF THE STATE OF HAWAII

Governor QUINN. Mr. Chairman, Senator Morse, whom I welcome here on behalf of the people of this State, also Senator Fong, Congressman Inouye, members of the staff, ladies and gentlemen: As you will see from the agenda and the list of witnesses who will appear before this honorable subcommittee, most of the persons who represent the agencies of the State concerned with the problem of the aged will appear and present the concerns of the State, present the program that the State is endeavoring to develop to grapple with what is indeed one of the most serious and growing problems that Hawaii faces, just as it is such a tremendous problem for the Nation.

Since you will hear in detail from our department heads and other persons who are interested and concerned with the problem, I shall not endeavor at this point to state in detail the various steps that the State is taking and our comprehension of the problem. I will make some general comments as they are embodied in the written testimony that I have submitted.

It is my pleasure to express to the members of this Special Committee on Aging and to your staff assistants the appreciation of the people of Hawaii for the work that the committee has set out to accomplish here in these hearings. The full facilities of the State government will be available to you to aid you wherever it is possible in your study of this important problem.

The State has been concerned for some time with the needs of its senior citizens. I am keenly aware that as our population increases,

as Senator Fong and Congressman Inouye stated, the needs of this segment of our population will also increase.

As Senator Fong said, Hawaii is a young State, not only in terms of our few years of full statehood but also in terms of the average age of our citizens. Nevertheless, 4.7 percent of our residents are over 65, as compared with the national average of approximately 10 percent. That 4.7 percent, however, is still 29,000 persons, and, as Congressman Inouye said, that is increasing and we know how rapidly it is increasing, and we know what to expect in the next decade.

So we face the challenge of making these years of retirement as satisfying as were the years of full-time employment. We would like to be able to make available opportunities for recreation, for volunteer activities, and for part-time employment if it is needed or desired to augment a retirement income. We want to be able to provide for increased health facilities which can be used in the prevention of illness, in treatment where it is required, and, of course, most importantly, in rehabilitation work.

We're trying to find every means possible. We're trying to keep up with all of the programs that are being developed throughout the country to see how we can make this life after 65 as fruitful, as productive; how we can keep the person over 65, who has so much to offer the community, in a position where he can offer it and where he can live a life that is dignified and full. And with the stimulation and assistance of the Health Committee of the Commission on Aging, the St. Francis Hospital, one of our private hospitals and a very fine institution, has become one of the first agencies in the western region to apply for a grant for home care services under the Community Facilities Act, which was passed at the last session of Congress. If this application is approved, Hawaii will be able to start a much-needed comprehensive program of home care.

As you hear some of our witnesses, you will hear some of the steps we are trying to take to get the elderly persons out of institutions as much as possible—get them in a family and home type of surrounding and, again, with the ultimate objective of rehabilitation and of a dignified, respected form of living where they can contribute, themselves, to the community as much as possible.

I appointed an interim commission on aging in 1959 to prepare for Hawaii's participation in the White House Conference on Aging. We had a State conference, and a very splendid State conference in May of 1960, preparing for that White House Conference of last year, and thereafter we sent 11 delegates to the White House Conference.

Since I am very much aware of the need to stimulate thought and action for the benefit of aging persons in all communities, I have continued the commission on aging, unfortunately still on an interim basis, from my own office until such time as it receives permanent status and support from the legislature. Thus far, I have been able to carry the operating expenses of the commission through my contingent fund. I am hopeful the legislature will see the necessity of supporting this commission as a permanent function of the Government.

One of the greatest contributions of this commission has been the creation of an increased awareness of the concerns of the aging in all parts of the State. This has been accomplished by a series of re-

gional conferences on the islands of Maui and Kauai, and by institutes and workshops here in Honolulu.

The agencies and the persons connected with the State Government who will testify before you will present the total picture of the problems of the aged in Hawaii. They will describe the actions, too, that have been taken, and actions which are contemplated for the future.

I would like to mention just a few things. I would like to mention that, effective last January, the income tax exemption for those over 65 was increased to $1,200. The 1961 legislature which adjourned last May enacted legislation which enables Hawaii to participate in the Federal medical care to the aging program as of July 1 of this year. Our proposal for a comprehensive medical-surgical and hospital insurance program for State and county employees, which takes effect January 1, 1962, was adopted by the 1961 legislature. I might say that that is unique among systems of medical-surgical and hospital insurance in that it provides coverage for the retired employees of the State, and their families as well. This is a type of coverage that the Federal system at the present time does not provide.

The legislature made several changes in the State retirement system. The pensioners' bonus is now a permanent part of the benefits, and present or future pensioners will receive an additional postretirement allowance, increasing their basic net allowance 1½ percent each year.

The fact that this subcommittee is meeting here and elsewhere throughout the country points up the fact that the time for action on the problems that confront the aging has come. It is a time for action which will be undertaken by the community, by the State, and by the Federal Government—an action taken in areas of housing—and we have some really serious problems with respect to housing for the aging here in Hawaii. In respect to health for the aging, there again we are taking constructive and forward-looking steps that you will hear about later in the areas of recreation and education.

The interest and concern which is generated now in the problems of the aging must be continually nurtured. Citizens must be constantly informed about their roles as individuals, and all levels of government must work together for the mutual benefit of all persons in the State and, certainly, for the benefit of those persons of the aged who have contributed so much to the State and to the generations which succeed them. Thank you very much, Mr. Chairman.

SENATOR LONG. Thank you, Governor Quinn. I am happy to tell you that it was largely the result of the work and recommendations of this special Senate committee that the Community Facilities Act was passed by the Congress; and I am certain that, when the question of support for the application of St. Francis Hospital comes up, you will have the united support of the delegation from Hawaii and of our good friends also.

Governor QUINN. We are very grateful for that, Senator.

Senator LONG. For some years, we have all been aware of the interest which Frank W. C. Loo, who is now chairman of the youth and general welfare committee of the State house of representatives, has taken in everything pertaining to the welfare of the people. We are delighted, Representative Loo, to have you as a witness at this time.

STATEMENT OF STATE REPRESENTATIVE FRANK W. C. LOO, CHAIRMAN, YOUTH AND GENERAL WELFARE COMMITTEE, HAWAII STATE HOUSE OF REPRESENTATIVES

Mr. Loo. Senator Long, Senator Morse, and members of the Special Committee on Aging. My committee handles legislation on aging in the Hawaii State House of Representatives.

I appreciate this opportunity to express my views on the problems confronting an important segment of our community.

Besides medical care for the aged and other services to be more fully covered by other speakers, the Government should provide these aids to our elder citizens:

1. GI bill for aging: "A square peg in a round hole" best describes a person employed in the wrong job, a job which does not suit his talents. This is a tragic waste of our human resources.

Besides wasting talents, untold human misery results. Now we are face to face with a menacing foreign power which openly threatens to bury us. We can no longer afford the expensive luxury of idling at half speed. We must employ the God-given talents of all, including the aging.

These unfortunate human beings are in jobs not suited to their talents through force of circumstances, ignorance, or family needs. These millions in chains can be helped to escape to a better tomorrow. Helping them attain their highest potential would pay rich dividends to themselves, their families, their community, their State, their Nation.

The Government should enact a GI bill for the aging. This legislation, open to those over 35 years of age, would provide for encouragement, counseling, and financial assistance, either in the form of outright grants or low interest, long-term loans.

Financial assistance would be granted to talented aging citizens to obtain training and education, either full or part-time or after their regular workday. Their family would be provided for.

The successful educational GI bill for our armed services veterans can be used as a model.

2. Reeducate unskilled aging in some skill: Unemployment statistics throughout the country underscore the obvious. This is an age which demands skilled workers. The unskilled, especially those over 40 years of age, find employment harder and harder to obtain.

The GI bill for the aging would have the Government provide these unskilled workers with encouragement, counseling, and financial assistance to learn a particular skill.

In the long run, it would be cheaper to furnish this assistance than to have them clutter up the unemployment rolls and obtain unemployment pay.

3. Think panels, think laboratories, think shops: Custom and practice have decreed that 65 is the right retirement age. Many retired oldsters still are capable of contributing to the progress of mankind. Many have pensions or other incomes, so compensation is not a large factor. In the sunset of their lives, many would be interested in leaving their mark in this world by helping their fellow men.

"Think panels," "think laboratories," and "think shops" composed of experienced retired persons can be set up by the Government to help provide answers to the problems and needs of the community,

State, and Nation. When a particular need is presented to them, they would "brainstorm" the problem or do research and experiment, until a solution is reached.

Climatewise and otherwise, Hawaii is ideal as the location for such "think panels," "think laboratories," and "think shops." As president of Foremost Thinkers, Inc., a Hawaii firm dedicated to making Hawaii the ideas capital of the world, I would like to volunteer the services of our firm to the Government to help blueprint and set up such a pioneer venture in thinking.

4. Build public facilities to accommodate the aging: Public buildings should be constructed to accommodate the young as well as the old. Concert halls, libraries, theaters, museums, art academies, exhibit halls, and other public facilities should be planned with the aging in mind. Stairs, sitting arrangements, and aisles need particular attention.

5. Taxation and financial assistance for housing—(*a*) When living with relatives: Taxes, such as income and real property taxes, should be adjusted to encourage relatives to invite the aged to live with them. Low interest, long-term loans by the Government should be available to relatives for the building of homes and home improvements, as another bedroom, to house the aged.

(*b*) Boarding homes and apartments: Income and real property taxes should be adjusted and low interest, long-term Government loans should be available to encourage private developers to build and operate boarding homes and apartments for the aged.

6. Housing in Urban Renewal and Redevelopment Agency projects: In Honolulu, as well as in other cities, Urban Renewal and Redevelopment Agency projects are present-day phenomena. The Government should make lands available in the project areas to private developers for the express purpose of providing housing for the low- to middle-income elderly. The Urban Renewal and Redevelopment Agency project areas are ideal for housing for the aged because of closeness of public transportation, markets, retail shops, banks, and recreational facilities. Many of these facilities would be within walking distances.

Gentlemen, because of time limitation, I have confined myself to painting only the bold outlines of the suggested solutions to problems facing the aging. I shall be most happy to answer questions and paint in the details.

Senator LONG. Thank you, Representative Loo. Your statement will be made a part of the record and I am certain it will be given careful attention.

The municipal organization in the city and county of Honolulu plays an important part in questions pertaining to the health, well-being, and social life of the people of Oahu. We are pleased to have as a representative of the city government a member of the council, Ernest Heen. Mr. Heen, will you take the witness stand?

He is not present. I hope that Mr. Heen will be here later.

We will move on, then, to something in which all of us have a tremendous interest, regardless of our age. That is the question of health—physical health, emotional health, mental health. And I am pleased to call upon Dr. Richard K. C. Lee, director, State department of health, as the first witness in this group. Dr. Lee, will you please take the stand?

STATEMENT OF DR. RICHARD K. C. LEE, DIRECTOR, STATE DEPARTMENT OF HEALTH

Dr. LEE. Thank you very much, Senator.

Members of the Special Committee on Aging of the U.S. Senate, members of the staff of this committee, as well as our Congressmen, Senator Fong and Congressman Inouye, and friends:

My statement this morning will be directed toward the health aspects of the aging population. Several years ago, Hawaii and our various agencies, official and private, conducted a Hawaii health survey, studying more than 3,000 household units of more than 13,000 people, with the support of the Bureau of Census and the Public Health Service, on the health record of our present population, and we found that those of 65 and over showed remarkably good health records as compared to the same age groups on the mainland and even to some of the younger groups in Hawaii. The survey that we conducted is in the material I will be submitting, Mr. Chairman.

Official and professional health services and their organization in any community are the core of community health, not only for the aging but for all our people. In Hawaii, our government vests all public health authority in a single department. There are district health offices in each county which assure uniform health services throughout the State. These district units implement specialized programs at all levels of our community. And so the Health Department of the State of Hawaii, an unusual one compared to many of the departments of health in the mainland jurisdictions, has a broad charter of authority throughout the State.

Now to speak, Mr. Chairman and members of the committee, about physicians, dentists, nurses, hospitals, and voluntary health agencies in our State as a general resource for the health of our people.

Physicians were among the earliest missionaries from New England who came to Hawaii. Today there are 638 resident licensed physicians practicing in every specialty of medicine of this State. Hawaii's physicians, to be licensed, must be graduated from a medical school or college approved by the Council of Medical Education and Hospitals of the American Medical Association. They must have lived in Hawaii for 1 year and must pass an examination or must be certified by the National Board of Medical Examiners or, if coming from foreign jurisdictions, must have additional approved hospital training and must have completed further examination requirements. We have a very active State medical association, affiliated with the American Medical Association, and four local medical societies with active committees serving the community. They sponsor symposia and conferences for the continuing education of their members.

In the area of dental health, since 1896 when 10 dentists were reported to be in practice, there has been a steady increase in the number of licensed and practicing dentists in the islands. Today there are 461 practicing dentists, for a ratio of 1 dentist to 1,300 people. For a license, potential practitioners need a year's residence in order to take the examination by the board of dental examiners.

In nursing, the board of nursing licenses professional nurses and is empowered to inspect and approve schools of nursing. In 1959 there were over 2,212 professional nurses licensed in Hawaii.

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Regarding hospital services, there are 4 general hospitals in Honolulu and 20 others serving our rural and neighbor island communities. There are 14 special use hospitals. Many of these hospitals are accredited and all are inspected for licensing by the department of health.

Under the Hill-Burton program, the Federal assistance program for hospital surveys, construction and expansion programs, hospital services in Hawaii have been greatly improved.

In the area of voluntary health agencies, the voluntary health movement in Hawaii started many years ago when Hawaii had a plague epidemic 60 years ago when citizens' committees planned future as well as immediate health measures. We have voluntary health organizations in the many categorical problems of health—in cancer, tuberculosis, heart disease, and so forth; and, in addition, we have health-minded civic groups such as the Lions Club, Kiwanis, community associations and the island chambers of commerce—all taking an active part in health promotion in our community.

Now, we come to the specific problems of health resources for the aging and the chronically ill in our State.

Several years ago, the legislature authorized the tuberculosis sanatoriums to accept chronically ill patients inasmuch as they had empty beds in their facilities. In addition, two of the sanatoriums, one on Maui and one on Kauai, have admitted chronically ill mental patients from the State mental hospital, thus relieving some of the crowding there. And these patients who have been admitted to Mahelona and Kula hospitals on Kauai and Maui, respectively, have shown wonderful response and some even have returned to their homes.

Senator MORSE. I would like to interrupt and ask if those are not senile patients, rather than psychotic patients?

Dr. LEE. These were, Senator, psychotic patients declared hopelessly ill at one time who had been given care for many years and then, in time, became senile. They were older patients who, with better care in the sanatoriums, better nursing services because of more adequate personnel, better food, not as much crowding, more attention, and together with visits from their families and friends, have shown excellent response. Some have gone home to their communities. Some were older patients, but they were not all older patients, Senator.

Senator MORSE. I would particularly like to underline your observation because we have found in hearings already conducted that there seems to be a considerable percentage of the elderly people in mental hospitals characterized now chiefly by senility or, as you say, greatly improved in their psychoses, very well—going to homes for the elderly outside of a mental institution; and, of course, the psychological effect is, in and of itself, terrific. I am very glad to know that you are following that course here.

Dr. LEE. Yes, Senator. If the Chair will permit me, I would like to say that we have a large number of senile patients who have stabilized and could improve much more than they are, because of overcrowding in our State hospitals; and we have an extensive program to try to get our people out into the homes and into the communities and other hospitals.

Now, I want to say something about our adult health program in the department, which has as its objective the promotion of positive

health in the aging members of the community; cooperation with other health and social agencies to alleviate some of the problems of aging; study of prevention, alleviation, and patient rehabilitation in chronic diseases associated with the aging process. In the rehabilitation field, this branch in our department, as well as other health department units, has actively participated in educational programs for physicians, nurses, occupational therapists, and physical therapists; and has also made it possible for patients in need of rehabilitative care to have direct evaluation and recommendations for their treatment.

The mental health needs for the aging and the aged are integrated into the total program of the mental health division of the department of health. In Hawaii, the mental health program is integrated in the health department program rather than separated as a separate department of mental health, as some of the other State jurisdictions provide. In the educational area, pamphlets, movies, and talks are used to promote mental health.

In the outpatient clinical area, all of the seven regional mental health centers and the convalescent centers diagnose and treat patients regardless of age. The Hawaii State Hospital has a medical-surgical ward for older patients with physical illness and open wards with activity programs for the ambulatory; patients are also sent to nursing homes and to tuberculosis sanatoriums on their home islands, which I have mentioned previously. I do want to say at this particular point, Mr. Chairman and members of the committee, that our Governor Quinn was chairman of the resolutions committee here at the recent meeting of the Governors' conference in Chicago on mental health, and he was selected to chair this resolutions committee because, I feel, that Hawaii with the Governor's support has enabled us to move ahead to carry out many of the recommendations of the Joint Commission on Mental Health Needs of the Nation. You remember that report for which the Congress provided appropriations to study the mental health needs of the Nation. And the Governor in the meeting in Chicago developed a resolution which, I am sure, will go a long way to extend and improve the mental health needs of our people in the Nation, as well as the aged who may become mentally ill.

Senator MORSE. Mr. Chairman, I am going to say very little in these hearings, but Dr. Lee is opening up a subject here about which I cannot remain silent. I am so glad to get your report, Doctor, in regard to this forward-looking program you are apparently developing in Hawaii with regard to the mentally sick. We have a national responsibility of cooperating with our States in this field. I have often put it this way: I think that the population as a whole seems to retreat into a psychological escapism when it comes to the matter of adequate care for our mentally ill, and, as you know, the President is laying great stress in his administration on the program for assistance in regard to the mentally sick. The problem is not limited, of course, to the elderly although when you get over into the elderly group you have a group of people that very well can adjust to the kind of care outside of the mental institution and that you have outlined here this morning. I happen to be one in the Senate who believes that our health program should not exclude aid to the mentally sick. I just don't understand how the American people as a population can have

accepted as long as they have Federal aid programs of all seeming which exclude care of the mentally sick. The mentally sick are just as sick as those that have some physical ailment. I think we have a moral responsibility as a people—we have a duty to translate into Federal legislation these great moral values that we prate so much about on Sundays. It's very fine to bow our heads to the spiritual teaching that "we are our brother's keeper," but as a people we are too prone to forget our brothers when they get into a mental hospital.

I want to commend you, Doctor, for the emphasis in your testimony you are giving this morning in the matter of being of some assistance to our mentally sick, because it is one of the great areas of neglect in the whole field of social-conscience responsibility on the part of the American people; and as I said in the Senate, and I repeat in Honolulu today, the President has my complete support in a program of greater Federal assistance to States in connection with the care of the mentally sick.

Dr. LEE. Well, I should say, Senator, that the support of our legislature, our people, our community and our profession and the citizenry in their understanding and their demand and their desire that physical and mental health of all our people, including the aged, are very important parts of our health program.

May I go on, Mr. Chairman? The hospital and medical facilities branch is organized:

To protect the public using hospitals, nursing homes, and related facilities;

To administer the Federal grant-in-aid program for the survey, planning, and construction of hospitals and medical facilities;

To provide hospitals, nursing homes and related facilities, personnel consultants, liaison and training in the administration and technical areas of operation of the facilities.

The regulation of hospitals, nursing homes, and care homes is a responsibility of the department of health, through this branch of hospitals and medical facilities. This not only makes the health and safety of patients of paramount concern but also makes possible the planning of a continuum of care from one facility to another.

A recent survey has been completed of the nursing and care homes in the State and I would like to present a few highlights of this study. First of all, a nursing home is one which has as its primary and predominant function skilled nursing care of adults. A care home is one which provides "personal care" with little or no "skilled nursing care."

Now, at the time of the survey, 15 nursing homes and 32 care homes were operating in the State. The bed capacity for nursing homes averaged 43.5, compared to only 12.6 for care homes.

An outstanding fact relative to patient-financing in nursing homes and care homes is the extensive part played by the department through public welfare funds. In both types of homes, welfare funds paid the full bill, rather than only a part, in the majority of cases. In nursing homes, 39 percent had private sources of income and 14 percent some form of pension. In care homes, only 7 percent had a private source of income, while 28 percent had pensions. In both categories of homes, the most usual type of pension was old age retirement.

A major difference between the homes of the United States as a whole and of Hawaii is the much higher proportion of single men in Hawaii.

Senator MORSE. Mr.Chairman, may I interrupt once more? On this nursing home care matter, I happen to be chairman of the subcommittee of this full Committee on Nursing Homes. I have been conducting hearings on nursing homes in various States. Would you, for the record, tell us what the contribution of the State of Hawaii is to a nursing home for a welfare patient?

Dr. LEE. Well, as I said, or, just read, Senator, most of the patients—or many of our patients—or a majority of the patients who are in nursing homes are being supported by public welfare funds.

Senator MORSE. But do you have a fixed amount for the care of each patient or is it variable?

Dr. LEE. I think the director of the department of social services, Miss Mary Noonan, will tell you that. It goes up to a figure close to $200 a month I think.

Senator MORSE. Well, that's remarkable. I happen to be an alderman, too, you will be surprised to hear, but I serve on the District of Columbia Committee of the Senate, for the District of Columbia. That really makes one an alderman because, as you know, we haven't given municipal rights to the citizens of the District of Columbia; we keep them second-class citizens and a group of politicians of the Congress run the District, which is a pretty shocking thing. In the District of Columbia—your Capital, we have a very serious nursing home problem. The top welfare payment for this case is $100 a month; so you can very well imagine what kind of care they are District of Columbia—your Capitol, we have a very serious nursing home; it is the fault of Congress. There is a direct relationship between the amount of money that is made available to the nursing home and the care that these elderly people get in the nursing home.

Here, again, I am a strong supporter—you know, that's one of the things that makes me a "creeping" Socialist, my critics say—I am a strong supporter of the Federal Government assisting the States in this nursing home care with the welfare patients to the point that they get an adequate amount for adequate care because this offers us, in my judgment, a great opportunity again to carry out some of the moral responsibilities we owe to the elderly. If you get up to $200, let me say you are way out among the top leaders in the country.

One other question to ask you. Do you follow the policy in this State, that unfortunately I have to report to you is followed in my State, that when there is an increase in social security benefits, small and inadequate as they were in the last Congress, in my opinion, that there then is a deduction from the welfare allowance in your State to the individual who is on welfare, equal to the amount of the increase in the social security benefits?

Dr. LEE. Senator, if you will permit me, I think I had better not tread into that area. That is Miss Noonan's area and she will have better answers than I can give you.

Senator MORSE. Very well. I hope she will give me a more encouraging answer than I got from the witnesses in my own State in regard to what Oregon does.

Dr. LEE. Mr. Chairman, I do want to take this opportunity to say to you, to the Senator and to the members of the committee and to the audience that we shouldn't put a premium on payment to nursing care only for the amount of nursing care done. I think one of the great areas that we must develop in this Nation today, as well as in Hawaii, is that we should put a premium on putting the aged and chronically ill on their feet sooner and faster, rather than on the amount of nursing care that they can get in a hospital or a nursing home.

So, may I go on here?

Senator MORSE. I just want to say I agree—except you have got to get them on their feet first, and that takes money.

Dr. LEE. Now the greater number of single men in Hawaii is because of the number of immigrant laborers who came to the islands without wives and who have never married. Many of them are now retired from work on the sugar and pineapple plantations. The survey showed that 33 percent of those in nursing homes and 42 percent of those in care homes had resided there 5 years or longer—that is, in these homes. Relatively few had been there less than a year. Such lengthy care frequently imposes great financial strain on the patients and their families. It is not surprising, therefore, that government through public welfare funds, wholly or in part, must be used to support a high proportion of these patients.

Our study also indicates that 32.5 percent of those in nursing homes and almost 58.9 percent of those in care homes did not have visitors. This shows a marked need for social visits which might be developed by government as well as by a volunteer agency.

Another item of note is that 2.6 percent of the patients in these homes were receiving physical therapy.

This brings me to a brief description of the use of the funds recently allocated under the Community Health Services and Facilities Act, which Governor Quinn mentioned earlier and which our chairman said that the committee had so much to do with getting this program on the road. I, as a health officer, would say that this is one of the forward, most forward, pieces of legislation for the care of the aged and the chronically ill in our Nation for a long time, and this will go a long way in improving the care of the aged and the chronically ill.

Hawaii received $40,000, which will be used to extend and improve services to nursing and care homes in Hawaii. We created positions such as a coordinator, an occupational therapy consultant, and a physical therapy consultant. The coordinator will assist in the recruitment of small "care homes" and assist in setting up a registry of all patients in nursing and care homes throughout the State.

The occupational therapy consultant will assist the various home administrators in developing an activity program while the physical therapist will demonstrate the need for and usefulness of habilitation physical therapy techniques.

Greater emphasis in the future may have to be placed in day care centers for the elderly. This is an area that needs to be developed.

Now on the question of Federal-State relations and on how the Federal Government can assist States in health programs for the aged, I have these comments to make:

(1) The present grant-in-aid funds for health purposes should be continued.

(2) They should continue the survey, planning, and construction funds for hospitals and related facilities—the Hill-Burton program.

(3) They should continue and extend funds for community health services and facilities for the aged and chronically ill. And, as I said, this program, this measure, will help us considerably.

(4) Continue and extend graduate and postgraduate traineeships and other educational opportunities for health personnel. There is a great shortage of health personnel throughout our Nation.

(5) Support basic and applied research. The Congress has done a great deal in support of research funds for the national health and extramural research programs, both in basic and applied areas.

(6) Study the possibility of amending the Social Security Act which now precludes patients in public and private institutions for mental disease and tuberculosis as well as patients in community nursing and foster homes from receiving Federal public assistance. The Senate Advisory Committee on Public Assistance recommended a review and study of this subject.

(7) The Kerr-Mills Act, which is a controversial item but it is our feeling, Mr. Chairman, that this represents an adequate means of providing assistance where it is needed, provided the States do their share. We feel the States must do more to implement the program.

The State's responsibility, therefore, is to provide leadership and direction, conduct overall planning for the aging in the State, and to set standards and evaluate programs and services. The State must provide certain direct services to the aging, provide matching funds where necessary, conduct community health education, and complement or supplement research and training efforts in this field.

We feel that both at the Federal and at the State level there needs to be greater emphasis on health programs and services for the aging population. As the Congress through the years has done so much for our infants and children and mothers throughout the Nation, I feel that our aging population in the coming years ahead must be given some attention nationally, as well as locally in our State. And if that is done, Hawaii will be able to move ahead in this area.

I wish to take this opportunity to thank the committee for allowing me to speak on behalf of the health department and for the interest shown in the health problems of Hawaii's aging population.

In addition, Mr. Chairman and members of the committee, I am submitting for the record documents prepared by the staff which are quite detailed and from which I derived material for this statement. It was prepared by Mr. George Tokoyama on "Population Background and Health Needs for the Older Persons of the State." Your staff has copies of that. Also I am submitting another statement on "Excerpts of Report on Nursing Homes and Care Homes, State of Hawaii," a preliminary report only, by Dr. Sumner Price, chief of the hospital and medical facilities branch; and another document on "Resources for Meeting the Health Needs of Older Persons," prepared by Dr. Norman Sloan and other members of the staff in the health department.

Thank you very much, Mr. Chairman.

Senator LONG. Thank you. Will you remain just a moment, Doctor? These statements will be made a part of the record.

(The documents referred to previously will be found in the appendix on pp. 1215, 1222, and 1226.)

Senator LONG. I think that practically everyone in this audience knows that Dr. Lee recently brought a very high honor to Hawaii, isn't that right, Doctor? Just about a week ago he was elected to the vice presidency of America's most important health group in the minds of a great many people—the American Public Health Association. We congratulate you, Doctor, and we congratulate Hawaii.

Doctor, how long has it been since you first became associated officially with the health program in Hawaii?

Dr. LEE. April 1936.

Senator LONG. Well, that's a good many years. Now during that time great progress has been made, as you have pointed out here. It has been brought about, I take it from statements made in your report, by the combined effort of the State and the Nation. I believe that is your viewpoint?

Dr. LEE. That's right, sir.

Senator LONG. So far, this system has not given any great concern to you? It has been carried out in the best of spirit in relation to the rights and the best interests of both governmental agencies?

Dr. LEE. Yes, sir.

Senator LONG. We have made a great deal of progress, but we need to make more.

Dr. LEE. That's right.

Senator LONG. That is the purpose of our coming here—to cooperate with all health workers, not only in this State but in each of the other 49 States, to assure that that progress will be brought about.

Thank you, Dr. Lee.

Senator MORSE. Mr. Chairman, I have one caveat that I think we ought to insert into the record at this point, not necessarily for comment but the record ought to show this statement: that the Federal law requires equal treatment of people in like circumstances under the old age assistance program. Therefore, if the OAA recipients who receive both OAA and OASDI were to receive the benefit of the increase in the OASDI payments, the State would have to raise OAA payments for all the other recipients, too. We are running into a problem in regard to that caveat in some of our States, and I wanted particularly to make it a matter of record here today because I think both the State and the Federal Government are going to have to deal with these discrepancies in the immediate future. Thank you very much.

Congressman INOUYE. May I be excused, please?

Senator LONG. Yes. Congressman Inouye has to leave. Thank you for coming.

Senator LONG. We have 14 names on this part of our agenda before the noon hour. We have covered seven of them. We have seven to cover. We have consumed 70 minutes of our 120 minutes. We have 50 minutes left. Certain topics have been fairly well covered. May I suggest then, in the interest of time to the remaining seven speakers, all of whom we are delighted to have on the program, that where a section of your statement has been fairly thoroughly covered that you refer to that and perhaps pass over it. However, we are going to use the next 50 minutes.

The next speaker whom we will have the privilege of hearing is Dr. J. Alfred Burden, president, Hawaii Medical Association.

Dr. Burden.

STATEMENT OF DR. J. ALFRED BURDEN, PRESIDENT, HAWAII MEDICAL ASSOCIATION

Dr. BURDEN. Senator Long, Senator Morse, and members of the panel, it is with a great deal of pleasure that I appear before you this morning to represent the Hawaii Medical Association at this conference.

I have with me a prepared statement, which I would like to submit for the record. However, because of the shortness of time, I will limit my remarks to comments on some of the high points that appear in the report.

Dr. BURDEN. Hawaii, like most of the States, has a very comprehensive program for providing medical care to its people, as you have heard in Dr. Lee's statement. It anticipates continuing its program, assisted by funds provided through Federal grant—funds returned to the States from taxes paid by these States.

The Kerr-Mills law, in effect in Hawaii since July of this year, has broadened the scope of the aid given to those over 65 through such a Federal aid.

Hawaii has long been alert to the needs of its people in the field of health and medical care. This is especially true in the field of preventive medicine, and Hawaii's record in wiping out Hansen's disease, tuberculosis, and in reducing infant and maternal mortality is well known. We, as medical men, are aware that there is no given age at which the need for medical care suddenly becomes a necessity, and our membership has worked closely with the health and the social services of our State to develop a program for providing total medical care to those of any age, whenever needed.

Many organizations have been developed through which laymen, as well as medical men and health and social agency personnel, work together toward this goal. I would like to mention, briefly, a few.

The Committee on Aging and Chronic Illnesses of Hawaii Medical Association has been active since 1951. The Governor's State Conference on the Aging, held in 1954, intensified efforts toward forming a permanent organization. The Oahu Health Council, statewide in scope, is an active catalyst in this field.

The Hawaii Nursing Home Administrators' Association is actively working to improve the standards of nursing and nursing home care. A statewide conference on this problem was held here last month.

Hawaii, through its child and family service, its various clinics, and its specialized schools, varying from institutions for retarded children to one of the most modern rehabilitation centers, is progressing toward the balanced program that we are working to perfect.

Because of this, the Hawaii Medical Association is disturbed over the threat to Hawaii's own voluntary health-care program that is posed by a measure now before Congress, best known as the King-Anderson bill.

The Kerr-Mills law affords practically unlimited medical, surgical, hospital, and other benefits to all aged persons who need help. The King-Anderson measure, which offers limited benefits, compels compliance of all persons under social security, regardless of need.

The successful operation of the Kerr-Mills law, in conjunction with the rapidly expanding system of voluntary health insurance, makes

unnecessary the more drastic approach to this problem proposed by the King-Anderson bill.

Some statistics concerning operation of the Kerr-Mills Act in Hawaii are applicable.

Latest estimates from the State department of health indicate that there are just under 30,000 people over the age of 65 in Hawaii. Of these, only 1,249 are currently receiving financial assistance through the old age assistance program. This assistance provides food, shelter, clothing, and basic necessities, including medical care.

During the first 3 months' operation of the Kerr-Mills law in Hawaii, there were 392 applications for medical assistance. Three hundred and two of these were approved and the balance was rejected because of financial reasons. The rejected cases, however, were not deprived of medical care. All were provided it through other sources. Everyone in Hawaii has access to medical care, irrespective of financial condition.

Based on this experience, it is believed that the number of persons taken care of through this program during the fiscal year will be around 1,200.

The Kerr-Mills law, with its matching funds from the Federal Government, will allow expansion of this program for the aged. Currently, all but 18 of the States are actively implementing the provisions of the Kerr-Mills law.

Although the program is just getting started in many of the States, it has proven successful. In doing the job locally, it is providing help to the people who need it without endangering the cash benefits of the social security program.

With more time and experience, we can further improve this program and continue to direct it locally rather than have it made a part of the Federal Government, directed from Washington.

This is only one phase of a far-reaching, locally directed program for medical care in Hawaii.

In the field of hospitalization, there is currently underway a survey of hospital facilities, which this committee should be informed of. The purpose of this survey is to evaluate all hospitals in Hawaii and to eliminate all duplication or overbuilding. This voluntary program is backed by the medical profession, by the hospitals, and is being developed by a voluntary hospital advisory council that includes leaders in the fields of industry, labor, government, and religion. It typifies the determination of the people of Hawaii to solve their own problems. It is locally directed for the purpose of solving a local problem.

I would also like to mention our independent living project, which is also aided by Federal funds. It is known as the program for the rehabilitation of the chronically ill in hospitals and nursing homes. Through this program, we are rehabilitating not only the aged, but all who are ill and handicapped—for the purpose of getting them on their feet and on a self-care program as rapidly as possible. We strive to treat such cases before their condition becomes irreversible, and the program is meeting with a great deal of success.

Previous comments have dealt with general objections to the King-Anderson bill. The balance of my prepared statement deals with more specific provisions of the bill to which we object, and they will

be included in the report. Time does not allow me to go into these, but I wish to submit them for the record.

(The statement referred to follows:)

PREPARED STATEMENT OF THE HAWAII MEDICAL ASSOCIATION

I am Dr. J. Alfred Burden, president of the Hawaii Medical Association. I have been engaged in the general practice of medicine on the island of Maui since 1939, except for 5 years of military service during World War II.

Hawaii, like most States of the Union, has been taking care of its own and expects to continue to do so, with some help from Federal funds—returned from taxes paid by the States.

The Kerr-Mills law, in effect in Hawaii since July 1, 1961, has broadened the scope of help to persons over 65 by giving such Federal aid. On the basis of the first 3 months of experience in operation of that act, physicians and health and welfare officials of Hawaii are confident of its continuing success.

Hawaii has long been alert to the needs of all its citizens in the field of health and medical care. There is no metabolic change in a human being on his 65th birthday and Hawaii's attention has been given to the health of its people of all ages. There must be healthy children in order to have healthy oldsters. The medical profession is interested in the people of all ages.

Hawaii, because of the dedicated interest of medical men, health, and welfare officials, and laymen alike, is on the way toward a balanced total program in the field of chronic diseases. Hawaii's record in the control of tuberculosis and Hansen's disease has attracted national attention.

The Oahu Health Council, statewide in scope, is a catalyst in the field. The Governor's State conference on the aging, held in 1954, resulted in intensified efforts to form a permanent organization in this field. The Committee on Aging and Chronic Illness of the Hawaii Medical Association has been active since 1951.

The Hawaii Nursing Home Administrators' Association has improved the standards of nursing and nursing home care. A State conference on nursing home and care home administrators was held here last month. Our home nursing and industrial nursing services are outstanding.

Hawaii, through its child and family service, its clinics, and its specialized schools, ranging from institutions for retarded children to a most modern rehabilitation center, is progressing toward the balanced program we are working to perfect.

Because of all this, the Hawaii Medical Association is disturbed over the threat to Hawaii's own voluntary health care program for people of all ages that is posed by a measure now before the Congress, H.R. 4222, the so-called King-Anderson bill.

The Kerr-Mills law, now in effect, affords practically unlimited medical, surgical, hospital, and other benefits to all aged persons who need help. The King-Anderson measure, with limited benefits, compels compliance of all persons under social security, regardless of need.

Operation of the Kerr-Mills law, in conjunction with the rapidly expanding and improving system of voluntary health insurance, renders needless a drastic approach to a problem which has not been shown to be drastic by proponents of the social security approach.

Some statistics concerning operation of the Kerr-Mills Act in Hawaii are applicable.

Latest estimates from the State department of health show the total number of persons in Hawaii who are over 65 years of age to be just under 30,000 (29,162), about 4.8 percent of the total population. The national figure is 10 percent. Last month (October) there was a caseload of 1,249 persons over 65 years of age receiving financial assistance under the old-age assistance category. This assistance includes food, shelter, clothing, and basic necessities, including medical care.

During the first 3 months' operation of the Kerr-Mills Act, July 1, 1961, through September 1961, the State of Hawaii received 392 applications for medical assistance from persons over 65. Of these, 302 were approved. There were 66 rejections for financial reasons. These cases are being restudied to determine whether the policy governing grants should be made more liberal. None of these cases, which possibly do not fall into the area covered by the Kerr-Mills Act, have been neglected. All are receiving medical aid from other sources. All people in Hawaii have access to medical care, irrespective of financial condition.

Actual number of payments during the 3-month period was 479. The total of such payments was $108,432. Of this amount the Federal matching share would be $57,791, or 53.38 percent of the expenditure.

Based on this experience, it is believed the number of persons potentially eligible in this category will be about 1,200 during the fiscal year.

Under the new program, with Federal matching funds available, the State will be able to expand its program for the aged, which is the intent of the Kerr-Mills Act. In this respect it should be noted that U.S. States and possessions where the Kerr-Mills Act has begun to function this year in addition to Hawaii include Maryland, Massachusetts, Michigan, New York, Oklahoma, Virgin Islands, Washington, West Virginia, Idaho, North Dakota, Oregon, Louisiana, Maine, New Hampshire, California, Tennessee, Kentucky, and Utah. Only 18 State legislatures adjourned this year without taking some action toward implementation of the Kerr-Mills Act.

Although the program has merely begun in almost half the States, it is in successful operation. It is doing the job locally. It is getting help to the people who need help without jeopardizing the cash benefit program of the social security system.

With more facts and more experience, we can improve the program and continue to direct it locally rather than have the system made a part of the Federal Government, directed from Washington.

But this is only one phase of far-reaching, locally directed work underway in Hawaii in the field of medical care for young and old.

In the field of hospitalization there is underway a survey of which this committee should be informed. It is an example of locally directed work, aimed at determining local needs. It typifies the determination of the people of a State to solve their own problems. And it is typical of surveys elsewhere in America that are improving the efficiency of hospital systems while reducing the cost.

This survey is aimed at evaluating all hospital needs in Hawaii and at meeting those needs without duplication or overbuilding. This voluntary program is backed by the medical profession, by the hospitals, and is being developed by a voluntary hospital advisory council that includes leaders in the fields of industry, labor, government, and religion.

A similar survey in California was cited by Gordon Cummings, chief of the division of hospitals of the California Public Health Department, as having saved $500 million in hospital construction during the next 5 years by eliminating overbuilding and duplication and hospital purchases of expensive, but seldom used, equipment.

Preliminary phases of our own survey are being completed. By spelling out statistically what is needed in future hospital construction we will be better able to finance the care of the chronically ill in hour hospitals, nursing homes, and convalescent homes.

We cite this as another example of locally directed effort in the field of health care which need not—must not—be controlled by the Federal Government.

And we will mention also our independent living project which is aided by Federal funds, but is controlled at the local level. This also is within the field of Federal-State activities with which this special committee of the U.S. Senate is concerned.

This enterprise bears a longer and more formal name. It is the program of rehabilitation of the chronically ill in general hospitals and nursing homes. The program covers young and old who need it.

We are rehabilitating not only the aged, but all individuals who become ill or handicapped. We are finding methods by which we reach patients early and put them on their feet when possible. We strive to treat such patients before their cases become irreversible. And at the same time we are trying to evaluate all hospital cases to the end that we may learn what types of cases may be benefited by certain programs and eliminate wasteful costs.

Previous comment has dealt with general objections to the King-Anderson bill as a measure that would take away individual enterprise and freedom, which proposes a federally sponsored program suited only to an impoverished society, and which would compel all, regardless of need, to participate.

Let us consider more specifically H.R. 4222, the so-called King-Anderson bill, called by its table of contents the Health Insurance Benefits Act of 1961.

While recognizing that the detailed provisions of any social security bill are immaterial in the long run, because the bill, if it becomes law, soon will be changed beyond recognition, we may yet observe that some of the provisions and statements in the measure are at variance with the facts, or with statements

made by the President—who cannot be expected to examine all the details of such measures personally.

H.R. 4222 provides that the Government shall collect taxes from employer, employee, and the self-employed. The Federal Government subsidizes the program and issues the rules and regulations. The detailed provisions of H.R. 4222 are only of passing importance, but the principle which it would set up is of the utmost importance. That is no less than acceptance of the idea of social insurance medicine under the social insurance mechanism.

This is the mechanism used around the world as a legislative vehicle for the nationalization of medicine, which is a prerequisite to further nationalization of industry and the professions.

In considering some sections of H.R. 4222 individually, let us cite page 3, section 2, which says: "(a) The Congress hereby finds that (1) the heavy cost of hospital care and related health are a grave threat to the security of aged beneficiaries, (2) most of them are not able to qualify for and to afford private insurance adequately protecting them against such costs * * *"

We answer that there is no proof that most of the aged beneficiaries are unable to afford private insurance adequately protecting them against the heavy costs of hospital care and related health care.

The facts, indeed, are quite to the contrary. Hawaii, with nearly 30,000 oldsters, expects only 1,200 applications for aid under Kerr-Mills during the fiscal year. And the Kerr-Mills machinery takes care of them.

Examine page 4, section 2(a)(4). This says: "It is in the interest of the general welfare for financial burdens resulting from hospital services and related services required by these individuals to be met through social insurance."

It is debatable whether "it is in the interest of the general welfare for financial burdens * * *" to be met through social insurance. We doubt that it is. Social insurance is the legislative vehicle for nationalizing medicine and has been so used in all countries having compulsory health insurance. In fact, the first social insurance law passed in Germany in 1883 was for social insurance medicine, that is, State medicine.

On page 4, section 2(b) (line 17) is the statement that the purpose of the act is to provide medical service "in a manner consistent with the dignity and self-respect of each individual."

We would question whether any service provided by government, for which the recipient has paid nothing, is consistent with his dignity and self-respect as an individual unless he is financially embarrassed. The costs of these services will be covered—insofar as these are covered by social security taxes—only by younger persons who are still working.

Any contributions paid in previously by recipients under this bill are obligated toward present benefits. These new benefits would have to be paid for by new money from people now at work.

The bill's statement concerning dignity is misleading.

Equally misleading are lines 19–24 on page 4 which assert there will be no interference with free choice of physicians and no exercise of Federal control over the practice of medicine by any doctor, or over the manner in which medical services are provided by any hospital.

This reference to noninterference is expanded in section 1601, page 5, which is not only completely misleading but can be characterized as doubletalk.

This states that there shall be no control over the practice of medicine or the manner in which the services are provided, but in line 23 it states: "Except as otherwise specifically provided." Since the bill does specifically provide for controls and for rules and regulations to be promulgated by the Secretary of the Department of Health, Education, and Welfare, why is it asserted that there will be no supervision or control?

Completely misleading is section 1602 on page 6 of the bill. Part of this section has been quoted for public consumption. The conclusion has been drawn that patients will have freedom of choice. But the section clearly states that the patient will have freedom of choice only among those providers of services who have made an agreement with the Government to provide such services. The patient is limited to such providers. Further, when rules and regulations are written there is likely to be some geographical restrictions. Patients presumably would not be allowed to go to providers of services at any great distance from their homes.

Continuing examination of H.R. 4222, we call attention to page 7, section 1603(a)(4) providing for certain exclusions of services. The Kennedy administration has insisted that the Government will have no control over physicians.

Yet, this section specifically states that the hospital services for which the Government will pay will exclude medical and surgical services provided by a physician, resident, or intern "except in the field of pathology, radiology, physiatry, or anesthesiology, and except services rendered in the hospitals by an intern or a resident in training under a teaching program approved by a recognized body approved for the purpose by the Secretary * * *"

That covers varied services by physicians. These presumably would be paid a salary by the hospital. Such salaries would be included in the negotiated costs to be paid by the Government. They would be a part of the Government contract and would, to that extent, be a part of nationalized medicine.

Page 10, section 1604 lists the deductible features of the plan. While we are in favor of the deductible feature, we should like to point out that this has not been publicized. The public is probably unaware of the limitations here provided.

And does the public know that care in hospitals is limited to 90 days? Does the public know nursing home care is limited to 180 days?

Page 23, section 1609(b), refers to determination of the costs of services which, it is stated, must be "reasonable." Who is to say what are the reasonable costs for which the HEW Secretary will pay? Who is to decide how they are to be determined? It is specifically stated that "regulations" shall provide the method or methods of determining costs. It is further to be noted that regulations "may provide for the use of estimates of costs of particular items or services." This covers a great deal—costs of drugs, salaries to be paid to physicians working in hospitals, salaries for nurses, and other items.

Progressing to page 28, section 1611, we call attention to the fact that the Secretary has great discretion in the reduction of payments if funds are scarce. This has been done in other countries.

Section 1612, page 29, provides for a Health Insurance Benefits Advisory Council of 14 persons to be appointed by the Secretary. Only four of these shall be persons "outstanding in the fields pertaining to hospitals and health activities" (line 20). One might be a physician, one a hospital administrator, one a dentist, one a nurse. But even this is uncertain. Who would the other 10 be? This should be spelled out.

On one hospital advisory council, appointed by the Federal Security Administrator before there was a HEW Secretary, one of the appointed members was Michael M. Davis, the leading lobbyist for the nationalization of medicine.

Membership of the council should be specified in the bill. Even so, if the members are appointed by the Secretary, they must be responsive to him. There should be provision for appointment of members of professional organizations including the AMA, ADA, ANA, AHA, the American Pharmaceutical Association, and others. Otherwise, there can be an objectionable loading of representatives including, even, lobbyists for nationalization.

Concerning regulations, we call attention to section 1615 on page 31 of H.R. 4222. This says: "When used in this section the term 'regulations' means, unless the context otherwise requires, regulations prescribed by the Secretary."

This is a key provision that gives Federal control, for these regulations have the force of law.

Since these regulations are not written until the providers of services have signed up, these providers are making a blind date with fate.

This measure also implies that the integrity of the separate trust funds now existing (OASI and disability) will be lost. The expansionist move in setting up a Federal social insurance trust fund—something new—is the key here. This is to have three accounts: one for OASI, one for disability, and one for health. But note that all the money now present in the two funds now existing, OASI and disability, are to be merged and transferred to the overall Federal social insurance trust fund.

Does this mean that if one account is in the red that it can get help from another account? The public is entitled to clarification.

Note well that there will be a sixfold jump in the tax on employers and employees after the first year, a fact that has not been adequately publicized.

Page 37, section 706(e)(1), provides that the tax on employers and employees shall be 0.1 percent the first year but goes to 0.6 percent the second year, six times as much. The self-employed person would pay 0.075 percent the first year and 0.45 percent the second year, also a sixfold increase. There is no indication of what the tax hike will be after that, also a point that should be specified now. It could be a warning to those who blindly embrace a plan controlled by regulations issued by a single individual.

Study carefully and note that the Managing Trustee, that is, the Secretary of the Treasury, may invest any funds which are left over in Government bonds at the going rate of interest. This is under terms of section 706(g), page 39. Most important, he may put up, as collateral, bonds made especially for investment by the trust fund (p. 30, line 9).

And on page 37, section 706(e)(1), we learn that the wage base is to be increased to $5,000.

This is part of the upward climb predicted by Wilbur J. Cohen when he testified at his nomination hearing.

We have gone into detail concerning a few points of H.R. 4222 because we have seen nothing in the record concerning these discrepancies and misstatements.

We will end this by making a brief comment on section 402, page 67, which we consider of paramount importance.

This section authorizes the HEW Secretary to study (3) "the feasibility of providing additional types of health insurance benefits within the financial resources provided by this act."

This is a customary method of authorizing fishing expeditions into the field of compulsory health insurance. It opens a wide field of exploration.

And since we don't know what the financial resources will be after such a program gets going, and taxes are increased, the Secretary could make practically any kind of "study" he wished.

He could even experiment with additional services under compulsory health insurance.

If this bill were enacted into law there would be an immediate clamor for more benefits for the aged, for a lowering of the eligibility age limit, and for payment of surgical fees.

Beyond doubt the younger workers, who would be compelled to pay the taxes and receive no benefits, would insist that as long as they were paying taxes for hospital benefits for the aged they should share in those benefits.

Within a decade, perhaps less, there would be a full program of medical care under Federal control.

Abuses, soaring costs, and general inefficiency of that system can be examined in England today. Nationalized medicine has become expanded there to complete welfare statism in which America need not become embroiled so long as the individual States care for their own needy and the majority of the people continue to take care of themselves.

We call attention to the fact this calls for limited hospitalization, not general care, and that it is not likely that our hospitals on Molokai and Lanai, or our small plantation hospitals could qualify.

The bill would give limited help to 70 percent of those persons, rich and poor, who are under social security, but would give nothing to the 30 percent who can never qualify no matter how poor and destitute they may be.

Gentlemen, we don't want guidance by remote control when we are doing so well by ourselves—without compulsion for all for the benefit of a few who are being taken care of already.

In conclusion we urge:

(1) That the States be allowed to continue to operate under the Kerr-Mills law which gives almost unlimited benefits to all until the full potential of that law is realized.

(2) That H.R. 4222, a limited, dangerous, compulsory approach to nationalized medicine, be rejected as unbecoming to the American people.

The Hawaii Medical Association thanks this committee for the opportunity to be heard.

Dr. BURDEN. I appreciate very much the opportunity of appearing before this group this morning, and I wish to assure the Congressmen that the medical profession in Hawaii are vitally interested in the care of the aged and are wholeheartedly behind any effort made to improve their condition and improve their care. However, we sincerely believe that the problems are local ones and the problems can be best solved with Federal aid through grants on the local level. Thank you very much.

Senator LONG. Thank you, Doctor.

Senator MORSE. All I want to say, Mr. Chairman, is that I am very glad to have the doctor's reasoned discourse. This is the way in a democracy for us to hammer out on the anvil of conscionable compromise a program that we think will best serve the public interest. I shall study very carefully the doctor's statement. As the doctor knows, I am one of the cosponsors of the King-Anderson bill. I have said many times in the Senate I don't think it goes even far enough. But what we have to do, the medical profession and all other groups, working together with their elected representatives, is to try to find an objective solution to this problem which will be workable and will protect the precious right of freedom which we are all interested in. And I want the doctor to know that his statement is going to receive my very careful study because I believe that my responsibility is to follow where the facts lead. If politics aren't going in the same direction, that is just too bad for the politics, as far as I am concerned. But I want the doctor to know—he probably knows my record anyway—I want him to know that I am not an enthusiast about the Kerr-Mills law. I voted for it but I think it should be an addition to and not a substitute for the King-Anderson bill.

Dr. BURDEN. May I make one additional comment?

Senator LONG. Surely.

Dr. BURDEN. I am sorry Representative Inouye had to leave because this has to do with one of his statements there. He made the statement about the degradation of the "means" test. I wish to argue that point because I think that each and every one of us is in these days constantly having to pass a "means" test every day. I believe the "means" test is a part of the Federal housing program, and I do not feel that the people who go into these housing facilities are degraded by their having to pass this test. I think each and every one of us in our business connections, in purchasing anything on time, are constantly having to undergo a "means" test, and it is not this degrading.

Senator LONG. Thank you, Doctor.

The next witness under the health section is Dr. Philip T. Chu, executive chairman, Hawaii Permanente Medical Group.

STATEMENT OF PHILIP T. CHU, M.D., EXECUTIVE CHAIRMAN, HAWAII PERMANENTE MEDICAL GROUP, CHIEF OF STAFF AND CHIEF OF SURGERY, KAISER FOUNDATION HOSPITAL, AT HONOLULU, HAWAII

Dr. CHU. Mr. Chairman and members of the U.S. Senate Special Committee on Aging, I am Philip T. Chu, executive chairman of the Hawaii Permanente Medical Group, and chief of staff and chief of surgery of the Kaiser Foundation Hospital in Honolulu.

I deeply appreciate this opportunity to appear and to express our great concern with the problem of meeting the health care needs of our elderly citizens. I approach this problem from a medical rather than an economic basis, and particularly wish to present the viewpoint of a medical group which is providing comprehensive medical care under a voluntary prepaid hospital and medical service program.

The Hawaii Permanente Medical Group, which I represent, now includes 35 physicians, who have contracted with the Kaiser Founda-

tion Health Plan to provide physician services to members of the health plan on Oahu. Hospital services for health plan members are provided by the Kaiser Foundation Hospitals, a nonprofit and charitable corporation which also provides hospital and emergency facilities for the general community.

Our medical group furnishes inpatient and outpatient services at the Kaiser Foundation Medical Center, an integrated hospital-medical facility. In addition, we staff clinics in Kailua, Pearl City, and Maili, to provide outpatient services to health plan members living in these areas.

Membership in the health plan is based on voluntary enrollment. Each of the approximately 40,000 persons on the Island of Oahu who now belong to the plan has voluntarily selected the Kaiser Foundation Health Plan. Because this program has operated for only 3 years, and initial enrollment—as in other prepayment plans—is made up principally of actively employed persons and their dependents, a relatively small proportion (some 3 percent) of the health plan members are 65 years of age or over.

Prepaid coverage for a broad range of hospital and medical care needs permits individual families to budget their health care costs. The prepaid funds are used to maintain a staff of physicians representing the major specialties of medicine and a modern medical center. As physicians working in a group, we believe that we are able to provide the members of the health plan with care that effectively coordinates the various skills and techniques of medicine for the benefit of each patient. In such a setting emphasis is placed on maintenance of health, prevention and early detection of disease, as well as on care for acute and chronic illnesses.

We have learned that direct advantages accrue to both patients and physicians through ready availability of hospital and outpatient services including special equipment and ancillary personnel, and that many economies in the costs of medical care are achieved through effective organization of these services.

Our experience in the organization of hospital, medical, and related services and our experience with prepayment are, in part, the bases upon which the following observations are made.

SERVICES SELECTED FOR SPECIAL EMPHASIS

While your committee has received testimony from witnesses who have much greater competence than I have in the field of medical economics, I believe it is important to stress one basic fact in this field. The aged as a segment of our population do not constitute an adequate base for spreading the costs of their medical care. A broader base is required. This is true because the medical care needs of the aged are much greater than those of younger persons while their financial resources are generally much smaller.

This is why some industries and some health and welfare funds are spreading the costs of prepaid medical care for retired employees over the total work force of the industry. This is why the Federal employees health benefits program provides equal benefits, at the same premium level, for active employees and for employees retir-

ing after June 30, 1960, thus spreading the higher costs of care for such retired persons over the total population of Federal employees. This is why the Hawaii public employees health benefits program, which goes into effect January 1, 1962, is designed to spread, over the total employee group, the higher costs of care for already retired employees as well as those who retire in the future.

While recognizing the importance of adequate and appropriate financing of medical care services for the aged, I would like to focus my comments on the types of services required by the aged and on the need for having these services organized in a manner aimed at preserving the dignity as well as the health of the aged. My point of view is that of a physician working in a group practice prepayment plan setting. It is also the point of view of one who—as with many of the peoples of Hawaii—derives from a culture with a very long tradition of deep respect for the aged, a tradition of great awareness of the social values and contributions of the aged to the societies of which they are a part, and a tradition of abhorring those events which tend to isolate or segregate aged persons from their families and from the rest of the community.

From my medical and cultural background, you will readily understand why, among the broad span of medical services required by the aged, I have selected, for special emphasis, health maintenance services including comprehensive outpatient care, organized home care services, and rehabilitation services. These services are not only directed toward the preservation or restoration of health, but also specifically concerned with avoiding the isolation of the aged by eliminating unnecessary hospital care, nursing home care, and care in custodial facilities.

HEALTH MAINTENANCE SERVICES INCLUDING PREVENTIVE SERVICES

In any medical care program for the aged, provisions must be made to permit the elderly to seek medical care early by making available a broad spectrum of medical services on an outpatient basis. We find that services for the prevention of illness and the complications of chronic illness, coupled with attention to early diagnosis and prompt treatment, help to keep our elderly members active and socially self-sufficient.

Programs should be designed to encourage patients to make effective use of the full range of outpatient services, including laboratory and X-ray diagnostic services. We know that this is an effective means to reduce unnecessary institutional care. Furthermore, early care may reduce a possibly serious illness or prevent unnecessary complications. We know that maintaining people in good health, at home, active, and interested in their daily affairs is good medicine as well as good commonsense.

Discussion of outpatient care must include consideration of the fact that elderly persons on limited incomes often have serious difficulty in paying for the cost of expensive drugs. We recognize this to be an important problem because in our program, as well as in most other prepayment programs, members pay for, rather than prepay, out-of-hospital drugs and medicines. Thus we believe it is important to bring outpatient drugs within the scope of prepayment.

ORGANIZED HOME CARE SERVICES

Services to meet the medical needs of the aged when they are acutely ill and require hospitalization are, of course, necessary in any meaningful medical care program for them. This, however, is but one part of the problem. In caring for the aged, we must be concerned with services for posthospital care, especially services to permit the early transfer of the patient to his home when care at home is medically indicated and feasible.

There are many instances of patients who could benefit by home care and for whom home care is medically feasible, but who for various reasons are retained in the hospital beyond the time they can benefit from the services of the hospital. In studying this problem we have found that programs have been established elsewhere (such as the home care program of Montefiore Hospital in New York City and the home care program of the Jewish Hospital of St. Louis, Mo.) which provide home care as an extension of medical care in hospitals.

Although the need for organized home care services is not limited to the aged—for example, there is need for such services for cancer patients and other patients with incapacitating chronic diseases regardless of age—the need is significantly greatest among the aged because of the greater prevalence of chronic illness.

Unfortunately in Hawaii we are just beginning to realize the significant contribution such programs can make in meeting health care needs and in minimizing institutional care which is both costly and inappropriate to the medical and social needs of many patients.

Demonstration programs are urgently needed in Hawaii to show the efficacy of organized home care services and to develop and train personnel in the techniques of furnishing these services. In this State, filial piety and responsibility for the care of one's parents are cultural characteristics of the people. The role of organized home care services and the other categories of service discussed here today is not to provide a substitute for family responsibility for the aged. Rather it is to assist the family in carrying out its responsibilty with the most effective use of the resources of the community.

For aged persons who are alone, without families, the homemaker and housekeeper services of the State department of social welfare are making a substantial contribution. Expansion of these services to provide proper care for the aged in their homes is desirable.

REHABILITATION SERVICES

Since World War II, Dr. Howard Rusk and other workers in the field of physical medicine have provided dramatic demonstrations of the value of rehabilitation services in restoring the disabled and permitting them to serve as useful members of the community. Hawaii has a great need for proper facilities for inpatient rehabilitation and for outpatient or day-care rehabilitation. The planning of these services must be done on a communitywide basis and the financing of these services—as with other costly services for the aged—requires a broader population base than the aged themselves.

SUMMARY

As a summary of my remarks, I would like to call attention to a statement made by the Subcommittee on the Problems of the Aged and Aging in its report of January 29, 1960, to the Senate Committee on Labor and Public Welfare. The statement, which applies to Hawaii as to other parts of our Nation, is as follows:

> The prevention of illness, its early diagnosis, and a restoration to health are the primary goals of an adequate health service. Diagnostic services and home care programs under supervision can be effective in reducing the high cost of hospitalization and institutionalization. A new, emphatic approach to organized home care services, particularly for chronic illnesses and for preventive efforts may reverse the rapidly rising costs of hospitalization as well as improve the health of American's older citizens.

This statement mirrors that made by Henry J. Kaiser on April 30, 1954, in hearings before the Committee on Interstate and Foreign Commerce, House of Representatives:

> A significant and hopeful trend is taking place in the building of doctors' offices and outpatient clinics in connection with hospitals. The Commission on the Financing of Hospital Care has pointed out the importance of utilizing outpatient services as much as possible. Visits by ambulatory patients to doctors often make their admission to costly hospital care unnecessary. The practice of preventive medicine—early diagnosis and early detection of disease—can cut the public's health bills and at the same time assure the people much better health.

I wish to thank the committee for this opportunity to be heard on a subject of great interest and concern to the organizations I represent. We are pleased to serve the aged as part of the general community. With increased Federal, State, and local attention to needed services for the aged, it is our hope that we will have the opportunity to participate effectively in the development of services aimed at preserving the dignity as well as the health of older persons.

Senator LONG. Thank you, Doctor.

The next witness will be the Chairman, Health Committee, Commission on Aging. Dr. Yamauchi.

STATEMENT OF DR. SHOYEI YAMAUCHI, CHAIRMAN, HEALTH COMMITTEE, COMMISSION ON AGING

Dr. YAMAUCHI. Senator Long, Senator Morse, distinguished guests of the Senate Special Committee on Aging, my name is Shoyei Yamauchi, M.D., a practicing surgeon in Honolulu since 1935, Chairman of the Health Committee of the Hawaii State Interim Commission on Aging, Chairman of the Chronic Illness and Aging Committee of the Hawaii Medical Association, a delegate to the WHCA 1961, and a new member of the Hawaii State Commission on Aging. I should like to confine my statements to the health aspects of the problems of the aged.

Before I proceed, I would like to thank the chairman, Senator Long, for permitting me to appear before this committee. I am also very grateful to him for supplying publications on the problems of the aged. They are most useful to many of us interested in the problems of the elderly people.

WHAT ARE THE PROBLEMS CONFRONTING ITS OLDER PEOPLE: EVALUATION

The problem confronting the older people is biomedico-socio-economic and spiritual in nature and involves all stages of man's life from the cradle to the grave. The total problem is broad and its many facets are varied and complex.

This broadness and complexity seems to grow with time, proportionately with the increasing number and longevity of old people.

Today, 4.6 percent of Hawaii's total population is 65 years or over. This is roughly less than half of those in most mainland States. The older Japanese comprise the largest percentage, 6.8 percent. These people are traditionally imbued with the concept of family unity and responsibility. Hawaii's laws also define the responsibility for care beyond the individual as that of the family and relatives before the State. Probably, these factors all have contributed to the milder impact of problems affecting the aged. Hawaii has not remained complacent; strong action programs are already operating and new ones are on their way, and I am sure that all of these will become evident during these hearings.

ADEQUACY AND INADEQUACY OF EXISTING PROGRAMS

The emergence of chronic diseases as this Nation's No. 1 health problem, unmatched in history, creates much concern to the elderly who are the primary targets of these diseases. Individual chronic conditions occupied, in the past, the interests and attention of communities, States and the Nation. This resulted in the mushrooming of many groups and agencies. It now requires books of considerable size to list these agencies. (See this Senate Subcommittee's "Reports on Voluntary Health Agencies, Related to the Aged.")

Unity of action using common denominators was advocated by the National Commission on Chronic Illness to cope with these problems. WHCA 1961 reiterated and supported this recommendation.

We in Hawaii have moved in this direction. The reactivation of the Oahu Health Council after World War II, creation of the Hawaii Medical Association's Chronic Illness and Aging Committee in June of 1951; the establishment of the Rehabilitation Center of Hawaii (1954); and the creation of State Interim Commission on Aging 1959, in preparation for the WHCA 1961 in which Hawaii's delegates participated. The Governor's First State Institute on Rehabilitation held in January 1960, First State Nursing Home and Care Home Administrator's Conference held a month ago, and the Institute on Housing for the Aged a week ago, all have influenced Hawaii's people in the right direction.

The health committee of the Commission on Aging has created four subcommittees to cover the following areas:

(1) Institutional care.
(2) Home care (comprehensive).
(3) Health maintenance.
(4) Research.

For each of the areas, subcommittees have been formed. The research committee now is directly under the Commission to cover its total interest.

In the establishment of these subcommittees by the health committee of the Commission on Aging, the thinking has been as follows:

(1) The health problem of the aged largely revolves around the chronic diseases and disabilities.

(2) Utilizing the guidelines, concepts and recommendations established by the National Commission on Chronic Illness, the White House Conference on Aging 1961, and the Governor's State Conference on Aging, a unified approach needs to be developed.

(3) It would be the primary function of these subcommittees to bring into fruition a master plan of action programs based on common denominator factors.

(4) Implementation of such a plan then should follow.

Thus, we are moving toward a unified approach to the total health problems of the aged.

INSTITUTIONAL CARE

Total coordinated regional and national planning for health facilities, sometimes called areawide planning, is a new approach. This decade will see its development and implementation.

General hospitals in this context are conceived as health centers organized and planned to offer diagnostic and therapeutic facilities and services to ambulatory outpatients and to those at home. Emphasis here will be on preservation and maintenance of health as well as out of hospital care whenever feasible.

Incorporated into this system must necessarily be the broadest concept of progressive patient care now so well exemplified by the plan worked out at the Manchester Memorial Hospital in Connecticut. This plan offers patient care according to his individual needs. A demonstration study project about 4 years old is now being widely adopted all over the country.

The Institutional Care Committee will look into these and other areas to see how such plans can be adapted to Hawaii's needs.

The Institutional Care Committee will also study the nursing and care homes in Hawaii and make recommendations for improvement or expansion of facilities as are deemed necessary.

The independent living project in Hawaii, now a year old and actively functioning, will probably help to develop guidelines in the development of a broad spectrum of institutional facilities and services oriented to rehabilitation. This project will be reported separately by the State Department of Vocational Rehabilitation.

HOME CARE PROGRAM

Another program in the planning stage, but soon to become a reality is the plan to take medical care, nursing care and rehabilitative programs directly into homes. Such schemes are commonly known as home care programs. That such a program is feasible and practical was first demonstrated at the Montefiore Hospital in New York by its director, Dr. Bluestone. Here in Hawaii, a similar program has been gestating for several years at the St. Francis Hospital under its able administrator, Sister Maureen, and is finally on its way. It will be a demonstration-research project to test its feasibility and develop guidelines for future statewide application. Grant-in-aid funds from the USPH to support this program have been applied for under the

recently enacted Community Health Services and Facilities Act. This program which will help to reduce medical costs and improve medical care for chronically ill persons not requiring in-hospital care is supported by the Hawaii Commission on Aged, Department of Health, Department of Social Services, and the Hawaii Medical Association.

HEALTH MAINTENANCE

Health maintenance from the standpoint of the aged requires the cooperation and coordination of medical, public health, and educational facilities. New attitudes must be created toward the aged and their chronic diseases. The public must be educated to the tremendous advantage to be gained in the early detection and treatment of diseases especially in the aged, and urged to have periodic health checks. The health maintenance committee is now studying the possibility of establishing a clearing house and information center to which the aged or their relatives may turn to find out what facilities or services are available to handle their problems.

The health committee, recognizing the importance of spiritual problems of the aged is exploring ways in which religious and social organizations can be helpful in expanding their facilities and services to the aged.

RESEARCH

Continued exploration into the world of unsolved problems relating to biomedico-socioeconomic and spiritual factors affecting man and society at community, State, and National levels is a necessary approach to properly understand and control the emerging problems which affect the aged. Hawaii's unique mixture of cultures and races offers opportunities to study at close range many factors bearing upon the problems of the aged.

The research committee of the State commission on aging is chaired by the chairman of the department of economics, who is also the dean in the College of General Studies of the University of Hawaii. This committee is composed of representatives of many disciplines within the university faculty, and doctors and health department workers in the community interested in research. Such a committee will probably initiate many longitudinal long-term studies, now lacking in Hawaii. The newly created Health Research Institute at the university and the East-West Center should make considerable contributions to this aspect of the aging problem.

SUMMARY

I have described the activities of my committee. Some of the programs are underway, others are still in the planning stage. It is hoped that continuing progress is made here in Hawaii to cope with the problems of the aged through solid action programs. It is to be hoped that the Hawaii State Commission on Aging which is now on an interim basis be made a permanent unit of government, with adequate authority supported by sufficient State funds, so that when a master plan of action programs is developed, it would be implemented throughout the State.

Thank you.

(The following diagram was supplied:)

THE FUTURE GENERAL HOSPITAL

INTENSIVE CARE UNIT

Special Care Unit

↓ for

Critically or Dangerously Ill

INTERMEDIATE CARE UNIT

Present Hospital Beds

↓ for

Ill but Not Critical

Some self-help e.g. Bathing and feeding self

Predictable Hospital Stay

SELF-SERVICE UNIT

↓ for

Ambulatory

↓

Extensive Diagnostic Work-up

or

Recovering e.g. Evaluation Counselling Education

CONTINUATION CARE UNIT

Long Term Beds

↓ for

Chronically Ill Requiring Hospital Services

↓

Unpredictable Hospital Stay Requiring 30+ Days Stay Due to Services Needed Above Those Available in Nursing Homes

HOME CARE UNIT

↓ for

Extension of Needed Services to Home Environment

SOCIAL SERVICE UNIT

All phases Socio-economic Counselling Family and Patient

PSYCHIATRIC UNIT

Evaluation Rehabilitation

Spiritual — Psychological

REHABILITATION

Evaluation Training and Counselling (20% of total beds)

Senator LONG. Thank you, Dr. Yamauchi. You covered a tremendous area of health in a short period.

Senator MORSE. Mr. Chairman, I want to take 30 seconds on the doctor's testimony. I want to commend the doctor on his testimony and also part of the testimony of Dr. Chu that raises one problem to keep in mind and that as far as our findings to date are concerned would seem to indicate is a serious problem, and that is the problem of diagnosis.

We apparently are dealing with a certain percentage of elderly people who, for various reasons, keep putting off, putting off, putting off diagnosis. Their reasons are varied. A mother or a father, 65, 70, 75 years old, living with a son or a daughter and, already feels some economic burden on that household, knows very well that he or she has some symptoms of an ailment that ought to be diagnosed, but for some reason keeps it to herself or himself and waits too long until the diagnosis finally is thrust upon that elderly person—only to get the sad report that time has been costly. The doctor's testimony and the testimony of Dr. Chu, and the type of program that you have outlined here this morning, it seems to me, often leads to a program for early diagnosis. It raises, as you pointed out, this question of economics; and it raises the problem as to what the rest of us in society owe as a moral obligation to the elderly in order to see to it that early diagnosis can take place without great economic hardship either on the elderly or on the members of the family with whom they may be living and upon whom they already consider themselves to be a serious burden.

It is only one little facet of the problem that confronts this committee, and I would like this record to show that I think the medical profession and all the health organizations are going to have to come to grips on this problem of working out a program for the earliest possible diagnosis so that we don't see too many of those tragic cases where they are told, "If we had only known this 2 years ago, we could have been of more help than we can now."

Thank you very much.

Senator LONG. Mrs. Mildred Kosaki, representing the Legislative Reference Bureau, is our next speaker.

STATEMENT OF MRS. MILDRED KOSAKI OF THE LEGISLATIVE REFERENCE BUREAU

Mrs. KOSAKI. In April 1961, the Legislative Reference Bureau published a report on the care of the chronically ill and disabled aged in Hawaii, at the request of the house committee on youth and general welfare of the first State legislature. Members of this committee were especially interested in three areas: (1) The effects of aging on physical health; (2) present provisions and needs in Hawaii for the care of the chronically ill and disabled aged; and (3) practices and programs in other mainland jurisdictions. My presentation this morning will concentrate on the second item.

A concern for the aged and the problems resulting from aging has only recently developed in Hawaii. This is somewhat understandable in view of the relatively low percentage of people who are presently 65 years and older. In March 1959 the territorial planning

office indicated that only Alaska and Puerto Rico had lower percentages than Hawaii of people 65 years and over in their population. However, the planning office also noted that the growth of this age group in Hawaii's civilian population between 1950 and 1957 was topped by only four States. The number of aged persons in Hawaii is expected to increase rapidly in the next decade. Population projections for Oahu alone for 1960–80 show that there will be an increase of 90 percent in the 65-and-over age group, or a total of 38,200 in 1980.

PRESENT FACILITIES FOR THE AGED IN HAWAII

The State of Hawaii and several of the counties own a few chronic disease facilities, some of which are largely inhabited by people 65 years and older. The health department in June 1960, using Hill-Burton Act standards, rated 169 beds suitable and 635 beds unsuitable in these institutions.

As a result of the decrease in the number of tuberculous patients in Hawaii, the legislature in 1959 enacted legislation which permits tuberculosis hospitals to admit indigents and medical indigents who are chronically ill, provided that beds for tuberculous patients are always made available when needed. This change in the statutes has resulted in the transfer of some aged persons from various hospitals to tuberculosis centers which now serve partly as chronic disease facilities.

In addition to the above publicly owned facilities there are privately owned nursing homes, chronic disease facilities, and domiciliary care homes run by nonprofit associations. These are briefly described in the bureau's report. Data on the suitability of beds are incomplete for these institutions.

NEEDS OF THE AGED IN HAWAII

In spite of the two favorable factors—of a small proportion of persons 65 years and over and of a higher health level of aged persons—there is still a shortage of adequate facilities to care for the aged who are chronically ill or disabled and there is doubt about the quality of some existing facilities. Using the accepted ratio of 3 beds per 1,000 persons to provide for nursing homes, homes for the aged, and chronic disease facilities, the department of health states that Hawaii should have a total of 1,797 beds available. The commission on aging reports that only 1,027 beds are in existence (57 percent) and only 712 (40 percent) are suitable.

The shortage of nursing homes and domiciliary care homes has resulted in the placement of aged persons in institutions which are not the most appropriate facilities to meet their needs. The Hawaii State Hospital, for instance, reports that it has more than 150 aged persons (out of a total of 228 patients 65 years and over) whose physical problems are more prominent than their psychiatric problems. The lack of adequate community resources has resulted in the commitment to the State hospital of elderly persons who might be better cared for in nursing or convalescent homes. Such misplacement is tragic for those misplaced and deprives others who may really need psychiatric care from receiving it. Furthermore, aged persons who might profit

most from being placed in domiciliary care homes may be found in nursing homes, thus depriving others who need convalescent care; and these people, in turn, might be placed in hospitals which are more costly and not the most appropriate means of caring for them. It is evident that the lack of a variety of facilities results in misplacement of individuals with all its tragic consequences and in loss of economy.

In addition to promoting the placement of elderly persons in the most effective facilities to give them appropriate care, planning to meet the needs of the disabled aged is generally guided by the principle that the aged should remain in their own homes and that they and their relatives should be provided with services so as to make institutional placement unnecessary under ordinary circumstances. The establishment of home care programs which make it possible for the elderly sick to be cared for at home with the aid of medical and nursing agencies reflects this principle. Homemaker services likewise enable the elderly to remain in their homes by lightening the household chores of those who are temporarily or permanently in need of some assistance.

It is evident that Hawaii needs more nursing homes, that it needs geriatric centers which conduct rehabilitation programs, that it needs halfway houses for patients who have improved sufficiently in mental hospitals to be almost ready for discharge, that it needs to establish home care programs and provide homemaker services. But this is only the beginning. Just as important is the necessity for preventing the ills often accompanying old age. In recent years there has slowly developed an emphasis on the necessity of preventive measures against senility and mental disorders. It is essential, for instance, to dispel the myth that aging necessarily brings physical and mental disabilities which can only be relieved, but not effectively cured, prevented, or minimized. Rehabilitation has been successful many times when managed by capable and trained personnel. Day care centers enable the aged to participate in interesting activities with fellow senior citizens. A positive attitude toward retirement and preparation for the wise use of leisuretime all contribute to good mental health. Low-cost housing and better economic conditions are essential to the well-being of the aged.

CONCLUSION

Accompanying society's greater concern and government's more active participation in providing for the economic and physical needs of the aged may come a new assessment and formulation of the role of the aged. Perhaps retirement will not mean a shift from independence to dependence and a loss of previous status. Perhaps retired people will be a unique source of strength, particularly as their problems are met, so that they can assume their positive roles in society.

Senator LONG. Thank you very much, Mrs. Kosaki. The picture that you have given of the limitations which we now have in relation to the number to be cared for is rather startling, particularly when we consider that our population is still a young population. As the next decade or decades come and go, we are going to have a real problem unless we begin working now. Thank you.

We are pleased at this time to have the executive secretary, Central Labor Council, AFL–CIO, Mr. Robert Hasegawa.

STATEMENT OF ROBERT HASEGAWA, EXECUTIVE SECRETARY, CENTRAL LABOR COUNCIL, AFL–CIO

Mr. HASEGAWA. Mr. Chairman, Senator Morse, and members of the panel, I have already, on behalf of the central labor council, submitted the formal part of my statement to the committee. I do not intend to read from the statement at all, but preference dictates that I should use the time available to me to supplement that statement.

The position of our central labor council and the unions affiliated with us on senior citizen affairs is well known and has been a matter of record here in the State of Hawaii for quite some time. I speak to you as one of the delegates from this State to the White House Conference on Aging, which I was very privileged to attend. Furthermore, while in attendance at this White House Conference on Aging, I was fortunate to be assigned to that particular work group which concerned itself with the question of medical care for the aged and how it should be financed.

Now, it is a well-known fact that all of our senior citizens have a multitude of problems, and the White House Conference on Aging more than proved this, for every delegate was considerably busy discussing and rediscussing and analyzing and studying all of these problems. But it is in the area of financing medical care to which the formal part of my statement has been addressed.

The concern of the AFL–CIO, the concern of our members, the concern of our leaders—both nationally and locally—is and has been and will continue to remain, insofar as the question of financing medical care for the aged is concerned, on the fact that all of the programs existing to date, including the Kerr-Mills Act, is not adequate or are not adequate to meet the needs of our senior citizens.

You have heard testimony here presented to you this morning about the extent to which our State has this problem and to what it might anticipate this problem to go to in 1970. But this is not the whole story. We are not so much concerned individually, as a State, within our own confines as to this particular problem. Our problem reflects the problem of the rest of the 49 States of the Union, and it is this concern which prompted us to present the statement that we did.

In furtherance of the statement that you have, I would like to indicate to you that sometime in 1961, this year, approximately June or so, President Meany appeared before the House Ways and Means Committee and presented testimony on H.R. 4222. At that time, President Meany stated, and I quote—well, stated that this problem of financing medical care is "too important to be decided by a contest between organized medicine and organized labor." I might indicate to the members of this committee that we are, in Hawaii, wholeheartedly in agreement with President Meany in this regard.

There is a question as to whether or not Hawaii as a State is fully participating in the benefits accruing it through the Kerr-Mills Act, and I find that there are standards under which much of these benefits are to be dispensed by the medical profession. Now, these standards are weighty, and I have a volume with me of a section of these particular rules and regulations, which I will not quote from but might indicate to the members of the committee that this particular

section deals with just one question: and that is: How to determine eligibility by the department of social services in our State on O.A.A. Now——

Senator MORSE. Mr. Chairman, I would like to suggest that this document be made an appendix to this hearing.

Senator LONG. It will be so ordered.

(The document referred to will be found in the appendix on pp. 1237–1316.)

Mr. HASEGAWA. Now, this document provides, as I indicated, only the standards under which eligibility is to be determined, but there are other pamphlets which our social services department gives to the personnel there which more than adequately spell out exactly how this need is to be finally determined.

Now, when we speak of need, I submit, Mr. Chairman and Senator Morse, that the means test, as was testified to earlier, is a common occurrence whenever you find programs of this nature existing in the State. Now, what is this means test that we are so much against? This means test provides that a person, an applicant for such medical care as he deems necessary, must first disclose all of his assets, everything that he owns, all his bank accounts if he has any, all his saving and loan accounts if he has any, what he owns in his home, what he owns outright as far as personal property and other property is concerned. After such disclosure, is the need determined? No, sir. The children of the applicant then must make the same disclosure, after which someone decides which of these assets are, in truth, resources; or which percentage of these assets might be considered to be resources. This, we submit, is a humiliating experience for anyone who needs medical care.

We also submit that on the question of need, a determination to be made by need is really an ex post facto arrangement. It is nothing but hindsight. For who is to say that we need a liability insurance when we die if we didn't get into an accident? Who is to say that we need something 40 years from now, or even 10 years from now? We submit that the need as expressed by some people in applying for public assistance, applying for medical care under public assistance, was due in fact to the very reason that these people have exhausted their finances through paying for medical care up to that point.

Now, in further testimony before the House Ways and Means Committee, President Meany indicated that the AMA's advertising has described medical care under social security as—

> a measure that would inject the Government into every consultation room; as a bill to deprive Americans of their free choice of doctors; as a plot to dictate the pattern of health care prescribed for every patient—

and much more.

I now call your attention to the addendum that we have submitted with our statement, which is, in truth, a reproduction of newspaper articles which appeared here in the month of February. One would guess after reading those articles and after reading President Meany's testimony before the House Ways and Means Committee in July that he might have had this in mind, when we are relatively confident that President Meany had no knowledge of these articles appearing in our local press.

I might conclude my portion of the time by indicating to the members of the subcommittee that the position of the AFL–CIO has been

traditionally and will continue to be, I am confident, that the responsibility of the individual to meet his needs first and foremost is paramount; and this is one of the reasons why we stress to our members the need for thrift, the need to be responsible members of the community in which they live, and the need, really, which is expressed by organized labor in its efforts to get a more meaningful wage rate for our members. But the position of the AFL–CIO is that the individual comes first; and if not the individual, it is his family. If his family is unable to meet certain crises developing in the family, then it is the responsibility of the community; and if the community is unable to respond to this need, through one reason or another, it becomes the responsibility of the State. And if the State is unable to respond to the needs of various families in trouble such as this, then it becomes, ultimately, the responsibility of the Nation.

And in this way, we feel that the question of financing medical care for the senior citizens of the United States is and can only be met through the social security mechanism. All we are asking for, really, is to let us pay for health care needs while we are able to, while we are working, so that when we are old, so that when we become unable to work, the health care needs at that time will be supplied us; for at that time, I might add, we will be too old to work and too young to die.

Thank you very much.

Senator LONG. Thank you, Mr. Hasegawa.

(The prepared statement of Mr. Hasegawa and the papers referred to in the statement follow:)

PREPARED STATEMENT OF ROBERT K. HASEGAWA, EXECUTIVE SECRETARY, CENTRAL LABOR COUNCIL OF HONOLULU, AFL–CIO

Mr. Chairman, we are especially pleased to appear before your subcommittee today, to offer the following statement on behalf of the AFL–CIO local unions in Hawaii, for the well-being of our senior citizens, and, indeed, the well-being of the men and women of our State and Nation has long been of major concern to us. And for the further reason that "to promote the general welfare" as stated in the preamble to the Constitution of the United States, is, after all, one of our basic aims.

That our senior citizens have mounting problems is an accepted fact by all segments of our community. Problems in such areas as income maintenance, financing medical care, housing, education, health and rehabilitation, religious and recreational needs, et cetera, are problems whose existence is and has been acknowledged by the clergy, State and county government officials, officials of institutions, both governmental and private, as well as officials of various clubs, lodges and labor unions. However, aside from the senior citizens themselves, we dare say that it is their children, in whose care most of them are, who are most intimately aware of the magnitude of their problems.

Mr. Chairman, in January of this year, I was privileged to go to Washington as one of 11 delegates from the State of Hawaii, having been appointed by the Governor, to participate in the White House Conference on Aging. The meetings I attended, the debates I participated in, the people I met and the discussions I entered into while a delegate to this conference are experiences I shall never forget. Upon leaving this conference and returning home, I returned not with a sense of futility at the mounting problems of our senior citizens—which were discussed in great detail at this conference—but with a sense of duty to do that which I could, to the best of my ability, with the help of those in the trade union movement as well as those without to bring about rapid solutions to these problems.

Some months prior to my going to Washington, and also upon my return from this conference, I met with quite a few of our members as well as senior citizens who wanted to discuss their problems as well as their solutions and how they might help in attaining these solutions. The one outstanding problem—the

common denominator of all of the problems or concerns of the senior citizens as well as those who are not yet old enough to call themselves senior citizens—is that posed by the high costs of medical care and how to meet such costs.

It is therefore in the area of financing medical care for our senior citizens to which I would like to address my remarks.

Whenever the subject of financing medical care for the senior citizens is discussed nowadays, there are only two schools of thought of any consequence: One school holds that there is no problem or that the problem is not so great that existing programs such as commercial insurance plans, nonprofit prepayment health plans, family resources, as well as full State participation in the Kerr-Mills Act provisions, cannot take care of the problem. The other holds that the problem is indeed of first magnitude and cannot be adequately solved by these existing means; and further, that the social security approach to financing medical care is the only practical means of insuring adequacy of benefits and maintaining or even elevating the dignity of the beneficiaries.

Is there a problem?

At the White House Conference on Aging, I was extremely fortunate to be assigned to the particular work group which concerned itself with the subject of financing medical care for the aged. I can attest to the fact that the debates were long, some of the arguments heated, some of the pleas of those who feared the social security approach to financing medical care for the aged, impassioned. Those who argued that there was no problem were driven from this position by the sheer weight of facts and statistics supplied by resource personnel and others. They must have acknowledged the existence of a problem for they next argued that commercial insurance companies are vigorously designing health plans and the sales of such plans coupled with the nonprofit prepayment plans such as Blue Shield and Blue Cross plus the passage of the Kerr-Mills Act, had more than adequately solved the problem. When this position, too, became untenable, this same group and their friends reverted to their tried and true credo: That financing medical care through the social security mechanism was "socialized medicine" and therefore, a threat to American liberty.

Experts in both administrations—the present and the one immediately previous to this—have confirmed and reconfirmed what we in the labor movement have known for quite some time: That medical costs have destroyed the hard-earned economic security of many persons and threatens the economic welfare of their children.

Former Secretary of Health, Education, and Welfare, the Honorable Arthur Flemming, submitted a comprehensive report to the Congress which found that three out of four aged persons would be able "to prove need in relation to hospital costs."

Yet another former Secretary of the Department of Health, Education, and Welfare, the Honorable Marion Folsom, also openly endorsed the social security approach to financing medical care for the aged during the course of the White House Conference.

The majority report of the section to which the problem of financing medical care was assigned, had this to say in part:

"The problem of furnishing an adequate level of high quality care for the aged is so large and so complex that its solution will require the use of a variety of approaches, including individual and family resources, voluntary health insurance, industrial programs, social security, public asistance, and a variety of other programs.

"Present Federal legislation providing governmental aid for recipients of public assistance and for the medically indigent is desirable and should be strengthened so as to provide a high-quality health care program. The States are urged to take full advantage of this legislation.

"Private voluntary effort and public assistance can contribute much to the solution of the problem of health care for the aged. However, they will continue to fall short of meeting the basic medical care needs of the aged as a whole. The majority of the delegates of section 2 (by a vote of 170 to 99) believe that the social security mechanism should be the basic means of financing health care for the aged."

Yes, there is a problem. It is real, it is extensive, and it is progressively getting worse.

How then, has this problem of meeting medical care costs for the aged been solved, if it has been at all? What are some of the methods which have been cited?

Let us examine private insurance plans which have recently been widely publicized and aimed at the senior citizens. I would like to note for this sub-

committee that the mergence of health plans for those above 65 years of age have come to the fore since the Forand bill was introduced in Congress by Congressman Aime J. Forand. I point this out only to illustrate the remarkable resilence and adaptability of the insurance industry as a whole to changing items and challenges. However, an examination of some of these nationally advertised health plans for those over 65 years of age shows that they don't come close to meeting the needs of our senior citizens.

As a multitude of commercial health insurance plans are devised by the mind of man and rushed to the marketplace, they all suffer from one common shortcoming and that is the fact that we have a high-risk group insuring itself. This obviously means that the premiums must be above average or the benefits below average, or more likely, a little of both.

We do not believe that congressional approval of financing medical care for the aged through the Social Security Act, will lead to the death of commercial insurance companies in this field. We are convinced that the precise opposite will be the result—just as the enactment of the Social Security Act resulted in increased sales of retirement income insurance as well as life insurance. Every successful life insurance counselor will tell you that this was accomplished by using the retirement income from Social Security as the base upon which they were able to help their clients build an estate. Such is the resilience and adaptability of the insurance industry to changing times and challenges.

Another existing form of protection is the voluntary, nonprofit prepayment plans such as that of the Hawaii Medical Service Association (a Blue Shield Plan). Another is the Kaiser Health Plan. Almost all of our union members are covered under one or the other of these plans—all gained through the collective bargaining process.

Here again, an examination of the plan shows conclusively that they just can't meet the problem—much less solve it. It is evident to us, therefore, that neither commercial nor voluntary prepayment health plans can adequately solve the problem.

Dr. Basil MacLean, retired president of the National Blue Cross Association, has put it this way:

"A lifetime's experience has led me at last to conclude that the costs of care of the aged cannot be met, unaided, by the mechanism of insurance or prepayment as they exist today. The aged simply cannot afford to buy from any of these the scope of care that is required, nor do the stern competitive realities permit any carrier, whether nonprofit or commercial, to provide benefits which are adequate at a price which is feasible for any but a small portion of the aged."

And now, we come to the Kerr-Mills Act. This act became effective on October 1, 1960, just 3 months before the White House Conference on Aging.

While it is well and good that the White House conference urged the States "to take full advantage of this legislation," there is a vast difference between what the States should do and what is really done. The financial conditions and problems of each State as well as its political pressures almost guarantee that such will be the case. This point was well illustrated at the White House conference. I can recall that there were a few State legislators in our particular work group. At least two of these gentlemen strongly indicated that the financial condition of their States made it unlikely that they would be able to take full advantage of Kerr-Mills. And, as a matter of fact, our latest information indicates that less than one-half of the States are currently participating in Kerr-Mills.

Mr. Chairman, we are not against the Kerr-Mills Act as some will have you believe. We welcome it. What we are against is the concept of medical assistance. This is the means test.

Under this act and the methods by which States administer it, we tell a person he can get all the medical care he needs provided he becomes a public charge; provided he has spent his savings; provided he has sold his possessions and also provided he has exhausted the resources of his relatives in an effort to meet the cost himself.

Our own State department of social services has a weighty section in its manual of operations on how eligibility for medical assistance is determined. An examination of this section makes it seem to me that our senior citizen is not in as much trouble as he will be the moment he becomes an applicant for medical assistance. For upon becoming an applicant, he must make full disclosure of all of his assets.

And what are assets? They are bank accounts, credit union, and savings and loan accounts. They are stocks and bonds, personal and real property. They

are cash on hand, life insurance, pensions. In short, they are anything and everything of value which may have taken a lifetime to acquire.

After this is done, the adult children of the applicant must also make full disclosure of their assets, too. This is followed up by someone in the department making a determination as to which of these assets or what portion of an asset is a "resource" and then a determination is made as to whether the applicant is "needy" and therefore, eligible for medical assistance. And if he is, the amount of his "need" is also established.

It is hoped that the applicant for medical assistance doesn't die during the time his application is processed and his "need" established.

Regulations or standards such as these are inevitable when you have a program based on need. We say that the means test is degrading to the applicant for assistance and an unwarranted imposition upon his children.

Mr. Chairman, as we said before, we welcome the addition of medical assistance to the scope of the public assistance program through the Kerr-Mills Act. But we submit that even this does not meet the need.

Under the social security approach of financing medical care, every worker and his employer will set aside a modest sum each payday to create a fund which will pay a substantial part of his medical expenses after he retires.

Is there anything wrong with this?

I think we must all remember that no social welfare program ever enacted or to be enacted, will cover every citizen. This utopian situation is something, I believe, that neither you nor I will ever see in our lifetimes. Even our Hawaiian muumuu, though it covers much, still leaves some areas of the body exposed to the elements.

It is true that some people may benefit under this plan who may not have paid their share or much of it. It is equally true that some people may not be covered by this plan. But are we to deny literally millions of our senior citizens now retired under social security and the tens of thousands of them reaching retirement age as each month progresses, this program? A program to finance medical care through the Social Security Act, a workable and intelligent program, the one program which can meet the need, which can provide the peace of mind for our senior citizens and their children, just because some may gain without paying for it and some others who may be just as needy may not be covered?

Mr. Chairman, I don't know of a Congress—and the gentlemen and ladies who made up that august body as our Nation grew—which approached legislation from the standpoint of the man or woman who didn't need it; the family or community that didn't need it; the county or State that didn't need it. Certainly the Congress which enacted the Social Security Act, did not approach this piece of legislation from the standpoint of the man who didn't need a Federal pension. I am confident that you are not going to approach the matter of financing medical care under social security from the standpoint of those who profess that they don't need this either.

This great Nation of ours, Mr. Chairman, spends millions of dollars daily to store our surplus crops and produce. And as if this problem was not bad enough, we also spend millions reclaiming land to grow more surpluses to be stored. Additionally millions are spent to subsidize airlines, the shipping industry, the railroads, the oil industry, and even newspapers and magazines.

The claim is made that because of this, our Nation is drifting toward socialism. A further claim is made when we ask that medical care costs be financed through the social security mechanism—and not a subsidy at that—that we are galloping toward socialism medicine.

More often than not, some of the very persons who are first in line for Federal subsidies and see nothing wrong with them, suddenly find a number of faults with financing medical care for human beings under the social security mechanism. This, I cannot comprehend at all.

Mr. Chairman, honorable Senators of this distinguished committee, when the 87th Congress reconvenes, the members and the leaders of the organizations I represent, the Central Labor Council of Honolulu, AFL–CIO, respectfully request and urge you to pursue the enactment of a measure which will provide that the financing of medical care shall be accomplished through the social security mechanism. We urge you to do this with new vigor, with new enthusiasm, for the benefit of all those who are retired, for those who are about to retire, for those who are barely beginning their working lives and for every American in between.

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[From the Honolulu Advertiser of Feb. 10, 1961]

ISLE DOCTORS RAP J.F.K. AGED HEALTH PROGRAM

President Kennedy's social security-based program of medical aid for the aged drew fire yesterday from members of Hawaii's medical profession, who prefer a locally administered program.

Dr. Harry L. Arnold, Jr., editor of the Hawaii Medical Journal, said the Kennedy program "leaves a good many people in need of help (those not on social security) and also covers a multitude of people who don't need it.

"It will be an additional and unjustifiable financial burden on wage earners. It will make medical care far more expensive for old persons who are not covered by social security, since it will compete with or eliminate health insurance programs for this group."

Dr. Morton E. Berk, chairman of the medical care plans committee of the Honolulu County Medical Society, said:

"It (the Kennedy program) increases the cost of medical care to the taxpayer of the United States. The program doesn't take care of a large number of people not covered by social security.

"It puts into the category of accepting charity people over 65 who are very much able to take care of themselves, and thus foists Government care on people who don't want it but who will have to pay for it nevertheless.

"We believe that every person in this community who needs medical care should be able to get it. If it takes Federal funds, well and good, but it should not be administered from Washington, D.C., by Washington, D.C."

Dr. Edward Cushnie, president of the Hawaii Medical Association, the State organization, said:

"Doctors agree that increased medical care for elderly persons is desirable, and they are actively working to promote it.

"But they feel that Government medicine at the taxpayers' expense is not the best answer. If medical care is tied to the social security program, only 60 percent of the people over 65 would be covered, and taxpayers would be paying for compulsory care whether some of the 60 percent needed it or not and whether they wanted it or not."

[From the Honolulu Star-Bulletin of Feb. 12, 1961]

DOCTORS, LABOR GROUP AT ODDS ON AGED CARE

The Honolulu County Medical Society yesterday urged the AFL-CIO Honolulu Central Labor Council to join it in pressing for State compliance with Federal rules for medical aid for Hawaii's aged under existing law.

Dr. Harry L. Arnold Jr., editor of Hawaii Medical Journal, issued a statement taking issue with the stand of the labor council favoring President Kennedy's social security care plan.

Arnold's statement, made in behalf of the medical group, noted that Robert Hasegawa of the AFL-CIO has said medical care must be put under social security because many people in need of help are not getting it.

"I urge Mr. Hasegawa and anyone else interested in getting help for all the aged—not just those under social security—to get behind the excellent law we already have," Arnold said.

"It is the Kerr-Mills Act, under which matching Federal funds are made available for every aged American who needs health care help. It is a broad law. It is economical and the quality and scope of care would be much superior.

"Hawaii will put this program into effect in the current legislature. It will keep control at the State level, where it belongs, instead of boosting the social security tax.

"Let's get behind this. Then every aged American who needs help can get all the health care he requires, without damage to his dignity.

"Let us not socialize any more. Let's keep our health care problem at the community level, where it belongs."

[From the Honolulu Advertiser of Feb. 11, 1961]

DOCTORS, AFL-CIO CLASH ON MED PLAN

The AFL-CIO Central Labor Council yesterday took issue with a group of local doctors who criticized President Kennedy's medical care plan for the aged.

The doctors said the President's plan would place a financial burden on wage earners and would benefit persons who do not need the coverage, at the expense of oldsters who do need it.

Physicians who commented were Dr. Harry Arnold, Jr., editor of the Hawaii Medical Journal; Dr. Morton E. Berk, chairman of the Medical Care Plans Committee of the Honolulu County Medical Society; and Dr. Edward Cushnie, president of Hawaii Medical Association.

Disagreeing with the physicians, the labor council said, "Dr. Arnold should be reminded that it is precisely because there are a good many people in need of help, who are not now having any help, that this medical care plan must be enacted.

"He should also be reminded that the cost of medical care for the aged now is a financial burden to the wage earner who is taking care of an aged relative."

"President Kennedy's plan will not foist Government care on people who don't want it or need it," said Robert Hasegawa, council executive secretary.

"Furthermore, this is not Government care, but medical care prescribed and performed by the very doctors who are now criticizing this plan."

Senator LONG. We had scheduled this program to reconvene at 2 o'clock this afternoon. I am going to shorten that and make it 1:30. We have two witnesses whom we haven't been able to hear this morning—Mr. Stevens, administrator, Hawaii Employment Service; and Mr. Sagara, director, division of vocational rehabilitation. By beginning at 1:30, we will give them time to share their opinions with us.

The meeting is now recessed until 1:30 p.m.

AFTERNOON SESSION

Senator LONG. We will begin our program where we left off, and the first speaker will be the administrator, Hawaii Employment Service, Mr. E. Leigh Stevens.

STATEMENT OF E. LEIGH STEVENS, ADMINISTRATOR, HAWAII EMPLOYMENT SERVICE

Mr. STEVENS. Senator Long, Senator Morse, Senator Fong, members of the staff who are making this special study, I am indeed glad that I am privileged to be here today and to have been invited to be on this program. But I must apologize—I'm not like Mr. Hasegawa; I'm afraid I'm just going to make it about even. I'm just getting over three broken legs and now a sore throat, and I think we'll just meet at the crossroad that when you quit working, you quit altogether.

The employment service, as you gentlemen all know, is financed through the Wagner-Peyser Act. We have six employment offices in Honolulu. One of them hasn't opened up yet. It will open up next week as soon as they get some furniture in it. There is a clerical and professional office, an industrial office, an office in Hilo; an office in Maui; an office in Lihue and Wailuku. These offices—I will not report on each one of them since you are going to the other islands and they will give you the statistics on their area which they cover, because each of the areas is different. The other islands, the neighboring islands, as we call them, are normally known as agricultural areas, and Honolulu is the only real labor market in the State of Hawaii at this time.

I will give you some statistics which—after I got them up, I was a little alarmed, myself, because they show that within the past year older workers in the active files have jumped almost 100 percent.

And also, in the active files, older workers who are handicapped have jumped 45 or 50 percent. So these charts, with some material, I gave you, will disclose that.

Now, I am not like the other speakers. I am not talking about the older worker when he is 65 or over. We are talking about workers 45 and over, because at that time they begin aging. Normally, when we look at a worker 65, under ideal conditions he is ready to retire. But where he does not and you have ideal conditions, we still try to service him and get him a job to supplement his income. But it is alarming—some of these definitions when a person is older.

Now, a chemist or a scientist or a professional man is not considered an older worker until he reaches 65; but a carpenter, painter, plumber, certain working trades, he cannot work sometimes after 45 because they will not hire him. They say, "You're too old."

Well, we have the same thing with our female secretaries-stenographers. They fall in our older workers category sometimes at 35 and 38. Now, the airline hostesses fall into the youngest age level and are called older workers at 27 years of age. They won't start them at that.

Still, labor market conditions could change all of these definitions and will bring other people into the labor market when they are needed and when they are hired, regardless of age.

In our active file in Honolulu, as of November 21, we had 2,416 workers in the employment service file which we call older workers. Most of them, about one-fifth of this group registered at the Honolulu office, are persons over 45. The majority of these older applicants have developed skills. The majority of them have obtained abilities with long years of service and experience. Many have held positions of trust and responsibilities, and, as a result, reached their highest earning level in their last job.

Another characteristic, 90 percent of them have at least 15 to 25 years of work experience. Once unemployed, this older workers group tends to stay unemployed longer than any other group. The average schooling of this older workers group is 8 years of formal education.

About 75 percent of the older worker applicants are males, of which 11 percent are veterans, and the 25 percent are females.

Fifty-eight percent of the older female applicants seek employment in the clerical and sales service occupations, while the male older worker seeks employment in all the major occupational groups.

About 20 percent of the older worker applicants have at least one type of physical disability.

Of the 486 older workers in the active file who had physical handicaps besides age, the following problems were disclosed on 249 applicants. This 249 is really a hard core of disabled and older workers to place. Of this 10 percent of the older workers group, they have multiple problems, not just one, not just one physical handicap, but they have several.

And into one of the groups, 60 of these fall into what we call physically and mentally disabled besides age. In the skilled trades, many older workers encounter the problem of keeping up with the younger workers. They lose their speed in their production operations and

there is decreased power of perception and lack of stamina. Although this may indicate a need for a change in occupation to less skilled jobs or smaller paying jobs, these older applicants fail or refuse to understand the situation.

Nonrealistic demands are 56. Because of the long period of continuous employment, older workers are unaware of the labor market conditions, thereby making unrealistic demands; and the following are some of the common ones—56 applicants were in this group:

Rigid demands for higher wages or as high as the top level of the job they last worked at; or, they want to go overseas to overseas jobs that require rigid physical examinations. They will not shift these older people to do these jobs because they do not have hospital services in these areas.

Then there is another hard-core unemployed group with other limitations, numbered 46:

(*a*) Poor appearance and attitude and sketchy work records, 20.

(*b*) Language handicap, 12.

(*c*) Continued domestic problems, 14.

Temporary layoff, waiting to be recalled, 18.

Want unemployment insurance only, 12.

Handicapped and retired and need extra income, 16.

Complex problems, alcoholism, complaints of multiple handicaps, poor work records, police and prison records, 20.

Must make vocational change because of disability, 21.

That covers the hardest group which have multiple handicaps besides age, and is about 10 percent of the older workers group. It is not too alarming because we have in the active file at this time over 10,000 active applications. Twenty-five percent of them are in the older worker group, but only 10 percent of them are in the hard-core group that have multiple problems.

Now, another chart is—I made a survey of what kind of service we are giving these workers. We started a little record back in 1958. I don't know why we started it but somebody said it would be a good idea to start it, and we kept a record of what services we have given applicants 45 or over.

In 1958, we had new applications of 2,545. In 1959, we had new applications, 2,835. And the next year, about the same, 2,987. And so far, in the first 10 months of this year, we have had 3,477, which is a standard increase of 500 applications. And of these numbers, the handicaps run just about 500 each year.

While the active file of older workers increased to 1,322 in 1958 to 2,416 in 1961, from 1960 to 1961 it is 1,288 to 2,416; so something has really happened in the last year in our older worker area in Honolulu. And the handicapped, likewise, had increased from 343 in 1960 to 483 in 10 months of 1961.

I might state that I am very much interested in this handicapped program and I have been very fortunate to serve on the Governor's committee for about 14 years, having been chairman of the committee for 12 years. And I finally gave it up to get a good man; so we got a Sears Roebuck man to take charge because I think it is time that private industry take over. And we have built it up from placing 67 the first year I took it to about 1,200 or 1,300 a year since then.

And this year we already have placed about a thousand. So I think private industry should take the lead and I am willing to serve on the team, but private industry, by taking the lead and showing what they can do, themselves, can bring others into the fold.

We have in this program a big blackboard, about 15 feet long and about 9 feet high, and we give awards, a roll of honor, to whoever contributes to the hiring of the handicapped. And through the Navy contributing the board, we operate without budget and we get by and maybe print some name plates in gold letters. And we have these meetings and get several hundred people out and we have now about 150 to 200 employers on this honor roll and Sears Roebuck is one of the outstanding ones in the country. Mr. Cummings, superintendent of Sears Roebuck, has agreed to take the chairmanship this next year.

(The papers referred to in the statement follow:)

EMPLOYMENT SERVICE DEFINITION OF AN OLDER WORKER

Any person who is encountering or may be expected to encounter difficulty in getting or keeping a job, primarily because of his age. For reporting purposes, however, the employment service considers applicants 45 years and over as older workers or aging.

It depends on the occupation, labor market conditions, etc.

(*a*) A chemist, scientist, or other professional worker is not considered old until 65 years of age.

(*b*) A carpenter, painter, plumber, and other skilled construction workers will be considered an older worker around 45 years of age.

(*c*) Female secretaries, stenographers, and clerks fall into the older worker category somewhere around 35 to 38 years of age.

(*d*) Yet the airline hostesses fall into a much younger age level and are called older workers at 27 years old.

Still labor market conditions might change the above age levels at which a person is considered an older worker.

Characteristics of the 2,416 older workers in the employment service files, November 1961 (see chart I):

(*a*) Most of them have skills. About one-fifth of our unemployed workers registered at the Honolulu local office are persons over 45 years old. The majority of these older applicants have developed skills and abilities through their long years of work experience. Many have held positions of trust and responsibility and, as a result, reached their highest earnings in their last jobs.

(*b*) Ninety percent of them have at least 15 to 25 years of work experience.

(*c*) Once unemployed, however, the older workers tend to stay unemployed longer than other groups.

(*d*) The average schooling of this older worker group is 8 years of formal education.

(*e*) About 75 percent of the older worker applicants are males, of which 11 percent are veterans, and the remaining 25 percent are females.

(*f*) About 58 percent of the older female applicants seek employment in the clerical and sales or service groups, while the male older worker applicants appear divided into several major occupational groups.

(*g*) About 20 percent of the older worker applicants have at least one type of physical disability.

CHART I.—*Honolulu local employment office active file inventory, applicants 45 years and older, November 1961*

Occupational group	Total		Female		Veteran			Handicapped					
								Total		Female		Veteran	
	45-64	65 up	45-64	65 up	45-64	65 up	Female	45-64	65 up	45-64	65 up	45-64	65 up
0 Professional, semiprofessional, and managerial	196	17	61	4	44	4	0	26	6	4	1	10	1
1 Clerical and sales	266	17	165	5	34	1	1	46	9	16	5	7	1
2 Service	418	37	150	16	35	4	0	102	10	14	14	15	0
3 Agriculture, forestry, and fishing	88	5	27	0	2	1	0	6	0	0	0	1	0
4 and 5 Skilled	470	33	41	2	55	7	0	68	11	3	1	15	2
6 and 7 Semiskilled	183	18	30	7	21	2	0	35	2	3	4	3	0
8 and 9 Unskilled	380	9	21	1	29	2	0	54	2	9	1	4	0
Entries	254	23	67	2	21	8	0	96	13	16	0	15	5
Grand total	2,257	159	563	37	241	29	1	433	53	65	26	70	9

Of the 486 older workers in the active file who had physical handicaps besides age, the following problems were disclosed on 249 applicants, or this 10 percent of the older workers have multiple problems including physical handicaps plus others. The following is an analysis of the 249 applicants:

1. Physical and mental disability besides age, 60.

In the skilled trades, many older workers encounter the problem of physical limitations, loss of speed in production operations, decreased power of perception, and lack of stamina. Although this may indicate a need for a change in occupation to less skilled jobs or smaller paying jobs, these older applicants fail or refuse to understand the situation.

2. Nonrealistic demands, 56.

Because of the long period of continuous employment, older workers are unaware of the labor market conditions, thereby making unrealistic demands. Following are the most common ones:

(*a*) Rigid demands on wages or overseas jobs, 56. All overseas jobs require rigid physical examinations which they cannot pass.

3. Hard-core unemployed group with other limitations, 46.

Although most older workers know their own limitations, some fail to understand, or refuse to accept these limitations. As a result, they blame the employers for their continued unemployment.

(*a*) Poor appeareance and attitude and sketchy work records, 20.

(*b*) Language handicap, 12.

(*c*) Continued domestic problems, 14.

4. Temporary layoff, waiting for recall, 18.

5. Wants unemployment insurance only, 12.

6. Handicapped and retired and needs extra income, 16.

7. Complex problems—alcoholic, complains of multiple handicaps, poor work record, police and prison record, 20.

8. Must make vocational change because of disability, 21.

CHART II.—*Services rendered older worker applicants by the State employment service on the island of Oahu, 1958 through October 1961*

	Workers over 45 years of age			
	1958	1959	1960	1961 [2]
1. New applicants	2,545	2,835	2,987	3,477
Handicapped	498	526	523	545
2. Active file [1]	1,322	1,615	1,288	2,416
Handicapped [1]	341	378	343	483
3. Initial counseling interviews	227	303	326	196
Handicapped	181	220	241	142
4. Job placements	823	1,056	983	814
Handicapped	114	103	135	72
5. Total, all applicants in active file, November each year	4,943	5,792	5,229	10,003
Total, older worker active file	1,322	1,615	1,288	2,416

[1] Includes only survey for November reports.
[2] Includes only 10 months of year.

As the active file and unemployment increase, the services to older worker applicants decline. This is because the present staff cannot keep pace with additional workload. There is no provision to add staff in a budget year for these services. Only for new applicants as they relate to increased claims are additional funds available for both applications and claims.

In comparing 1960 workloads with 1961 on chart II, new applications in 10 months of 1961 already increased 500 over older workers in 1960. The active file for older workers has increased 90 percent above the 1960 total. Also, the active-file, handicapped older workers have increased 40 percent over 1960, while the main services needed have declined. Counseling interviews declined 40 percent in 1961, placements decreased by 169, while handicapped placements decreased 45 percent below 1960.

We recommend funds for additional staff to be made available. The additional staff is to be assigned to the older worker program to increase the

counseling services and to conduct a job development program in the community; also, to develop better organized occupational labor market information that can be used, especially for this group.

Senator LONG. Thank you, Mr. Stevens. You have brought in a different slant on aging problems and given us a very comprehensive statement.

The next speaker and the last one on the first part of the program is the director, division of vocational rehabilitation, Mr. Sagara.

Mr. Sagara, will you take the witness stand, please.

STATEMENT OF KUNIJI SAGARA, DIRECTOR, DIVISION OF VOCATIONAL REHABILITATION

Mr. SAGARA. Mr. Chairman, members of the Senate Special Committee on Aging, my name is Kuniji Sagara, director of the division of vocational rehabilitation.

VOCATIONAL RAHABILITATION AND PROBLEMS OF THE AGING

The division of vocational rehabilitation of the State department of education administers three programs on a statewide basis pertinent to the aged. These are:

1. Disability determination of applicants for Federal social security disability insurance benefits. This program is financed entirely by Federal funds.

2. Vocational rehabilitation of disabled persons. This program is financed on a State-Federal matching basis under the provisions of Public Law 565, the National Vocational Rehabilitation Act.

3. Rehabilitation of the chronically and severely disabled toward independent living. This program, too, is a federally matched program under the National Vocational Rehabilitation Act.

In all of these programs, the aged are provided services along with other groups, if disability is a problem. The goal of vocational rehabilitation is to restore the employment capabilities of the disabled. Within this context we have become acquainted with the problems of the aged, which may be categorized as medical, educational, and employment.

Today, the medical profession performs many miracles of lifesaving and alleviation of pain, but frequently is unable to prevent the crippling effects of illnesses and accidents. We know that the crippling residuals can be prevented because our business frequently calls for either reducing the severity of disablement or removing the disability entirely. The difference between prevention and cure in this instance is the timing—that is, if rehabilitation procedures are instituted at the onset of the disability, prevention is possible.

We believe shortage of trained personnel and the high cost of rehabilitation, which involves a large number of trained personnel, as the obstacles. We believe that these obstacles can be overcome through greater Federal-State financial investment in public health and rehabilitation programs since the ultimate effect will be a reduction of costs in existing Federal-State programs of sustenance, institution, and medical programs.

A second major problem we have become acquainted with is the great lack of retraining opportunities for the older persons whose job skills have become obsolete because of the changing demands of our changing economy. This problem becomes doubly great for the older person who is disabled.

We believe that the solution is a simple one. Although employment places a premium on youth, when shortage in skilled labor occurs, age and disability barriers become nonexistent. Therefore, the changing economy, though it creates a problem for the older person, can also work to his favor if he is adequately prepared. We strongly believe that the Federal-State financial partnership in vocational education should be expanded to include the retraining needs of the older person; further, that the type of skill training to be offered be left to the individual State to determine since the changes in the labor market demands are more frequently confined to regions and States rather than nationwide.

A third major problem encountered by the aged is in employment. A glance through the "help wanted" section of the newspapers will quickly verify the fact that in employment premium is placed on youth.

Here, three suggestions offer possible solutions:

1. Expansion of vocational and adult education to enable the older workers to either regain new skills or modify their present skills to meet the changing demands of the economy so that loss of employment can be minimized and if employment is lost reentry would be easier.

2. A general educational program for employers to emphasize the assets of the older person as employee, patterned after the present President's Committee on Employ the Physically Handicapped.

3. A frequently mentioned reason for not hiring an older person is the high cost to employers for pension payments supplementing the Federal old-age insurance benefits because of the limited contribution to the pension plan made by an older person. The Federal old-age insurance can offer a possible solution through increases in its retirement benefits.

As workers directly concerned with provision of services to many, including the aged, we can offer only our experiences and observations, rather than the results of research. We hope that these experiences may offer your committee a clue toward solutions of problems encountered by the aged.

Thank you.

Senator LONG. Thank you, Mr. Sagara.

That concludes the first section of the agenda as it was originally planned.

We come now to the last part of it. There are a total of 25 names. There were 14 this morning. We have a half hour longer this afternoon. It will be necessary, however, for me to watch the time and if the various speakers cannot limit themselves to somewhere between 3 and 5 minutes, then I will have to, as much as I regret to do so, call attention to the fact that the time is up.

The first speaker is Dr. Andrew Lind, director, Social Sciences Research Institute, and professor of sociology at the University of Hawaii. Dr. Lind is a longtime worker in this field and we are delighted to have him.

STATEMENT OF DR. ANDREW LIND, ACTING DIRECTOR, SOCIAL SCIENCES RESEARCH INSTITUTE; PROFESSOR OF SOCIOLOGY, UNIVERSITY OF HAWAII

Dr. LIND. Senator Long, members of the committee, since my statement is going to be very brief, I think I can keep myself within the limits that you have imposed. Knowing the weakness of professors, however, I am going to confine myself to a few written statements.

I should preface my brief report by observing that owing to the relatively youthful character of Hawaii's population, the social scientists at the University of Hawaii have not regarded the problems of the aging as one of their major or chief concerns. There have always been more urgent matters that seem to have demanded their attention. As a consequence, the studies of aging have been somewhat incidental to other research, such as the studies in the field of race relations or of cultural contacts. I believe, however, that some of the findings which have emerged in these studies may have special significance for the handling of the problem as it is now emerging in Hawaii, for owing to the fact that we have not encountered the more acute problems of the aging, as experienced in many mainland communities, we have, perhaps, a little more breathing space in which to prepare more adequately for the problem as it develops and to take advantage, likewise, of the experience of the older communities.

It is difficult to say how much of a timelag there is between Hawaii and the continental United States in this regard. In 1950, for example, our proportion of the population 65 years of age and over was about that of the continental United States in the year 1900. On the other hand, certain of our ethnic groups have matured more rapidly than the others and their proportions of persons 65 years and over have approximated those of continental United States. The older immigrant groups, for example, the Chinese, the Japanese, and the Korean, quite obviously present more of a problem in this regard than the younger or more recently arrived immigrant groups such as the Filipinos and the Puerto Ricans or than the native Hawaiians and part-Hawaiians.

But I want particularly to emphasize, however, the potential advantage which Hawaii possesses in dealing with the problem of aging by virtue of the high proportion of its people who still retain a vigorous heritage in which the family plays a dominant role, and the concern for the aged parents or relatives is a major moral obligation on every able-bodied person. Well over 50 percent of our population are only one or two generations removed from a culture whose cornerstone was filial piety, and our people of oriental ancestry, including those even of the third and fourth generation, are still highly responsive to the proposition that a person's prestige and significance increases with age. But, incidentally, the obligation of the younger generation is to care for the physical requirements of their aged parents and relatives.

Insofar as this tradition persists, retirement does not represent a loss of status or a stepping down, or a failure but, rather, an advancement to a position of great honor and veneration. It has been

suggested, for example, that the feelings of tenderness and chivalry which Western males commonly express toward the female were traditionally expressed by people of Asian ancestry toward their aged. It might take the form, even, of encouraging the parents to withdraw from the active economic support of the family in case there were other areas of life that appeared more appealing. And such a shifting of the burden of support from the father to the son or from the caring for the household from the mother to the daughter or daughter-in-law does not imply any loss of status but is really, on the part of the young person, a gesture of love and appreciation for the services rendered.

Is my time up?

May I conclude by simply pointing out that this heritage that we do possess, and which I personally feel we ought to take advantage of to the maximum, is one that is rapidly disappearing as Western influences intrude in the island situation and as our population is becoming increasingly, shall we say, westernized and Americanized.

Senator LONG. Thank you, Dr. Lind.

We now come to the group interested in social services. The first witness, director, department of social services, Miss Mary Noonan.

STATEMENT OF MISS MARY NOONAN, DIRECTOR, DEPARTMENT OF SOCIAL SERVICES

Miss NOONAN. Senators, thank you for letting us have the opportunity to share with you our thoughts on the aging here.

INTRODUCTORY STATEMENT

The State's social services for the aged in Hawaii are administered by the department of social services, one of the largest of the 18 departments of the State government. Comprised of eight former government agencies, including, among others, the department of public welfare and the Hawaii Housing Authority, the department of social services is charged by statute with being responsible for helping promote the social well-being of the people of Hawaii. There are no county social service or welfare departments.

The statutes give the department authority and responsibility to administer a number of programs for the benefit of all persons including the aged. Among these are economic (public) assistance, including medical payments; rehabilitation toward self-care and self-support; services to assist persons with their problems of daily living; activities which will prevent or reduce dependency and the provision of adequate housing for persons with low incomes.

The first part of the department's prepared testimony today deals with the statewide picture of social services exclusive of housing. The second part will review briefly the local picture on the Island of Oahu, while the third part will be focused on statewide public housing for the aged. At each of your subsequent hearings a representative of the department will present a brief statement concerning State social services (exclusive of public housing) in that particular county of the State.

STATE SOCIAL SERVICES FOR THE AGED IN HAWAII (EXCLUSIVE OF HOUSING)

What is being done: Hawaii has one of the youngest populations in the United States and has a lower ratio of aged in its population than all but the State of Alaska. However, Hawaii is not waiting until the problem becomes acute but is planning ahead in anticipation of the new and expanded program of social services that will be needed to meet the challenge of increasing numbers of aged. These expanded and new services will be built on the foundation of today's programs, which include:

Economic assistance: Aged persons whose resources are insufficient to maintain a minimum standard of living compatible with decency and health are receiving old age assistance and medical assistance for the aged, regardless of citizenship or residence.

During the past fiscal year old age assistance payments in Hawaii totaled $1,198,287 of which $757,874 was Federal money and $440,413 State funds. These expenditures provided maintenance and medical care for an average of 1,456 aged persons each month at an average payment of $68.61. In addition, the monthly value of other resources in cash and kind averaged about $23 for a total monthly income of about $92 per aged person in need.

As of June 1961, Hawaii's average monthly old-age assistance payment was $70.59 as compared to the U.S. average of $67.85. In 1960 only 1 out of 20 aged in Hawaii received assistance in contrast to 1 out of 7 aged in the United States as a whole. Only New York, Pennsylvania, Maryland, Delaware, and New Jersey had lower rates than Hawaii. We believe Hawaii's low ratio is due, in large part, to our commendable cultural heritage of families supporting their elderly members.

Because of the immigration pattern many years ago, 7 out of 10 OAA recipients are males.

Medical assistance for the aged started July 1, 1961, the date on which statutory authority for determining medical care payments in behalf of medical indigents was transferred from the county governments to the department of social services. It is estimated that during the current fiscal year $585,146 will be spent for this program ($312,350 in Federal funds and $272,796 in State moneys) for an average of 232 aged persons at a cost of $210 per person per month. The small group receiving medical assistance for the aged (232) compared to nearly 1,400 each month receiving is due to the fact that eligibility provisions for medical assistance for the aged are only slightly more liberal than those for old-age assistance because of a limited appropriation of State funds. Cost of nursing home care is included in the above figures.

Counseling, information, and referral services: Aged persons seeking help—whether financial or otherwise—are assisted in solving their problems by individual consultation and, where indicated, by referral to sources of help outside the department. Examples of problems which come to the department's attention include household budgeting, securing retirement benefits, arranging for personal care and economic support, if needed, working out suitable housing, preparing for institutional care, securing legal aid, and getting medical care.

Substitute home care: Continuing efforts are being made to recruit boarding and personal care homes for aged persons who are unable to care for themselves and have no families who can care for them but who are happier and less expensively cared for outside of institutions. You will be hearing more about these activities from our island division administrators.

Services to aged who are blind: A study conducted in 1959 showed that during a 6-month period there were 239 aged blind who received social services from the State. These included such services as casework, placement services, recreational and other group work services, medical referrals, mobility instruction, and talking book services.

WHAT WE PLAN TO DO IN HAWAII

Economic assistance: We plan to restudy our standards and eligibility requirements for all needy persons, including those receiving old age assistance and medical assistance for the aged. We are still in the first 6 months of medical assistance for the aged and are just beginning to gather evidence with which to evaluate present standards. Should the evidence indicate a need for a change in levels of assistance we will request the Governor and the legislature to provide the necessary funds.

Counseling, information, and referral services: These services need to be expanded to meet present as well as future needs. We will be studying the need for informational centers and counseling services for all aged persons, not only those in need.

Substitute home care: Recruitment of small group care homes has lagged behind the need for such facilities almost everywhere. Hawaii, along with many other States, is evaluating the adequacy of planning for those in substitute homes and developing estimates of the growing cost of such care in the years ahead. The department of health's stepped-up program for regulating and improving nursing and convalescent as well as care homes is focusing much needed attention on the problem. We are studying the problem of extending this protection to aged persons in residential and boarding homes as well as in small hotels and roominghouses.

Other areas of need

Services to aged persons in their own homes: There are many more aged persons who want to and could remain in familiar surroundings if only the proper services, including social services, were available. For example, these would include home remodeling to remove hazards and provide aids, mobile food service, podiatric care, friendly visitor services, housekeeping and homemaker services, home care, transportation, rehabilitation, recreation, and educational services. We are including the development of these services in our planning for the future.

Social services in institutions: These services will be encouraged as an integral part of institutional care to evaluate admissions, counsel residents, plan for discharge and work with families and friends to prevent loss of contact.

Social work personnel: Too few practitioners are themselves equipped to deal with the rapidly expanding field of social services to

the aged. Our department plans to increase training of its staff to understand and cope with the problems of the aged whom they serve. We hope that more provisions for such training can be included in the school programs also.

Demonstration and research: Our department expects to develop projects which will furnish the facts and demonstrate the value of new social services to the aged.

WHAT CONGRESS SHOULD DO

Old age assistance: Increase the maximum amount which will be matched by the Federal Government in view of rising costs, especially of medical care and substitute home care.

Remove the restriction on matching of payments to or on behalf of persons who are diagnosed as mentally ill and do not require care in a public institution.

Medical assistance for the aged: Remove the 42-day restriction on matching payments on behalf of persons who are diagnosed as mentally ill and do not require care in a public institution.

Permit Federal matching of payments to as well as in behalf of eligible persons.

Services toward independent living: If and when Congress appropriates funds to finance services designed to promote independent living for dependent persons, including the aged, such funds should be made available to State agencies responsible for administration of old age assistance and medical assistance for the aged in accordance with the Social Security Act which encourages services designed to help aged recipients attain self-care.

CLOSING REMARKS

Again, we should like to thank you, Mr. Chairman, and the members of your committee for this opportunity to inform you of our activities and what we believe should be done to promote the best interests of the aged both here in Hawaii and throughout the United States.

There is attached for your information social service information which is, to a large part, statistical for the persons on Oahu, and I won't take your time to read that.

Senator LONG. We will include that in the record. Thank you.

(The document referred to follows:)

SOCIAL SERVICES FOR AGED PERSONS ON OAHU

1. Economic assistance to aged persons: During the past fiscal year July 1, 1960 to June 30, 1961, the average number of aged persons assisted on Oahu each month was 825.

The average payment per month was $68.14 with a total assistance to aged persons of $56,191.61 per month. The total assistance to the aged for the fiscal year 1960–61 was $674,299.34, with participation of $427,190.66 in Federal funds and $247,108.68 in State funds.

II. Medical assistance for the aged program started on July 1, 1961. It is estimated that an average of about 100 aged persons will be receiving assistance from this program each month. Many are aged persons who reside in nursing homes and whose assistance payments for such care exceed $95 per month.

III. Living arrangement of recipients: Recipients who live alone, with relatives or friends constitute the largest group. As of September 1960, 428 lived

in their own homes, 82 with adult children, and 166 with friends or elsewhere other than institutions. It is still our emphasis to assist aged persons to live independently or with relatives wherever possible.

The breakdown of the aged population in domiciliary institutions as of November 1, 1961, was as follows:

Kuakini Home	30
Palolo Chinese Home	19
Korean Old Men's Home	8
Lunalilo Home	5
Total	62

Only one of these institutions admit both men and women. These institutions are set up for ethnic groups of the Japanese, Chinese, Korean, and Hawaiian groups. There is no institution for the Filipino recipient group, which is the largest ethnic group. These institutions are supported by the Honolulu Community Chest and by board payments from Department of Social Services. The average board rate is $73.

There are 134 old age assistance and medical assistance for the aged recipients in nursing or convalescent homes as of November 1, 1961. These patients reside in a total of 9 nursing homes located throughout the island. Department of Social Services patients are admitted upon recommendation of physicians that nursing care is required.

These nursing homes are privately operated and provide care to private as well as publicly supported patients. The costs of nursing care vary from nursing home to nursing home and also with the amount and kind of care required by the patients. The board rates vary from $100 to $250.

IV. Social services to the aged: In addition to economic and medical assistance, this division extends other social services to the aging. These services include household budgeting, securing potential resources as public and private retirement benefits, arranging for family care and support, arranging for suitable housing or admission into institutions.

This Division recognizes the need to provide more social services to the aging to those in their own homes as well as to those in institutions. We need to look at the total person in meeting his total needs, including social and emotional, rather than just his economic and medical assistance needs.

Senator MORSE. Mr. Chairman, I want to take a half a minute. Miss Noonan, in my judgment, is not only one of our most helpful witnesses but can really render the committee further help; and I would like to make, Mr. Chairman, for his ruling, this suggestion: That we keep this record open for 10 days or 2 weeks with the understanding that any witness such as Miss Noonan, or any other, who would like to supplement their statement for the record or who would like to supply us with questions that the members of the staff under our direction may address to them, that they have, say, 2 weeks in order to supplement the record. There will be other witnesses here this afternoon, I am sure, who would like to say for the record much more than time will allow, and I think it would be very helpful, Mr. Chairman, if we could have the ruling that the official record will be kept open for 10 days or 2 weeks, with the understanding that supplemental statements can be filed.

Senator LONG. Thank you, Senator Morse. In my opening remarks I stated that the record would be open for 30 days. We would appreciate it, however, if contributions would come in within 10 or 15 days.

Senator MORSE. With that in mind, Mr. Chairman, I would like to have you, without taking our time this afternoon for a long discussion of it, supplement the record on two matters of interest to me: (1) a further extension of the discussion on mental illness and the

program for that; (2) the point I raised this morning, whether or not in Hawaii if there are increases in social security benefits, the same amount of money is taken away from your welfare payments that are offered by the State. I would like to have a discussion of that.

And I would like to have a third one, which your testimony here this afternoon has caused me to think about. The Kerr-Mills bill was represented as a bill which was to be of assistance to the States in extending service of medical care to groups not now covered. Quite frankly, we have found in some places that about all that has happened to date under the Kerr-Mills bill is that the States simply pass the financial responsibility to the Federal Government to assume part of the previous paid costs by the State, and that there hasn't really been an extension of medical service to groups not now already covered.

And, of course, wherever that exists, I say most respectfully that it is certainly not in keeping with the intent and the purpose of the Congress when that bill was passed; and, therefore, I would like to have you supplement this record by telling us whether or not in the administration of the Kerr-Mills bill thus far in Hawaii your program could be characterized as one which has simply transferred part of the cost from the State to the Federal Government, without any extension of medical care to groups that were not previously covered.

We have to be frank about this. The purpose of matching funds is not to be just of assistance to the State by taking up some of their present expenses; but the purpose is to encourage the States to extend their services to people that aren't already covered. And unless that is being done in Hawaii, then I say most respectfully that I just think it is only a matter of an administrative gimmick, whereby all the taxpayers of the country are paying the cost that Hawaii, itself, ought to assume.

We have found that situation to exist in other parts of the country and, of course, as a watchdog on the committee, I am looking for those things; and I would like to have you file a supplemental statement on that problem.

Miss NOONAN. We would be very happy to.

(Supplemental statement follows:)

STATE OF HAWAII,
DEPARTMENT OF SOCIAL SERVICES,
Honolulu, January 3, 1962.

Subject: State social services for aged in Hawaii.

Hon. PAT MCNAMARA,
Chairman, Special Committee on Aging,
U.S. Senate,
Washington, D.C.

(Attention of Senator Oren E. Long.)

DEAR SIR: This letter supplements testimony we presented to your committee during hearings conducted in Hawaii by Senator Oren E. Long and Senator Wayne Morse in late November and early December. Following are replies to questions raised by these members of your committee during hearings on November 27 and December 1, 1961.

1. Question. In determining the eligibility of an applicant for public assistance, does the department of social services take into consideration social security benefits which the applicant is receiving?

Answer. Yes. Such benefits are considered a resource which must be deducted from the applicant's requirements in order to arrive at the amount of the public assistance payment.

2. Question. Has Hawaii's implementation of the Kerr-Mills amendment (which created the medical assistance for the aged category) resulted in extending medical care to persons who otherwise would not have been covered?

Answer. Not yet. Hawaii's implementation of medical assistance for the aged on July 1, 1961, was made possible by transferring county responsibility to the State. The State is now compiling data—not presently available—on which to estimate costs of extending medical payments in behalf of aged persons otherwise able to meet their living expenses.

3. Question. How many (aged) individuals received medical care through the Hawaii Department of Social Services during the periods July–September 1960 and July–September 1961 and what was the cost per case?

Answer:

Aged persons receiving hospital care under department of social services

Period	Number	Cost per case
July to September 1960	111	$191.70
July to September 1961	221	299.65

The increase in number is due almost entirely to the addition of the MAA group which prior to July 1, 1961, was handled by the counties. The increase in cost per case is largely due to the fact that prior to July 1, 1961, the department of social services paid for a maximum of 30 days for any single hospital admission with the counties taking care of the balance. Beginning July 1, 1961, our department has paid for the full period of necessary hospital care. Another factor is the ability of some of the aged with low incomes to pay for the short periods of hospital care.

4. Question: What is the estimated cost of investigating an application for medical assistance for the aged (exclusive of transfers from other categories)?

Answer: We have not yet compiled data specifically on MAA. However, using the data compiled in connection with a time study of OAA in 1958 and our work programing and reporting in 1961, we estimate that the cost of an initial eligibility determination for MAA is about $9 for salaries alone. We do not have a pro rata figure for other costs.

We hope this furnishes you with the additional data you desired. If not, we shall be pleased to assist you in securing further information you may need.

Sincerely yours,

MARY L. NOONAN, *Director.*

Senator LONG. Mrs. Clara Boyer, head of south branch, Oahu division.

STATEMENT OF MRS. CLARA BOYER, HEAD OF SOUTH BRANCH, OAHU DIVISION

Mrs. BOYER. Mr. Chairman, members of the committee, Miss Noonan has just completed a summary of activities on a statewide basis. My information will be concerned primarily with activities with the aging on the island of Oahu.

During the past fiscal year, July 1, 1960, to June 30, 1961, the average number of aged persons assisted on this island each month was 825. The average economic assistance payment per month was $68.14, with a total assistance to aged persons of $56,191.61 per month. The total assistance to the aged for the fiscal year, 1960–61, was $674,299.34, with participation of $427,190.66 in Federal funds and $247,108.16 in State funds.

The medical assistance for the aged programs started on July 1 of this year. It is estimated that an average of about 100 aged persons

will be receiving assistance from this program each month. Many are aged persons who reside in nursing homes and whose assistance payments for such care exceeds $95 per month.

Comments on living arrangements of our recipient: Recipients who live alone, with relatives, or friends constitute the largest group. As of our September 1960 figures, 428 individuals live in their own home; 82 with adult children; and 166 with friends, or elsewhere other than institutions. It is still our emphasis to assist aging persons to live independently or with relatives, wherever possible.

The breakdown of the aged population in domiciliary institutions as of November 1, 1961, was as follows: Kuakini Home, 30 individuals; Palolo Chinese Home, 19; Korean Old Man's Home, 8; Lunalilo Home, 5; for a total of 62. Only one of these institutions I mentioned admits both older men and women. These institutions are set up for ethnic groups of the Japanese, Chinese, Korean, and the Hawaiian races. There are no institutions for the Filipino recipient groups, which is the largest ethnic group.

These institutions are supported by the Honolulu Community Chest and by board payments from the department of social services. The average board rate is $73 per month.

There are 134 old-age assistance and medical assistance for the aged recipients in nursing or convalescent homes as of November 1 of this year. These patients reside in a total of nine nursing homes located throughout this island. The department of social services patients are admitted upon recommendation of physicians that nursing care is required. These nursing homes are privately operated and provide care to private as well as publicly supported patients. The cost of nursing care varies from nursing home to nursing home and, also, the amount and kind of care required by the patient. The board rates vary from $100 to $250 per month.

In addition to economic and medical assistance, this division of the department of social services extends other social services to the aging. These services include household budgeting, securing of potential resources such as public and private benefits, arranging for family care and support, arranging for suitable housing or admission into institutions.

This division recognizes the need to provide more social services to the aging—to those in their own homes, as well as those in institutions. We need to look at the total person in meeting the total needs, including the social and emotional, rather than just economic and medical assistance.

Senator LONG. Thank you.

Our next witness is Mrs. A. Q. McElrath, of the membership service department, International Longshoremen's & Warehousemen's Union.

STATEMENT OF MRS. A. Q. McELRATH, MEMBERSHIP SERVICE DEPARTMENT, ILWU

Mrs. MCELRATH. Senator Long, Senator Morse, Senator Fong, and members of the committee, I am Mrs. McElrath. I am the social worker with the membership service department of the International Longshoremen's & Warehousemen's Union, Local 142.

We have submitted a written statement for the record. At this time, rather than reading the statement, I shall extemporize and possibly summarize some of the remarks which we have made in the statement.

I would like first to discuss what we have done as a union for the members of our union. As you know, we represent 23,500 workers throughout the islands. We have sugar workers, pineapple workers, hotel workers, laundry workers, auto mechanics, and we even have a few score cowboys on the big island; so we do represent a fairly diversified section of the population here in the 50th State.

As a result of our collective bargaining agreements, we have been able to negotiate pension plans for a great number of our retired individuals from the ages of 55 and over, as well as negotiating medical coverage for these individuals who retire 55 years of age and over. We have fairly comprehensive plans for some of these workers in sugar, pineapple, and longshore. However, we haven't been successful in our attempts to negotiate either pensions or medical care programs for workers in smaller industries which find it costly to buy either pension plans or medical plans for such workers.

As a result we find that many of our retired employees are faced with the same problems that retired employees throughout the Nation face—the financial inability, for example, to buy the wherewithal, particularly, in this case, medical care for themselves and their spouses; with the result that we in the membership service department are aware of a wide range of problems which face our retired workers.

For example, we are aware that the State of Hawaii, at the moment, has taken very little advantage of the Public Housing Act which would provide for low-cost housing for retired employees. We know that there are only 96 housing units in the Punchbowl housing area which are open to the aged. We know, for example, that, as someone mentioned, out of the 1,027 beds in nursing homes, only 721 meet the standards of adequacy of the Hill-Burton Act.

We also know, for example, that there is no home nursing care—almost none. We know there is very little rehabilitation service for our elderly workers. We know that they have a great deal of difficulty finding employment if they are retired at the age of 55 with a heart or an arthritic condition. As a matter of fact, the union has assisted in the cutting, so-called, of the work force which has been displaced by automation and by mechanization in negotiating lump-sum settlements for these individuals under the pension plans so that they can go back to their native lands and, we hope, live in comfort and be able to purchase the wherewithal with which to live, which would include housing as well as medical care.

Now, we are, however, directly concerned with one problem. It is a problem which has been touched upon by other speakers, and this is the adequacy of medical care.

Three weeks ago, a 65-year-old, retired, intermittent worker from the pineapple industry came to see me about purchasing medical care. Now, remember, an intermittent worker in the pineapple industry does not benefit from a company-union negotiated medical plan nor from a pension plan. In other words, at age 65 she is let out of industry and the only thing she can retire with is a social security

pension. In this instance, she received $71.60 as a result of working in covered industry.

So she came to see me, and she said, "Mrs. McElrath, what can I buy with my $71.60—what kind of medical care?" So we looked over the whole gamut of plans that she could buy—voluntary plans, commercial plans, any of the service plans which she could get into for herself—she is a widow. And we found that one plan would have cost her $8.40 per month with a limited range of coverage under surgery, as well as hospital care. Another commercial plan would have cost her $21.75, which would have meant nearly 30 percent of her monthly income. A service plan turned her down because she was not a member of a group. Many service plans are loathe to enroll an individual as an individual because of the risks involved.

Now, we submit that these problems of a medical nature, of a housing nature, of a financial nature, of an employment nature, which come to our department every day of the week, make it incumbent upon us to furnish the leadership that is needed to take care of the estimated 49,000 65 and over who will retire by the time 1970 rolls around.

We feel that one of the basic answers to the medical problem, at any rate, is to tie in medical care with the social security system. The union does not feel that the Kerr-Mills Act with its demeaning criteria for care is the answer to our problem. The Department of Health, Education, and Welfare reported several months ago that only 14 States have extended the provisions of Kerr-Mills to 10,000 individuals who are not now covered by various medical plans under the public assistance system. This is less than one-tenth—this is less, rather, than 1 percent of the total number of aged in the United States, which now stands at 16 million individuals.

Also, only eight States have enacted legislation which is ready to roll in 1962, and eight other States have pending legislation or have enacted legislation but provided no funds. In a State like Kentucky, for example, we find that the amount of care is limited to 6 hospital days, two doctor visits, and $48 for dental care. And in the aged, I daresay that the amount of hospital care, as rated against the amount of dental care, is probably not as high. Many of us lose our teeth at 65.

At any rate, we are opposed to the unequal, discriminatory distribution of medical care under Kerr-Mills, which makes States depend on the Federal Government for contributions; and States are unable, because of the lack of money, to distribute equal medical care to all of its citizens; and for that reason we feel that tying in medical care to social security provides the only answer to our problem in that area. It is the answer to a clamor for medical facilities, which do not now exist. It means the answer to giving the people of the country adequate personnel, adequate nursing home care, and, we hope, adequate facilities in a country that boasts that it has advanced the farthest insofar as medical care is concerned.

This, in effect, is what we feel are the needs of our people, not only in Hawaii, but also in the other 49 States of the Union.

I wish to thank the committee for allowing us the time to put forward our feelings on this particular problem. Thank you.

Senator LONG. Thank you, Mrs. McElrath.

Senator MORSE. I want to say for the record, Mrs. McElrath, that I would be very glad to have you supplement your statement with a fuller statement. It would be very helpful to the committee.

(The prepared statement and a supplemental statement of Mrs. McElrath follow:)

STATEMENT OF THE INTERNATIONAL LONGSHOREMEN'S & WAREHOUSEMEN'S UNION, LOCAL 142

I am Mrs. A. Q. McElrath, a social worker representing International Longshoremen's & Warehousemen's Union, Local 142.

This union represents 23,500 workers throughout the islands for purposes of collective bargaining. It is the single largest union in the State and is composed of sugar and pineapple workers, longshoremen, bakery and laundry workers, auto mechanics, hotel workers and truckers, supermarket workers, other miscellaneous workers, and even several score cowboys. Every national strain that has come to the islands to stay is represented in the union.

No doubt this hearing will be concerned with all aspects of the aging in Hawaii. We shall be apprised of the fact that there has been no advantage taken of the Public Housing Act to construct housing for the aged; the fact that older people have extreme difficulty in finding employment, the fact that 91 percent of Hawaii's 29,000 oldsters have monthly incomes of $100 and less per month.

We wish to direct our remarks today to the area of health and medical care for the aging.

For many years this union has been able to provide some protection for its members 55 years and over by negotiating pensions and medical care for them upon retirement. In the sugar industry, the system of medical benefits for a retired member and spouse is fairly comprehensive as there is a service plan.

In the pineapple industry, where there is an indemnity plan, the amount of benefits is fairly high.

In the longshore industry, an indemnity plan also provides for a scale of benefits which takes care of the basic medical needs of our retired members and their spouses.

There are several other small industries where our union has been able to negotiate medical care under indemnity plans.

In addition this union has negotiated lump sum pension and severance settlements which permit older workers to return to their native lands with amounts which would help them to live in comfort and to obtain medical care if needed.

There are, however, many other industries where it has not been possible to negotiate medical care for retired employees. Small companies find it costly to purchase medical care for such employees even when they do not bear the entire cost.

The result is that a number of retired members of this union face the problem that millions throughout the United States face, viz., the financial inability to purchase even minimum medical care after retirement age—that period when the incidence of chronic and expensive illnesses is most high.

While the union is proud of its efforts in negotiating medical plans which provide some medical care for part of its membership, its efforts alone are not sufficient to take care of the problems which face retired workers.

By 1970, it is expected that Hawaii will have 49,000 individuals 65 years and over. Presently, the figure is 29,000. This represents an increase of nearly 60 percent.

No one knows how many of an estimated 19,000 who will retire by 1970 will have medical coverage by virtue of company-union negotiated plans. Even if those individuals were able to purchase some kind of medical coverage at the time of retirement, the scale of benefits will be limited and their out-of-pocket expenditures will be high, what with the costs of medical care skyrocketing all over the country.

In June 1961 the consumer price index for medical care was 168.8 percent as compared with a reading of 105.4 percent for 1950. In the same 10-year period, the overall cost of living index rose from 101.8 percent to 127.6 percent. The rise in medical care was nearly threefold that of the rise in the total cost of living index.

We feel that the needs of the aged for adequate medical care cannot be met by the chaotic organization of medical care in the United States today. Voluntary service and indemnity plans are too costly to purchase.

The organization of public and private agencies providing medical care is a hopeless entanglement of individual standards and tests. Every State, every county, and every municipality have their own criteria for medical care.

In addition there are over 100,000 voluntary agencies throughout the United States which purvey health and medical services. Invariably the individual seeking medical care is caught in a hopeless maze. Surely this is the situation of want in the face of plenty.

The union strongly feels that this is the time for the U.S. Government to provide the direction out of the maze. There must be an overall plan to provide medical care for our retired residents, a long-range plan which takes into consideration the ability of an individual to pay for future medical care at a time when he is most able to purchase it, when he is fully employed.

The union is in favor of tying in medical care for the aged with the rest of the Social Security Act. It wants no part of the philosophy of the Kerr-Mills Act with its demeaning criteria for care.

In August 1961, 1 year after the passage of the Kerr-Mills Act, the Health, Education, and Welfare Department reported that only 14 States had begun to pay for medical care for those not on public assistance; 8 other States have legislation ready to roll in 1962; another 8 have pending legislation or have enacted a program, but provided no funds for its operation.

At the end of 6 months of operation the same department reported that only slightly over 10,000 individuals received medical care under the Kerr-Mills Act. This is less than 1 percent of the 16 million oldsters of our population at the present time.

The Kerr-Mills Act results in discrimination and uneven administration of benefits. Because the act is tied in with the matching principle, there is no assurance that all States will expend or appropriate enough money to take care of the needs of the aged.

For example, the State of Kentucky limits hospital stay to 6 days; physicians' services to 2 days, and a ceiling of $48 annually on dentists' services.

Medical care through the social security system is the only way to assure adequate medical care and equal treatment for the aged, and the elimination of drains on State treasuries.

Medical care through the social security system is the only way of encouraging States into enacting legislation to provide many of the unmet medical needs of the retired person.

In Hawaii, for example, there are no facilities for home care which could relieve the load on general hospitals. Our nursing homes provide only 57 percent of the total needs and of the 1,027 beds now available, 712 are completely suitable according to the Hill-Burton Act.

There are only a few foster and boarding homes scattered throughout the islands and no geriatric centers. Rehabilitation facilities for the aged are practically nonexistent. There are absolutely no provisions for drugs for old people whose condition often require huge outlays. There are 150 aged people in the State hospital for the mentally ill who don't belong there, but for lack of other facilities, they remain in the hospital.

Any forward-looking legislation for the aged must provide for the planning of medical facilities where they do not now exist. This means provisions for more extensive outpatient service than has been contemplated in any piece of legislation which has thus far been introduced in the U.S. Congress. This means a system of prepaid drugs and a revamping of the whole system of care for the aged, whether in specialized hospitals, nursing homes, or home care.

This union feels that the only way of providing adequate medical care for the aged is through the social security system. There is no other way out of the chaos which now exists in the dispensing of medical care for the aged.

NOVEMBER 24, 1961.

SUPPLEMENTAL STATEMENT OF THE INTERNATIONAL LONGSHOREMEN'S & WAREHOUSEMEN'S UNION

Since representatives from this union have appeared before the Senate Special Committee on Aging in Oregon and Hawaii, this statement will attempt to set

forth in summary the feeling of the membership in the International Longshoremen's & Warehousemen's Union with regard to medical care needs for the aging.

In the Longshore Division there are 18,720 members and their families on the Pacific coast covered under a joint trust fund totaling some 52,000 persons; 86 percent of these are the active work force, 14 percent are retired. The union has been successful in negotiating with its employers to provide identical medical care benefits for the retired men as for the active work force. In every instance where good quality "comprehensive" plans were available like the Kaiser program, service benefits were purchased for longshoremen in Washington, Oregon, and California.

In addition, there is a group of 400 men covered in Alaska under similar benefits. We can speak from primary experience in the Longshore Division, having provided prepaid voluntary care for our retired work force through industry contributions, since 1952.

(1) The most comprehensive care we can purchase does not provide drugs, rehabilitation services, rest home care, home nursing, to mention just a few categories of necessary medical needs. These items are not available not only because of cost, but because they are not organized into the medical facilities on the Pacific coast so that an attempt could be made to purchase them.

(2) In some areas we have only an indemnity-type plan available, covering 16 ports and Alaska. These benefits are considerably fewer and there are no full payments for medical and hospital care and the needs of even acute illness.

(3) Despite the purchase of these benefits we cannot assure a supply of physicians nor adequate hospital facilities in some areas.

(4) We have no assurances in our programs as to the quality of medical care our people are receiving.

These represent serious lacks that flow from a program which is unique in the United States in that it provides comprehensive benefits through labor-management negotiations for its retired workers. As a corollary it is becoming clear that if medical care costs continue to rise there is question as to whether even these benefits can be maintained by a single industry.

In order to meet the problem of automation in an orderly fashion, the employers and the union have recently negotiated a mechanization and modernization fund on the Pacific coast. When workers retire under this plan at even younger ages with fewer man-hours in the industry it will be a staggering cost to continue to provide medical care for the work force that has to be retired because of automation.

In another segment of the union, the warehouse division, there is just beginning to be some medical care coverage for retired members which will be, at best, coverage for acute short-term illness, which as you know from your own data, falls far short of meeting medical care needs of the aging. It is our position that no one segment of industry through collective bargaining, or largesse, can undertake the responsibility for the increased services and facilities needed by our aging population.

It has been demonstrated that a program of early and vigorous rehabilitation can reduce the length of hospital stay and return the patient to at least partial self-support. But such programs must be coordinated, communitywide programs which can draw on all the resources available, and expand resources where necessary. They must include physical rehabilitation as an aim from the time of diagnosis, nursing home facilities to receive patients ready to leave the acute hospital, but unable to care for themselves, and provision for home health care so that the older person may return to his own environment as quickly as possible, with enough community support to enable him to maintain himself insofar as possible. We must look to the total community for programs of comprehensive services in chronic disease control, mental illness and alcoholism, rehabilitation, reduction in the cost of prescription drugs.

There is only one rational answer to meeting medical care needs for our aging population, which is to spread the base through a system of sound social insurance like the social security program. As a corollary, there must be planning for facilities so that there is not waste and duplication, since not only is there a shortage of funds but also a shortage of qualified personnel.

Rational organization of medical care must be an integral part of the financing of medical care and only through regional planning and financing through a broad tax program, will we be able to provide what we proudly call the best medical care in the world, now the privilege of just a few. Health maintenance

for our working population would appear to be the first step in any conservation of natural resources.

It has become apparent that the articulate foes of social insurance are articulate against even such inadequate measures as Forand-type legislation and the King-Anderson bill. An attempt to compromise with the irrational statements of these adversaries will lead to irrational schedules of benefits, such as nursing home care without regard to outpatient care and will produce some of the results they predict, such as unnecessary hospitalization and high-cost nursing homes.

Hence, those of us who are proponents of a broad-base social insurance program, rather than the indirect tax which already exists, since industry gets credit as a labor cost for health benefits, must insist on protecting the tax dollar. This requires good organization of medical services, patient oriented, so that there are preventive services, care for acute illness, custodial care, and home care that can return the patient to the community at the earliest possible time without duplication of facilities and without depending on the exigencies of the collective bargaining strength of any given industry.

Concurrently, there must be training of well-qualified personnel, including those in our medical schools, based on ability, regardless of economic position, and without regard to race, color or creed.

The report of the officers of the union to the ILWU Convention in April 1961, after citing accomplishments of the ILWU health and pension plans and listing problems external to them which set limits to their continued development, summed up this point of view: "The officers are more than ever convinced that the only satisfactory answer to the problems of adequate income for the aged and adequate medical care for all lies in national legislation. Social security must be steadily improved. And, in the field of medical care, some form of national health insurance is essential. Union action in these areas is but a stopgap. There are even indications that some employers, becoming weary with steeply rising medical care costs are coming around toward the view that some type of public control over medical care is necessary. What is needed is effective legislation on both the State and National levels to prevent costly duplication of facilities and maldistribution of medical personnel, to assure everyone the medical care he needs, whether he is rich or poor, working or retired, or whether he is or is not covered under a collectively bargained health plan."

Senator LONG. We come now to another area in which we are all vitally interested and concerned, that of housing.

There are, I believe, a total of six speakers in that area, and, due to the shortness of time, where you can telescope some of your paragraphs will you please do so as a courtesy to the considerable number that are to follow after you.

The first speaker is Mr. A. V. Sullivan, executive director, Hawaii Housing Authority.

STATEMENT OF A. V. SULLIVAN, EXECUTIVE DIRECTOR, HAWAII HOUSING AUTHORITY

Mr. SULLIVAN. Mr. Chairman, Honorable Senators, members of the committee at the outset, I would like to call your attention to something that Miss Noonan stated in her presentation—that the Hawaii Housing Authority is now a part of the department of social services. That is unique to Hawaii. This has opened up wide possibilities for cooperation between the authority and the county division which administers social services, not only for elderly, but for all requiring these services.

The Hawaii Housing Authority's activities with respect to the elderly are limited primarily to providing rental housing for those of low income. The authority gives first preference for placement in its projects to elderly individuals and to elderly couples. Because

of this preference, any elderly individual or couple, whose income does not exceed $5,000 per annum on the islands of Oahu and Hawaii, can be placed in one of the authority's projects within a very short time after making application.

The authority, in December 1960, completed a project that is primarily for the elderly. Ninety-six of its 156 dwelling units are designed especially for the elderly and are located on the four upper floors of a seven-story three-wing structures. The project is located on the slopes of Punchbowl Crater, and the view from the homes of Honolulu, its harbor with its busy shipping activities and the Pacific beyond, is magnificient. The project has been fully occupied since shortly after its completion.

There are a total of 106 elderly families in Punchbowl Homes, including the 96 families living in the units that are designed primarily for the elderly. There are 10 living in other units. Incidentally, "single elderly" are included in the term "elderly families," as I used it. The 106 elderly families break down as follows:

Elderly individuals	75
Elderly couples	19
Head of family or the spouse, but not both elderly	12

The total number of elderly persons in this one development is 125.

Approximately 4,000 square feet of space on the first floor of the seven-story building has been provided for tenant activities, including an 832-square-foot clinic area that has been turned over to the department of health. The project manager, assisted by various governmental and other interested agencies, is developing a well-rounded activity program for the senior citizens living in the development.

The authority is also housing an additional 139 elderly families in others of its projects, and these break down as follows:

Elderly individuals	22
Elderly couples	31
Head of the family or the spouse, but not both elderly	86

The total number of elderly persons in these projects is 190. This includes 20 who are living with nonelderly families. We, thus, have an overall total of 315 elderly persons living in Hawaii Housing Authority projects.

The authority has recently requested the Honolulu Redevelopment Agency to make available an area within its Kukui redevelopment project for the construction of a high-rise building of 176 units, all of which are to be designed exclusively for the elderly. Additional projects designed for the elderly will be developed as a need and market are demonstrated and approved by the Federal Public Housing Administration.

Because of an amendment to the U.S. Housing Act of 1937, contained in the Housing Act of 1961, which provides for an additional subsidy, if needed, of up to $120 per annum per dwelling unit occupied by an elderly family, we anticipate no difficulty in developing additional housing for the low-income elderly as the need develops.

The State legislature during the 1961 session, by the adoption of House Concurrent Resolution No. 4, has requested the Hawaii Housing Authority and the Department of Land and Natural Resources to study the feasibility of developing communities particularly suit-

able for the use of our senior citizens on Government-owned lands and to make appropriate recommendations to the legislature.

A group of governmental, business, and other leaders in the community were consulted. It was the consensus among them that before concrete recommendations could be made, it would be necessary to make a survey of the needs and wishes of the elderly. The Hawaii Housing Authority, with the assistance of the State department of planning and research, is proceeding with the preparation of a schedule for such a survey. The Public Housing Administration's Central Office in Washington, as well as its regional office in San Francisco, has promised assistance. We believe the information developed by the survey will be of invaluable assistance to governmental agencies as well as to labor and religious groups and to entrepreneurs who are interested in planning for the elderly.

Mr. Chairman, there is one matter that is not in my prepared statement that I think perhaps I should mention.

In developing our project for the elderly at Punchbowl Homes, we wish to include facilities for providing meals for the elderly because of the concern as to whether some of these people get proper nutritional meals. The Federal agency required that we have an agreement with the local agency that it would provide such service on a noncourse basis for a period of no less than 3 years before they would approve including this in the development cost. We think this can be remedied administratively, but I thought I would bring it to your attention.

Senator LONG. Thank you very much, Mr. Sullivan.

Senator MORSE. I have heard a great deal about your project, and trust I can find the time, while here, to go out and see it. I would like to see it very much.

Mr. SULLIVAN. I would certainly enjoy showing it to you, Senator.

Senator LONG. The State department of planning and research plays an important part in housing. Mr. Robert Schmitt will tell us about it.

STATEMENT OF ROBERT C. SCHMITT, SENIOR PLANNER, HAWAII DEPARTMENT OF PLANNING AND RESEARCH

Mr. SCHMITT. Mr. Chairman, members of the committee, I have been asked specifically to outline some of the problems likely to be encountered in surveying the attitudes of elderly and retired persons toward a retirement community in Hawaii of the type described in House Concurrent Resolution 4 of the 1961 State legislature.

The questions posed by this resolution are essentially as follows: Would a community "created primarily for their use and occupancy" on public lands appeal to a significant number of older and retired persons, including "self-supporting retired persons from the mainland"? What are the characteristics of this market? What form should a community take?

Although a sizable body of opinion exists regarding the answers to these questions, there is little available in the way of current, comprehensive, and objective research. A definitive answer requires an actual survey of the attitudes and characteristics of older persons toward the proposed community.

An adequate survey would unfortunately have to overcome at least three major technical difficulties: first, the relatively small number and wide geographic dispersion of older and retired persons in Hawaii, factors tending both to increase costs and decrease accuracy in any field study. We have no clusters of older persons in Hawaii. They don't concentrate in any single area. Some of you may have seen the 1960 census report which indicated that the percentage of oldsters runs from about 2 percent in Nanakuli, which is the most youthful community in the State, to about 9 percent in the plantation town of Puunene, which is the oldest town in the State.

A second factor is the difficulty of reaching the potential mainland market noted in House Concurrent Resolution 4, a population scattered throughout the remaining 49 States.

Third, the virtual impossibility of finding a meaningful measure of persons' attitudes toward a community as yet unbuilt and for which neither architectural renderings, written descriptions, nor rent schedules as yet exist.

I think these problems are probably a little technical for many of the members of the audience and may be of somewhat limited interest to them; and if the chairman would prefer that I skip the detailed description and leave it as the written statement, I certainly would be happy to do so.

Senator LONG. It will be included. Thank you.

(Remainder of prepared statement follows:)

The first of these three major problems, that of the size and distribution of the local universe, is a technical one which could be easily surmounted with cooperation from Federal agencies. When the Public Housing Administration and Hawaii Housing Authority surveyed the housing needs of Hawaii's older population back in 1956, for example, the Bureau of the Census (which conducted the survey on a reimbursable basis) was able to base its sample in part on the addresses reported in the 1950 census of persons 59 years of age or more at that time. A similar approach might be used in 1962, with a sample drawn from the population 63 and older at the time of the 1960 census. Unfortunately, such a list of addresses would probably be made available only if the survey were made by Bureau of the Census personnel, an assignment not deemed possible within our time limitation.

An even better basis for a sample of old persons would be a list of addresses of social security recipients. Such a list could be used either in conjunction with a mailed questionnaire, enclosed perhaps with monthly OASI checks, or as a basis for addresses to be visited by interviewers. The former procedure would entail the risks of nonresponse and respondent misunderstanding. There is some question, however, whether Federal officials would make address lists available to other agencies for the admittedly superior household interview approach.

Without access to address lists of older persons, the survey team would be compelled to rely on an extremely expensive probability sample of island households. An adequate sample of, say, 1,000 or 1,500 persons 65 and over—the minimum if detailed analytic tables are to be feasible—would require a total sample of 5,000 to 7,500 households. A sample of this magnitude would cost perhaps $75,000 or more, including costs of planning, interviewing, tabulation, analysis, and publication. (This estimate is based on recent correspondence with Richard M. Scammon, Director of the Bureau of the Census, in which Mr. Scammon noted that a sample census of our State, involving 10,000 households, would cost about $150,000 on a reimbursable basis.)

The second of the three major problems confronting anyone making a survey of the kind under consideration, that of inability to reach the potential mainland market for retirement housing in Hawaii, is less easily solved. The best approach from a technical point of view, but one far beyond the financial resources of the State, would be to employ the Bureau of the Census or a mainland

research organization to conduct a sample survey in the other 49 States. Another approach, less direct but far more practical, would be to request the Hawaii Visitors Bureau to track down and interview persons classifying themselves as retired or past 60 on the baggage declaration form completed by all passengers arriving in Hawaii by westbound civilian carriers. Visitors bureau officials have unfortunately declined to do so, pleading lack of time and staff, although they have offered as a substitute procedure to undertake cross-tabulations of the statistics for a 20-percent sample of these older or retired persons, on a reimbursable basis. The small number of older or retired visitors and intended residents in the HVB sample unfortunately minimizes the value of a tabulation of this kind.

Perhaps the best available approach to the problem of the mainland market is an indirect one, involving comparison of recently arrived retired residents found in the local survey with those who have lived in Hawaii for many years. The small proportion of malihini oldsters in Hawaii would militate against the usefulness and accuracy of such comparison unless the overall survey were assigned a sample size sufficiently large to insure an adequate representation of this special group.

The final major problem, that of obtaining meaningful responses to attitude questions for a nonexistent development, will be most difficult of all to overcome. The type of retirement community envisioned by House Concurrent Resolution 4 is left undefined in the legislation. Although communities of this kind exist on the mainland, it is questionable whether the signers of the resolution had such prototypes in mind and whether the respondents in the proposed survey would be sufficiently acquainted with these mainland developments to offer an informed, objective opinion. If we assume that a given form of retirement community was indeed intended by the framers of the House Concurrent Resolution 4, and if we are able to offer the respondent an easily understood picture of this community—through sketches, a written description, and other aids—it is still unlikely that his survey response would prove a wholly reliable predictive tool. Too many factors—architectural design, location, and accessibility, presence of friends and relatives and rent levels, to name but a few—will modify his attitude once the community is built.

The value of any survey intended to determine the feasibility of a retirement community on public lands will be determined by the degree in which these limitations are solved. Even an optimum solution will, however, leave many questions unanswered, and anything less will require utmost caution by the analysts, planners, and administrators relying on the data.

Senator LONG. One thing that I am thoroughly enjoying as I watch the reactions of this splendid audience is the number of points on which there is disagreement; and I think that is most wholesome because it is basic to our system.

The next speaker is the chairman of the housing committee of the commission on aging; a builder and contractor, Mr. E. F. Fitzsimmons.

Mr. Fitzsimmons, we will be glad to have you take the witness chair.

STATEMENT OF E. F. FITZSIMMONS, CHAIRMAN OF THE HOUSING COMMITTEE OF THE COMMISSION ON AGING; BUILDER AND CONTRACTOR

Mr. FITZSIMMONS. Thank you; Senator Long, Senator Morse, members of the panel, I have no prepared statement for you today; however, we will have one which we will submit to you on the results of our conference that we had here just a week ago, which I think is quite lengthy and quite edifying.

Out of this conference we did find that there was one phase of housing which governmentwise or Federal Housing does not cover. There is a need for adequate financing through the Federal Housing Administration for a type of loan which would cover what we call the "boarding house" type of occupancy. We discovered that the Nursing

Home Act does not cover this; so I know that here in Hawaii we do need that and need it very badly.

Secondly, we also found out in our conference that the nursing home provisions of the Federal Housing Act were at the maximum a 25-year loan and should be lengthened so that the amortization of this loan can be spelled out over a longer period so that, therefore, it would reach a greater number of people.

Also we feel that, administratively, the Federal Housing Act, which we know of as "housing for the elderly, section 231," more so for nonprofit organizations, just too cumbersome for them to enter into. An expert has to be hired by them to wade their way through this act. They don't have the money to do it with; and, therefore, administratively, the Federal Housing Act should be simplified so that more persons or organizations can take advantage of this act. It is not everybody who can afford to go out and hire a fee man. It usually costs 10 percent of whatever is earned. They just can't afford it.

So with these few words, I will end; and we will submit to you the full results of this conference.

Senator LONG. Thank you.

Senator MORSE. I want to thank you, too. I agree with every syllable you spoke.

(The statement referred to will be found in the appendix on p. 1317.)

Senator LONG. The next witness is a member of the commission on aging, Mr. L. Rockwell Smith.

STATEMENT OF L. ROCKWELL SMITH, MEMBER, COMMISSION ON AGING

Mr. SMITH. Mr. Chairman, members of the Senate committee, we are very highly honored to have this visit from our Congress here. Why? I will go back to 1951 when we first started out as a lay committee to work on the problems of the aging. And when it came along to about 1954, I complained to one of our high officials in government, "It seems like we are not making any progress." And he said, "How long have you been at it?" And I said, "3 years." And he said, "4 years is par for the course." And here it is 9 years.

It is a little bit rough to work on the problems of the aging when the vast majority of our society is looking in the direction of youth. "Enjoy youth while you may; when you are senile and 21, why, there is no more to live for."

Now, we seriously quarrel with that; and so our communitywide committee struggled along and got one housing project off the ground, which you will hear more of later when Mr. Fulford takes the stand. And then we got our government, then the territory, to set up an interim commission which has started to work in the area of coordinating the many and various activities throughout the State that go into answering the problems of the aged.

Now, we are glad to have you because it lends prestige to answering the problems of the aged. It brings out people. In our early days, we were lucky to have 35; and if it was on housing, we would have 70 people come out and listen to a seminar or a discussion. Now we have this wonderful large group here today and we had a meeting of 500 people in our conference on aging in May 1960.

It occurs to me that with the addition to our core of workers, such as those you have heard already, and Mr. Fitzsimmons just now appearing before me, we are getting people of interest in the community lending a hand to this area; and the current problem of those who are 65 and who, of themselves, can do little to alleviate their circumstances, is fast being caught up with, and we can see our way clear with hearings, White House conferences, and the wonderful work of the Health, Education, and Welfare Department, and so on, at the Federal level and our local level.

However, there is one area that we have tried to tap but it has been a little bit slow, shall we say, because of the tremendous emphasis required by housing, health, and financial maintenance, or income maintenance. It is the business of getting people trained or reeducated or rehabilitated. We will hear later on from the adult education people.

I would like to suggest that, even as our doctors are discovering, from 50 to 80 percent of illnesses have their basis in emotional maladjustment or conflict situations within the persons themselves. And I suggest to you that the person who has been devoted to his job as a matter of habit, an occupation, and who has taken very little interest besides that, has to retire at 65. He can't go into community activities. And then he has a very great problem and we have a great problem to take care of him.

On the other hand, the persons who mature in the strategic area of age 21 and age 30, as I mentioned, and go on to extend their mental resources, to extend their mental outlook, to keep growing, and to keep growing emotionally and learn to understand themselves, can keep on working—whether it is on a job or whether it is in a community activity, after they are 65. I think it is Dr. Lindsey at the Bishop Museum who has just put together a planetarium out there, he never speaks of his age, but it is 80. He is working. He is with his son in a trucking concern. I think of Dr. Harper, former University of Denver chancellor, who flew back a few months ago from Rhode Island in a hurricane to attend actively a dedication of a new building in the Denver Law School, and flew back, after a round of golf, to Rhode Island—78 years old.

I would like to mention our committee right here today—our good Senator Long. He's just kept right on going. And our good friend, Mr. Bo Boustedt, with whom we consulted, as Mr. Fitzsimmons mentioned, last week. They don't speak of people who have retired as people apart. They are people—same as anyone else. And if they wish, then it's our hope that they may retire and go fishing or go on a vacation; or, if not, if they want to be active, whether it is in the community or whether it is on a job, we feel that they should have that opportunity.

We are very grateful to you for coming down and lending your prestige to us. Thank you very much.

Senator LONG. Thank you, Mr. Smith.

The next speaker is Mr. Oscar Fulford, administrator of Pohai Nani.

STATEMENT OF OSCAR FULFORD, ADMINISTRATOR OF POHAI NANI

Mr. FULFORD. Senator Long, members of the committee, Pohai Nani is the community-sponsored retirement home, that Mr. Smith

referred to, under the leadership of the Methodist Church. The community itself laid the groundwork for this organization in 1951 when a joint study committee was formed with representatives from the Oahu Health Council, the Honolulu Council of Social Agencies, and the Board of Public Parks and Recreation. This committtee made the following recommendations to each of its council boards:

1. That census data be collected and compiled into the form of a report which would be useful to all member agencies, and furthermore

2. That further consideration be given to sponsorship of a widely representative community group to coordinate existing efforts and stimulate further interest in the subject.

This committee also, then, sponsored a weekend conference in 1954 in April, and from that was formed a group called Action Group on Aging. Mr. Smith was one of the very active—and still is—leaders in that, as was Miss Catton who many of us will hear this afternoon.

This group then invited the Methodist Church to sponsor a retirement home such as they were sponsoring on the mainland—some 112 of them—but with the stipulation that here in Hawaii this must be a community-sponsored project, interdenominational, interracial, and with preference in consideration for membership being given to residents of Hawaii. This is still a very important part of our program.

However, in 1959, because it seemed expedient to do so, this group merged with Pacific Homes of California, which is an institution of the Southern California-Arizona Conference of the Methodist Church; so that we now are part of an organization presently operating five retirement homes, the oldest having been in existence 52 years. So the operation of retirement homes is something with which our organization has a lot of experience.

Pohai Nani will offer to 263 residents from Hawaii, and from the mainland, we presume, permanent security and happiness through a twofold program of housing and complete care.

Members select their accommodations and pay for lifetime occupancy—either couples or individuals—of apartments ranging from single rooms to two bedrooms, two baths, cottages, whatever they desire.

The second part of the program is complete care. Now, this includes utilities and the other daily needs such as meals under the direction of a dietitian, and full medical care. This will go farther than most retirement homes. We include full medical care. Now, we are not a rest home or a sanatorium; but having been admitted, we assume full responsibility for their medical care from that point on for nonpreexisting conditions. They must be well and ambulatory when they come in.

Another part of our program about which we are particularly proud is that we guarantee that, once a contract is signed, the life-care fee may not be raised on that person during his lifetime. In other words, if he can afford the program now, regardless of how high the economic level goes, he can afford to pay it 15 years from now. We have people living in our homes for 10, 20, 25 years; so if they come in now, they can come in and afford it 15 and 20 years from now.

We will have outside recreational areas. We presently own 16 acres on windward Oahu. And there will be a crafts and hobby

shop and recreational activities available indoors; and a medical program which includes infirmary facilities in the building; outside facilities will be used for hospitalization and surgery but at our expense.

And one thing that we are very fond of, too, is our Pohai Nani Foundation, which is a new feature that has just been added to our program not too long ago. Realizing that wherever you set the levels of fees, there are those who just can't quite make them; so we have set up the Pohai Nani Foundation, a separate corporation which is administered locally, as is our entire program. Even though we are part of the California group now, we administer it locally. The Pohai Nani Foundation will accept grants and gifts and remembrances in wills for the benefit of those who would like to come in—who are deserving, but who just can't quite make it financially. Already we have received contributions to that fund and I have just received word last week that more is coming in by the end of the year.

And may I say, too, that we receive no endowments for capital gains. We finance this through the sale of lifetime occupancy of the apartments. For the balance, we are using FHA under section 231, and I agree with Mr. Fitzsimmons that that is a pretty rough program.

I do appreciate the opportunity to tell you about this. You have the written report, which is more in detail. If there are any questions, I would be happy to answer them.

Senator FONG. May we ask how much is the occupancy, Mr. Fulford?

Mr. FULFORD. I beg your pardon?

Senator FONG. How much do you charge an individual?

Mr. FULFORD. Well, there are two fees. The first is the accommodation fee which pays for the lifetime occupancy. Those fees begin at $7,500 for an apartment. And the life-care fee—and we break them down because the accommodation fee is variable with whatever type of apartment you want. The life care fee is $200 per month per person. That includes all their meals, their linens, utilities, maintenance of their apartment, and full medical care as needed. That may be paid either by the month or it may be prepaid for one's lifetime, and in a lump sum. That is based on life expectancy.

Senator FONG. What happens when the individual is unable to pay the monthly sum?

Mr. FULFORD. Well, in order to come in, they must have an assured income. By that, I mean social security, blue chip stocks or pensions from reliable companies, and that sort of thing. However, it is possible through our endowment fund, which we have built up in our older homes and which we will build up through the Pohai Nani Foundation, to assist those people from the Pohai Nani Foundation if something goes wrong with their income.

Senator LONG. Mr. Fulford, in order that there may be a clear understanding, what do you mean by health care, how extensive.

Mr. FULFORD. Our health care is without limitation. When they come in, they must be well and ambulatory. We can't assume responsibility for a preexisting condition. But once they have been accepted into membership, we assume full responsibility with the exception of eyes, teeth, and feet; otherwise, hospitalization, surgery,

ambulance, doctor bills, vitamins—anything that our doctor prescribes, they get; and it is without limitation. We have had instances of where we have spent over $10,000 on one person for one illness.

Senator LONG. Including emotional difficulties?

Mr. FULFORD. That's right.

Senator LONG. Mental troubles?

Mr. FULFORD. That's right, either mental or physical, we assume full responsibility from that time on.

Senator LONG. Thank you.

Mr. FULFORD. Thank you.

(The prepared statement of Mr. Fulford follows:)

PREPARED STATEMENT OF OSCAR FULFORD, HAWAII PACIFIC HOMES, POHAI NANI

The foundation for the organization of Hawaii Pacific Homes Corp. and Pohai Nani was laid by the community in December 1951, when a communitywide joint study committee on the aged was formed. Members represented the Oahu Health Council, the Honolulu Council of Social Agencies, and the board of public parks and recreation. Soon, the committee made the following recommendations to each of the council boards:

(1) That census data be collected and compiled into the form of a report which would be useful to all member agencies, and

(2) That further consideration be given to sponsorship of a widely representative community group to coordinate existing efforts and stimulate further interest in the subject.

Receiving the financial support of various trusts and foundations, professional studies were made and in April 1954, a territorial conference on "Planning for Hawaii's Aging Population" was held. Resulting from this was the formation of a corporate body "Action Group on Aging—Oahu." It took as one of its prime objectives: housing. Sometime thereafter the group invited the Methodist Church, which sponsors some 112 retirement homes on the mainland, to sponsor such a home here with the stipulation that it still must be a community project, interdenominational, inter-racial, and with preference in consideration for membership being given, but not limited, to residents of Hawaii. This is still an important part of our admission policy.

Hawaii Pacific Homes was thus chartered in 1958 and Pohai Nani (meaning surrounded by beauty) was chosen as the name for the first home. The local corporation, in 1959, became a part of Pacific Homes of California, a Methodist corporation of the Southern California-Arizona Conference of the Methodist Church. Thus it became part of a corporation presently operating five such retirement homes, the oldest one having been established 52 years ago.

Pohai Nani offers to 263 residents permanent security and happiness through a twofold program of housing and complete life care:

(1) Members select the accommodation of their choice and pay for lifetime occupancy. Available in a high-rise building and cottages are single room apartments, semi-suites and one- and two-bedroom apartments for persons alone or couples. Each apartment has a private bath and dressing room, and most have a private lanai. Larger units have small supplemental cooking units.

(2) Complete care is provided by the payment of a life care fee. This includes maintenance of the apartment, utilities (except telephone), linens furnished and laundered, meals, and full medical care except for preexisting conditions. This may be paid monthly or prepaid upon entrance based on life expectancy.

Activity facilities will include outside recreational and planting areas on our 16-acre site on windward Oahu. Indoor will be a club room, hobby shop, craft room, library, game room, chapel, lounges, and auditorium. Solariums and a homelike kitchen will be on every floor. Meals will be served at small tables in a glass-paneled dining room affording a beautiful view of the valley below and the Koolau Mountains.

Infirmary facilities will be in the building with a nurse on duty at all times. Each accommodation will have direct and immediate communication with the nurses' station. Preventive medicine clinics will be held twice a week. Serious illnesses and surgery will be taken care of in outside institutions, but at the corporation's expense except for preexisting conditions.

Even though arrangements for membership are consummated by a lifetime membership agreement, the member may withdraw and receive a pro-rata refund of fees based on his length of residency. The corporation also has the right to ask for a resignation. Probably the most important factor in assuring permanent security and peace of mind for the resident is our guarantee that once a contract is signed, the life care free will never be raised for that particular person. Thus, regardless of where the economic level may go, his future is secured.

[The brochures which accompanied this statement will be found in the committee files.]

Senator LONG. Mr. Alfred Aki, board member of the Palolo Chinese Home is the last speaker in this group.

STATEMENT BY ALFRED AKI, BOARD MEMBER, PALOLO CHINESE HOME

Mr. AKI. Senator Long, members of the Senate committee, distinguished guests, friends, I have been asked to speak of the Palolo Chinese Home, its facilities and future plans. Rather than speak extemporaneously, which I was prepared to do although I submitted to you a written report, I am going to read from my notes.

The Associated Charities of Hawaii—now known as Social Service Bureau—on September 20, 1920, by written trust instrument, provided for the conveyance with the Governor's consent of 15 acres of land in Palolo Valley to the Palolo Chinese Home.

Palolo Chinese Home, a Hawaiian corporation, was chartered on May 28, 1941, and said land was conveyed to the corporation on that date. Its purpose was to care for the aged and indigent Chinese in Hawaii.

The Palolo Chinese Home is taking care of approximately 50-odd aged men, ranging in age from 65 to 101, at a very low cost of approximately $77 per month each.

Today, the buildings and accommodations are old and substandard and according to the State health department, as you heard from Dr. Lee this morning, the home is nonacceptable on the basis of fire and health hazards.

What steps have the directors of the home taken to remedy this bad situation you may ask. Permit me, then, to enlighten you on this point.

As its first vice president and chairman of the future planning committee, I have worked on the program for several years. A master plan has been completed. The first modern structure, the combination kitchen-dining room-social hall was finished 2 years ago. The second increment, 2 fire-proof single story hollow tile units, each housing 16 persons, 2 and 4 persons per room, will be built as soon as we are able to raise the necessary funds—$95,000—by public subscription. The third increment will be the dispensary and office structure and two additional housing units.

All of the above units will be conveniently grouped together and the grounds turned into a landscaped Chinese garden with every known flower and fruit tree introduced into Hawaii by the Chinese pioneers and planted.

The master plan will utilize about one-third of the 15 acres of land. How are we going to utilize the balance of the land? Low-cost hous-

ing for the aged. Here we have a large parcel of land that can be utilized for housing for the aged.

First, we can sell a portion of the land to a developer who will put up housing units for the aged, and from the proceeds complete the home's building project.

Second, we can lease the land to a private builder, and with the lease agreement go to a bank or financial institution for finances to complete the balance of our facilities for the indigent.

Third, we can apply through the Public Housing Act for a loan and build homes for the aged, ourselves.

The rental proceeds will eventually make the home self-supporting as the Palolo Home today is a member of the Community Chest.

It sounds simple enough—but the original grant has restrictive clauses that we cannot mortgage, lease, sell, transfer, or convey premises without the State's and the Governor's consent. We must secure a court interpretation and ruling or go to the Governor and legislature for relief.

In this connection, I might say that Senator Fong, upon his recent return, has consented to try and untangle some of those legal problems for us.

Furthermore, there is so much Government redtape that one is discouraged before he starts.

In closing, let me say get rid of as much redtape and make it as easy as possible for those who want to assist in solving the problem of better low-cost housing for the aged.

Thank you.

Senator LONG. Thank you, Mr. Aki.

Senator MORSE. Mr. Chairman, if I may take a minute, I want to give Mr. Aki a little encouragement. I have shared the views expressed here this afternoon in regard to the elimination of what we call redtape or complex procedural requirements in respect to FHA. It has always been my position that much of it could be eliminated by administrative procedural changes within the agency itself. Our present administration is very anxious to proceed with the actual construction of housing units for the elderly.

I am going to ask Mr. Reidy, counsel for this committee, to take out of the record today each one of these comments by way of complaint as to redtape in connection with FHA and send those comments directly to Mr. Sidney Spector, who is now appointed by this administration in charge of all housing for the elderly under FHA. Mr. Spector used to be the counsel for the committee on the aged; so he knows our problem.

I am sure that you have made more of a constructive suggestion here today than some of the witnesses may realize, because out of just such a hearing as this will come this direct request, through Mr. Reidy, by way of giving them the excerpts from the testimony, your suggestion to see what can be done about simplifying the FHA procedures so that we can get on with the job of actually building the houses for the aged, which this administration is dedicated to doing.

Senator LONG. I am not of that number who believes that all change is good. I do believe, however, that variety intensifies our interest a little bit. We have been hearing now for a number of hours from the experts—at least those who have made studies in official ways of the problem which we are concerned with.

We are varying it now and we are turning to a part of our program entitled "Town Meeting of Senior Citizens"; and we are going to call on senior citizens to share their thinking with us.

There are four of them who are scheduled on the program who either represent groups of senior citizens or who have indicated that they would like to be heard. We will then call upon anyone who is interested to appear before one of the microphones. We will ask that each person give his name and address to the reporter so that she can get it down for our official record of the hearing because we are very anxious for the Members of Congress to know how our senior citizens, themselves, feel about the problem.

Now, in order to be entirely fair with a great audience like this, outside of the first four speakers—and we hope that they will limit themselves to 3 or 4 minutes—we are going to ask the others to try to limit themselves to 2 minutes. You can't make a speech. We simply want you to share with us one major thought, one problem, one thing that you think should be done, and I know that you will play the game on that basis. Following that, we will return to the technical witnesses.

The first speaker that I wish to call upon is Mrs. Viva Mayes of the Senior Citizens Club of Honolulu. Mrs. Mayes.

STATEMENT OF MRS. VIVA MAYES, SENIOR CITIZENS CLUB OF HONOLULU

Mr. MAYES. Senator Long, Senator Morse, Senator Fong, Mr. Chairman, members of the committee, as president of the Honolulu Senior Citizens Club, I would like to tell you about our activities, our needs, and our problems.

We are sponsored by the Honolulu Parks and Recreation. Mr. Theodore Nobriga is our boss. He is the executive director. And Mrs. Marie McDonald is our adviser.

We call ourselves the Fun After Fifty Club. We have many crafts and activities that we can participate in 5 days a week, if we care to.

There are about 19,000 older people, they tell me—I am not sure about this number—on our island but we only have about 700 members, for we don't have the space or the facilities to entertain a larger number. We would like to have every one of these nice folks join us, for we really need something like this because so many of us, when we retire, feel that we are through with life. All at once we find that our children are grown, have their own interests, and just don't need our help and guidance any more. Then when they join a club like ours, they soon learn that there is still a lot of life, lots of crafts to help keep idle hands busy, lots of wonderful friends in a group of their own age, lots of fun and laughter.

The Honolulu Parks and Recreation and the Young Women's Christian Association have graciously donated to us the use of several buildings, owned by them, where we can hold our meetings, dances, and so forth.

But we need our own clubhouse—several, in fact; for if we had these places of our own, we could have many more members and groups in several parts of the city and also on the windward side of our island.

Recreation for us is a basic need, just as important as medical aid, because for us older folks idleness and loneliness can really harm our health just as quickly and surely as any ailment.

Now, we aren't asking for all this to be handed to us on a silver platter. We have been and will continue to be helpful in any way, to contribute our time and efforts for the improvement and betterment of our club. But we do need more aid and assistance from our State and Government.

For the past 7 years, Mr. and Mrs. Hersh Mann have given unselfishly of their time and have worked hard for this club. They have had a lot of headaches and heartaches, but have never stopped trying to aid us.

I would like to end my talk with this short poem that I have written, for it does give you a good idea of the meaning of the Senior Citizens Club:

On the island of Oahu
In a city by the sea,
There's a club called Fun After Fifty,
And it's just for you and me.
We won't let the young folks join it,
Just the old and tired and gray,
Just the ones that's really had it,
But—the results are not that way.
For we're full of fun and laughter,
Lots of pep in everyone;
All these oldsters turned out youngsters,
And we keep the city on the run.
So, if you're old and tired and lonely,
And think you're going 'round the bend,
Throw that armchair in the ocean,
And join our senior citizens, my friend.

Senator LONG. Thank you, Mrs. Mayes. And if you wish to extend your remarks—and this applies to everyone else, since you are limited—will you expand your remarks and send your paper in within 2 weeks or 3 weeks or 30 days, but the sooner the better.

We will now be delighted to hear from a very old friend of mine—I don't want to emphasize the age, but for many years we were associated together and worked in the public schools—John Luiz, Retired Teachers Association. Mr. Luiz.

STATEMENT OF JOHN C. LUIZ, HAWAII RETIRED TEACHERS ASSOCIATION

Mr. LUIZ. Senator Long and distinguished members of the committee, I will stay with my notes because I am concerned with conserving your time. I know you want to save as much time as you can, so I will not be able to read everything I wrote. I will pass over certain portions, but I do want to read certain portions and, with your permission, I will do so.

Senator LONG. Yes; and your entire statement will appear in the record.

(The prepared statement of Mr. Luiz follows:)

PREPARED STATEMENT OF JOHN C. LUIZ, HAWAII RETIRED TEACHERS ASSOCIATION

The Hawaii Retired Teachers Association is an organization of chapters located on Oahu, the big island, and Maui. Until such time in the future when there will be enough members to operate as a chapter, Kauai makes its needs

known through the Oahu Retired Teachers Association. Hawaii's retired teachers living on continental United States and other countries have been quick to realize the need of a State association by joining, according to a suggested plan to strengthen local units, the chapters of the islands on which they retired. In order to express our loyalty to, and confidence in, the large body of loyal, active teachers, plans are being perfected for the Hawaii Retired Teachers Association to become a department of the Hawaii Education Association.

It is quite evident that Hawaii's retired teachers, both here and elsewhere, realize the need for a strong association. They have given it their loyal, financial support from its beginning and believe that it is the best means through which all members have the opportunity and the challenge to serve with their compatriots in areas of common concern. All this is well proved by the very high percentage of all retired teachers who are paid up members of the Hawaii Retired Teachers Association.

The main problem that triggered the organization of retired teachers in 1954 was that a considerable number of them were receiving less than $75 per month as their total retirement income. We wish to state here that we are interested in all retired people, teachers as well as others, and in all the areas under study by this special committee; but because other groups have organized and are representing their members well and effectively, it was felt that our efforts could best be expended in certain, special interests of retired teachers.

The first project undertaken and kept under constant study was our effort to improve the pension plan in order to reduce the gap between the pension and the spiraling cost of living. While much improvement has been made, for which we are thankful, much more needs to be done. It is by no means the complete answer, and plans are now under way to work for a more equitable solution.

The second project was the opportunity of retired teachers to supplement their income after age 65 as substitute teachers. This pressure has been relieved, as the Department of Education has since then changed its policy of retiring teachers at 65 only on the basis of age. By action of the Commissioners of Education on June 19, 1961, it accepted and approved the opinion of the Attorney General to the effect that teachers now in active service may continue to teach until age 70, provided they pass an annual physical examination.

In this connection it should be stated that the Hawaii Retired Teachers Association is aware of the need of protecting the active, vigorous quality of educational service for the youth of the State. Both on Kauai in 1960 and in Honolulu in 1961 resolutions were adopted calling attention to the inflexible age of retirement, but recommending study and caution in reaching a solution.

The resolution adopted on Kauai in 1960 reads as follows:

"Whereas the U.S. Senate Subcommittee on Problems of Old Age and Aging has conducted exhaustive hearings, surveys and staff studies, and as an outcome of these hearings, suveys and studies, urges the States to consider, at their next sessions, legislation to outlaw discrimination in employment because of age, therefore be it

"*Resolved*, That we, here in convention assembled, hereby urge that further study of possible action for Hawaii be considered by the appropriate agencies, with particular reference to the teaching profession, and that copies of this resolution be sent to the Governor's commission on aging and to the president of the Hawaii Education Association."

The resolution adopted at the 1961 convention reads as follows:

"*Be it resolved by the Hawaii Retired Teachers Association, assembled this 29th day of March 1961, at Honolulu, Hawaii*, That the Department of Public Instruction of the State of Hawaii be urged to establish a plan for retirement at the close of active service that, if possible, does not depend solely on the element of age; and be it further

Resolved, That copies of this resolution be sent to the Hawaii Education Association and to the superintendent of public instruction."

A third problem was the matter of medical and health insurance for retired teachers. This area was very successfully developed by the National Retired Teachers Association and is currently meeting a vital need that was a very disturbing source of frustration and insecurity.

It is a pleasure to state here that the State has recently initiated a Medical and Health Plan that retired teachers are privileged to share. This is a boon for retired teachers and we welcome this opportunity to express our grateful appreciation.

The fourth problem was an adjustment in the formula to calculate the annuity and pension on the basis of one-sixtieth instead of one-seventieth. The guaranteed allowance, including annuity and pension, will be equal to one-sixtieth of the final compensation multiplied by the number of years of creditable service for all persons retiring at 65 or more years of age after June 30, 1961. While we feel that legislators were possibly justified in this action as a first step for financial reasons to make this formula apply only to 1961 retirees, and to other retirees after them, we believe that there is some justification for feeling that treating groups differently gives many people reason for doubting this basic thinking, regardless how well intended it is.

We could not close this report without expressing our sincere thanks to such groups and agencies as the Hawaii Education Association, the State retirement system, the Hawaii Government Employees Association, the Hawaii Government Retired Employees Association, and the Commission on Aging for their interest and cooperation in our efforts to improve the living conditions of retired people. We particularly wish to express our genuine appreciation to such individuals as Mr. James R. McDonough, executive secretary of the Hawaii Education Association; Mr. Harold Hill, executive secretary, and Dr. Hubert Everly, chairman of the board of regents of the State retirement system; Mr. Fred Clowes, who served for a number of years as chairman of the Committee on Legislation of the Hawaii Retired Teachers Association; the many legislators who showed high interest in trying to meet our just needs; Governor Quinn, who displayed a realistic view by recommending and approving funds for retired people; many other individuals who helped in one way or another; and the officers of the association who have given of their time and effort in the interest of a good cause. To all these good people we say "Thank you very much" for your cooperation, your guidance, and your understanding of our problems.

As a proper and fitting climax, we wish to express our sincere thanks and appreciation to this subcommittee of the Senate Special Committee on Aging. Particularly do we wish to say mahalo nui loa to Senator Oren E. Long and his colleagues for their interest and effort in assisting the retired people of Hawaii and of the Nation to achieve, with dignity, the financial and social status they so richly deserve.

Aloha.

Senator LONG. The next senior citizen to be called will be Miss Social Service of Queen's Hospital—and just about everything else pertaining to health, nursing, and otherwise—Miss Margaret Catton.

STATEMENT OF MISS MARGARET M. L. CATTON

Miss CATTON. Senator Long and members of the Special Committee on Aging, you are aware of the Federal and State law concerning the sale of one's residence whereby if he does not invest in another home within certain time limitations, he must pay a capital gains tax.

There are some elderly persons in Hawaii who would like to purchase an apartment and life care in Pohai Nani, the residential home for the aged soon to be established in Kaneohe, but they cannot afford this cost unless they sell their present homes. They have been informed, however, that the purchase of an apartment in Pohai Nani does not release them from the capital gains tax. This seems to be grossly unfair and should be remedied.

In addition to the cost of an apartment, there will be a monthly charge of $200 for complete life care in Pohai Nani. If the law regarding the capital gains tax is so amended, elderly persons of modest means, selling their present homes, might have funds not only to purchase an apartment but perhaps a balance to help toward the monthly charge of $200 for life care.

That the need of money may not be a deterrent to otherwise desirable residents, I would like to urge, Mr. Chairman, that the Special Com-

mittee on Aging take steps for amending the statute concerning the capital gains tax on sales of their homes by those persons who wish to purchase accommodation in a residential home for the aged.

Senator LONG. Thank you, Miss Catton.

Over a long period of years, the next witness to be called, Mr. Frederick A. Clowes, has taken a keen interest in the whole question of retirement and what happens to people when they retire and what should happen.

I am privileged to call on Mr. Clowes at this time.

Apparently, Mr. Clowes didn't get here this afternoon.

We will now come to the next part of the program of the senior citizens in that anyone who wishes to volunteer—and I hope there will be a considerable number—may speak. Will you please go to the center aisle, give clearly your name and address, and please limit yourself to a single thought because we have to limit this, as a matter of courtesy, to about 2 minutes each. Thank you.

STATEMENT OF EDWARD C. SPENGEMAN, HONOLULU, HAWAII

Mr. SPENGEMAN. May I speak first?

Senator LONG. Yes. Will you give your name and address, please?

Mr. SPENGEMAN. I am Mr. Edward C. Spengeman, 1555 Pensacola Street, Honolulu 14—better known, I guess, as Edward Edwards on the airwaves here as I have two programs each week on radio station KMVI. I will be 66 years old this coming January and, therefore, I started drawing social security last January 1960.

I want to speak very briefly and quickly on the relationship between the effects of inflation and those of us who are practically retired on a fixed income.

To begin with, very quickly giving you a little background so that you many understand that I have, I think, enough background to figure this thing out a little bit, I am one of the first and original radio announcers in the United States. There were seven of us who put radio into commission. We were the first seven to be heard over the airwaves in this country—such men as Milton Cross, Norman Gordon Childs, Raymond McNamee, myself, and two others.

Furthermore, I was in radio as an announcer and diskjockey and other capacities—writing, producing, and acting—in radio for some years. I took a reprieve from radio, a sabbatical vacation from radio, in 1924 to become executive secretary for the State of New Jersey for the Progressive Party, and I conducted a State campaign in New Jersey in 1924 for Robert M. La Follette and Burton K. Wheeler, and we made a very creditable showing though we did not elect our candidates. However, we were a new party at that time.

And in that capacity, I spoke all over northern New Jersey—in Newark and Orange and other cities of New Jersey—to audiences of 5,000 and 6,000, and sometimes 10,000 in Orange and in Newark. So I have done a little public work.

Now, I am back in radio in Hawaii at KMVI with an hour's program every Saturday morning, which I broadcast from 6 to 7; and on Sunday mornings, I conduct, as an ordained minister, which I am—I conduct a 15-minute program on Sundays, starting this coming

Sunday at 7:30 to 7:45 on KMVI. You are all invited to listen in, if you care to.

And speaking of KMVI, I am instructed by the ownership of that station to inform this committee that our station is available to you or any of your members, free of any charge whatsoever for whatever air time you wish, to discuss problems of the aged; so if you care to make yourselves available of this opportunity, any accredited member of your committee—this does not include private organizations but only your committee members—we will give you free air time at any time that you desire.

Senator LONG. Thank you very much. I am certain there will be some of the senior citizens who will wish to take advantage of that.

Do you have anything in half a minute of talking? We have to give you just a moment.

Mr. SPENGEMAN. I will be very quick. We have heard generalized terms today on various phases of the problems of the aged. At the expense of revealing to this audience, who does not know me, some of the facts and figures of how we have to live, some of us, let me reveal to you, to my chagrin and embarrassment, my own situation.

I have a total income, varying a few hundred dollars a year one way or the other, of $3,200 a year to live on. This is my gross income. This is derived from a trust fund, which my mother set up upon her passing 4½ years ago. The major portion of it comes from that, and the balance comes from $900 a year social security. In other words, the trust fund provides me with $2,400 a year; and social security, $900—making approximately $3,200 a year. This, I repeat, is gross income.

It is necessary for me to support my family, certain members of my family, with $225 every quarter. This sum must be deducted from moneys that I have available for myself. In addition to that, my taxes run about $400 a year. In 1960, I paid $462 in income taxes upon my income for 1959 because I had supplemented it by part-time work.

In other words, instead of having an average of $270 a month to live on, I find myself with a net income of $155 a month. Now, in this day and age, with living costs what they are, you can figure out yourself what you can do with less than $40 a week upon which to live.

And I say to you that we senior citizens are entitled, I think, to more tax relief than we have, I do not see why we should have worked 44 years, paid income taxes since 1910, and now are taxed heavily at the rate of 20 percent of our gross income when we are no longer earning a livelihood and have to pay this out of funds derived from trust funds and from other sources apart from employment.

I think that the Federal Government should grant us some additional tax relief when we have passed 65. It is true that we do get an additional allowance of $600, but we should have more.

Senator LONG. We are going to have to ask you to make one more statement and stop there because we have a great many——

Mr. SPENGEMAN. All right—one more. I think, too, the State of Hawaii should in some way try and give us a little additional tax relief on sales tax. And if the bus company would afford us a special rate, that would be helpful to us; for I can't afford 50 cents a day for one round trip on a bus. Thank you, sir.

Senator LONG. Thank you.

STATEMENT OF COL. THOMAS R. AARON, KAMEHAMEHA SCHOOLS, HONOLULU, HAWAII

Colonel AARON. Mr. Chairman, members of the committee, I want to say a word about a man between 65 and 72 who works part time. If you have an outside income of $500 a month or if you have a pension of $500 a month you lose none of your benefits. If you own a plot of land and you can make $500 in 1 month from that, you lose 1 month's social security payment. But if you are unfortunate enough not to have any income and are dependent upon social security, you are going to lose 50 percent of what you get between $1,200 and $1,700—and every dollar, dollar for dollar, after that. That, in effect, is paying 70 percent Federal income tax on the money you make between $1,200 and $1,700.

In addition to that, you pay State income tax on that. In addition you pay social security tax, which they charge until you are 72.

Now, there is another factor. There are a number of jobs available on a part-time basis for the people who can make maybe a couple of hundred or $250 a month. And a young man can't afford to do that and support his family. The older man between 65 and 72 can do that. And even if he has nothing but social security and he makes as much as $250 a month, he can get by; but I don't think he can on $100 a month.

One more thought. As you get older, I think those who are physically able to do so, if they have a part-time job, it not only gives them a little extra money, but deep satisfaction in doing something and in doing some good, and you are younger by doing it.

I think that this committee should consider raising the ceiling to $1,200 as a maximum amount a man can make without losing some of his social security benefits.

Thank you very much for allowing me this time to talk.

Senator LONG. Thank you.

STATEMENT OF MRS. LOTA COOPER, HONOLULU, HAWAII

Mrs. COOPER. Mr. Chairman, I am Lota Cooper and I live at 2470 Cleghorn Street. I am a member of the Senior Citizens' Club and I also consider myself a citizen of Hawaii.

Having traveled in nearly every State of the Union except Alaska, I wish to state, first of all, that I think the city of Honolulu, especially the recreation department, is providing more recreation for the older citizens here in Honolulu than I have ever seen in all the rest of the United States.

My first problem: I think the greatest problem to be considered is housing. And if you provide homes such as Punchbowl Homes at a moderate cost to those of us who are growing older, that will solve a great many of the other problems such as senility and the emotional upsets that cause that. It can relieve the tensions of living by providing a dignified way of living where one can support yourself in your own home at a very moderate cost, which will solve a great many problems.

Now, I am honored by these gentlemen of our U.S. Government, and I have one question which I wish to address to all of the Senators,

with the exception of Senator Fong. I wrote to him and told him that I approved thoroughly of his bill for the aid of the ones who were ill. But I want to ask both Senator Long and Senator Morse what legislation you would present that would give aid to those of us who are not on social security.

Senator MORSE. In 1958, I introduced the Morse version of the Forand bill in the Senate, which would cover all those who are on social security. Subsequently, I had an amendment which would have provided the same program for people on railroad retirement. I still stand for both because I think it is the clear moral obligation that we owe to the old people of our country. We are getting more and more support for it. I hope eventually to pass it. But when it failed to pass in 1960, we passed the Kerr-Mills bill instead, which applies directly to those who are not under social security.

Mrs. COOPER. And do you have an answer, Senator Long?

Senator LONG. Yes, I have been supporting Senator Morse and others on the drive—and it is the only solution, in the minds of a great many—to place principal emphasis of this problem under social security.

Thank you for your contribution, and I——

Mrs. COOPER. We want to be considered who are not on social security.

Senator LONG. Yes. And, as Senator Morse indicated, his idea includes people who have not qualified for social security. That is, they will be taken care of. They should be.

Next?

STATEMENT OF SCOTT B. BRAINARD, HONOLULU, HAWAII

Mr. BRAINARD. Senator Long and members of the committee, my name is Scott Brainard. I am a humble businessman and a taxpayer. I have noted here today references to the beginnings of the Commission of Aging Population of Hawaii as being back in 1951. I had the pleasure of working with the community committees which held conferences and brought people together and began to study this problem, some of which has been brought into very material evidence today.

Now, in 1960 I resigned from the Interim Commission on Aging, and I think in about 2 minutes' time I can give you the gist of why I resigned, and make a point, Senator Long, that I think will please you because it doesn't agree with a lot of other things that have been said here today.

My letter was addressed to Dr. Komuro, the present chairman of the commission (reading):

> Please accept this letter of my resignation from the Interim Commission on Aging, State of Hawaii, effective at your discretion though with a request for early consideration.
>
> Your leadership and ability have made this assignment stimulating, fruitful, and pleasant. I have gained a great deal from the associations and discussions.
>
> I am not now nor have I ever been fully in accord with the organization of the commission or its apparent approach to a solution for the problems of the aging. Aging is an individual family and community problem, not a governmental or a political problem. The finest, busiest, and most able citizens in the State should comprise the majority of the commission membership. The State should help, but not solve the problem; and it should not usurp the community interest area.

The problems are great, both remedial and preventive. Of the two, the latter is less drastic but very important. In a certain institution for the mentally ill, a unique test was used to determine whether the patient was sufficiently recovered to be released. He was confronted with a stoppered sink into which water was pouring from a faucet. He was given a dipper. If he was not ready for release, he ignored the faucet and attempted to prevent an overflow by using the dipper. If he was ready for release, he turned off the faucet.

There are many elements contributing to the rapidly increasing senior citizens that care must be taken not to lose sight of the preventative in the urgency and onrush of the remedial.

As long as Government depends on the citizens of the city, State or Nation, that city, State or Nation has a chance to survive; but when the citizens depend upon their Government to solve any problems that they, themselves, can solve, that city, State or nation embarks on a weakening course.

There are some things which can better be done by Government than by citizens, individually or collectively. Proper preparation for the later years of life does not appear to be a function of living to be suddenly solved by Government benevolence or political opportunists.

My sincere hope is that the Interim Commission on Aging for Hawaii may be put on a permanent status and that it may be reoriented to a position of powerful community force.

The move, when it first started here, came from the citizens of the city and the State. It has now assumed a governmental aspect and it needs to be returned to the people of this community. Thank you.

Senator LONG. Thank you, Mr. Brainard.

The next speaker?

STATEMENT OF MRS. LULU ROBERTS, HONOLULU, HAWAII

Mrs. ROBERTS. I am Mrs. Lulu Roberts, a resident of Punchbowl Homes, and a very happy resident, I assure you. I have had many communications from Senator Long, which I thank him for from my heart, on different things that came up of interest to me, who are growing older—of course, I'm not old; I'm just growing older. But after listening to the many fine talks that I have heard here today, I feel assured that we older people haven't as much to worry about.

I also feel that as older people, we should keep on trying, and not only expect somebody else to solve our problems for us.

I happen to be an aged widow of many years—I'm not going to tell you how many—and I have social security, very low; but I also have a fine son who backs me up in what I need.

I just want to take this opportunity to thank all you men who have been so kind to come here and listen to all our many problems.

I thank you.

Senator LONG. Thank you.

STATEMENT OF DR. W. S. CHAR, HONOLULU, HAWAII

Dr. CHAR. Mr. Chairman and honorable members of the Committee on Aging, my name is Dr. W. S. Char, a practicing dentist for 35 years, 4 of which were in China, 4 at Palama Dental Clinic, and 27 years in Honolulu.

On coming to this meeting on geriatrics, I would like to voice my humble opinions on this important question concerning the health, broadened social service, vocational rehabilitation, housing, retirement, and education of the aged. I represent no group or organization. I merely speak as an individual who tries to better the lot of

our senior citizens, for I, too, am fast reaching the twilight years of my life.

I am 59 years of age. Many of my friends and patients nonchalantly suggested, "Why don't you take it easy and prepare yourself for retirement?" My answer to them is that I so love my profession that I will continue practicing until the day when I am not able to—that is, something due to either sickness or death.

Should I retire at the age of 62 when I can collect from social security, the benefit thus derived from social security may be not enough to sustain the time of living in this age of high cost of living. A lot of us oldsters do not have enough insurance to retire on. Years ago, $25,000 life insurance would be sufficient to enable a senior citizen to retire. An oldster, if retired without any hobbies, will get uneasy with too much time on his hands. He will be a nuisance around the house, and when his beloved wife looks at his face 365 days throughout the year, she will get tired just to avoid him.

Most of our senior citizens do wish to continue on with their chosen profession and trade as long as they can—even after the age of 65. I would like to recommend to this committee that a plan be instituted whereby an elderly person can still continue to work at the age of 65 to 75. Why not make it optional for a person to retire at the age of 65; and if his health is good, he can work until 75. An elderly employee is a seasoned and experienced worker. He knows all the tricks and shortcuts of his profession and trade. He is certainly an adjunct to the company he represents.

If a person is on the payroll of the company, he is entitled to group medical and dental insurance, which, accumulated with retirement funds, will be sufficient for him to buy his own apartment to devote himself to some social and community activities and to enrich himself by taking some night courses at the University of Hawaii.

Every oldster should have some hobby, whether gardening, writing, music, art, or other things.

I hate to be like a political football, being kicked around from home to home and not knowing where I can safely have a roof over my head. I do think there should be a law whereby the grown children who are able to earn a livelihood should contribute 10 percent of their earnings to the support of their elderly parents, just like the Mormons do for the support of their church. They do their part in contributing in the form of tithes.

If the Government is to allocate sums of money for all the aged, let the Government sell these apartments to the aged persons with long terms of payment and very small deposit. The pride of ownership is a tremendous incentive for our senior citizens to better themselves.

As part of my remarks, I wish to say that our senior citizens do want to have a sense of belongingness and security in this community; and, believe me, they want that independence and not to take charity, especially from their children.

Thank you.

STATEMENT OF JAMES WILLIAMS, HONOLULU, HAWAII

Mr. WILLIAMS. Gentlemen, I am a retired policeman from Washington, D.C. Every 2 years I am required to take an examination. I

went to the VA here and they refused to examine me. The VA in New York has examined me; but here, they won't. If I don't receive an examination here, I will have to go back to Washington, D.C., to take it. That will cost me about $1,000. I only get a pension of a little over $2,500. How can I get an examination?

Senator LONG. I am assuming, if the speaker wants an answer to that, that the only suggestion that can be made is that you work through the Veterans' Administration.

Mr. WILLIAMS. In New York, the Veterans' Administration has me examined. Out here they won't.

Senator LONG. You have a real problem and I think it is one that you should take up——

Senator MORSE. I've got an answer.

Senator LONG. All right. Senator Morse says he has an answer.

Senator MORSE. I hereby appoint Senator Long and Senator Fong to take it up with the Veterans' Administration.

Senator LONG. We get a great many requests like that and we always act on them very promptly. I know of no place other than the Veterans' Administration where relief from a situation like this can be secured.

Mr. WILLIAMS. I have been to the Veterans' Administration.

Senator LONG. You take it up, as Senator Morse suggested, with Senator Fong and with me. We will be returning to Washington in January. Don't expect us to do it tomorrow because we can't go back to Washington now, but write the letter tomorrow, requesting it.

Mr. WILLIAMS. Thank you very much.

Sentor LONG. Thank you.

STATEMENT OF MRS. MARGARET MOREIRA, HONOLULU, HAWAII

Mrs. MOREIRA. Mr. Chairman and members of the committee, I want to present my problem to you. First of all, I want to say that I am a Hawaii-born person and a member of the Honolulu Senior Citizens Club. I have a problem that I can't solve and it has been very much impossible for me to have it solved.

I was turned to the Hawaiian Homes when it was a Territorial property at the time that we took that lease, but it was with the Hawaiian Homes. And I have three homes to move out from that property. I haven't got the means to move them and I don't have the means to buy a piece of land to put them on. And I was told the first part of the year they are going to landscape and subdivide that property in ten lots. They are going to turn my houses over with a bulldozer.

I am a widow. I lost my husband 6 years ago. And those are our life savings. I can't bear to lose those homes and have no place to put them.

My pension—that is, I have an annuity that came to me after my husband passed away of $53. After I take the Federal insurance for medical and hospital plan, it only leaves me $30.50 a month to live on.

So I would like to know what can I do—or if I can get—I am not eligible for social security because my husband was a Pearl Harbor employee and he retired in 1945.

Senator LONG. Thank you very much. Now, in answering your question, if there is an answer, the first thing is that you should take it up immediately with the city and county authorities. They are in charge of the land situation, generally, in the county. Now, if it were the Federal authorities that were to use your land and tear down your houses then you would take it up with the Federal authorities.

But even though it is a city and county matter, I would be very glad to have you write a letter to me and I will have my staff check it.

Mrs. MOREIRA. Senator Long, I had this with the legislature. I went through so many angles.

Sentor LONG. Well, you write a letter about it.

Mrs. MOREIRA. I am trying to have a piece of land from the State land commissioner—to release a piece of land as a lease for me to move my houses, and the senators were in favor but when Mr. Siu took Mr. Reppun's place—they asked him if he wanted to release a piece of land and he told me he would say yes; and at the time when they asked him that question, he said no.

Senator LONG. Well, thank you for bringing the problem to us.

We have time for one or two more.

Mrs. ALEXANDER FAYE. Mr. Chairman, I am speaking for a Mrs. Ruth Tanfield, who is the mother of a career Air Force man. She came to Hawaii 7 years ago. She is sitting in the audience but prefers not to speak. She has a written statement, which I am reading for her.

(The prepared statement of Mrs. Tanfield follows:)

PREPARED STATEMENT OF MRS. RUTH TANFIELD

I came to Honolulu 7 years ago last July with my son who is a career Air Force man.

In the fall, I discovered the wonderful Volunteer Service Bureau and was sent to the armed services YMCA as an adult volunteer.

The following May, I joined the Y staff as a part-time worker, which position I held for 6½ years, until November 5 of this year. Also putting in around 2,000 volunteer hours, to date, aside from the paid time.

A little over 2 months ago, with absolutely no warning whatsoever, I was called into the executive office and told there had been a committee meeting and the members had decided upon a policy governing the age limit of 65 for employees who can stay on from year to year if able. Being 70, my services were being terminated as soon as I could arrange to go.

I know that my two immediate bosses tried their best to get exceptions made for me and one other woman, who had been there 19 years, as they were not considered as capable of running our departments well but were actually needed in them.

I, myself, asked the executive director to let me stay on until after the first of the year when my son is due on leave from Tachikawa Air Force Base and could help me make the trip, if we decided going to Japan was right for me. As a matter of fact, he tried to talk me into stop working and go with him, when he and his wife came through Honolulu last summer, but I have been independent so long, loved my work in the Y library, which had become a big part of my life, and really thought I was important to it.

I don't want to leave Hawaii and the many friends who have become so dear to me, and my son is fairly certain he will be transferred back to Hickam in the spring.

It has been a shock to me, so unexpected and so unprepared for, leaving me with no income aside from social security and unemployment benefit checks.

I not only want to work but am able to do so, and must work at something to keep well and happy.

I have not only been deeply hurt by being dismissed from a much-needed job, especially just before the holdup, but, for the first time in my life, been made to feel old and rather useless.

Senator LONG. This gives emphasis, of course, to the necessity of some kind of employment. I don't have the answer to that. I don't know of any agency in the community that does have the answer. I should think that if the YWCA still has its employment division, that would be the place to go.

Next?

STATEMENT OF MISS MARTHA DANIEL, HONOLULU, HAWAII

Miss DANIEL. Mr. Chairman, I would like to ask about the consistency of urging people to take care of their health in order to live for a long, long time. Many people are improving their health, and now you turn around and tell a man that he can retire at 62 and you will carry him on social security.

I, myself, do not want to hold out my hand to Uncle Sam. I worked from 1924 to 1942 on a salary of $850 a year. I can take care of myself. I pay my own doctor bills, which I do not have. I pay my own insurance. And I pay my bills. If I can do that, I think a great many other people can do it. There are too many of us who hold out our hands to Uncle Sam. We may break his back.

Senator LONG. While we are waiting, may I point out that if there is anyone who has a thought that he or she would like to share with the committee, we urge you to submit it to the committee any time within the next 30 days. I might add that we have envelopes and paper here with the proper beginning for your statement. We want your statement.

STATEMENT OF HENRY THOMPSON, ASSISTANT DIRECTOR, REHABILITATION CENTER OF HAWAII

Mr. THOMPSON. Senator Long, members of the committee, my name is Henry Thompson. I am the assistant director of the rehabilitation Center of Hawaii. I am not one of the honored aged, but I work with the aged and the aged disabled.

I would like to speak on a subject that does not concern the care of the aged, but something else.

Senator LONG. Well, we are here for the aged, exclusively. If it is related to it, we will be glad to give you the time; but we have a list of speakers yet.

Mr. THOMPSON. Yes, it is very related and I will make it very brief.

Senator LONG. It is all right if it is related, but make it very short. Proceed.

Mr. THOMPSON. Yes, sir. We have been very successful in putting our aged back on their feet to send them home, and each time we send them home we ask ourselves, "What for?" And the thought that has occurred to us time and time again and the thought I would like to pass on to this group is—in your planning for the aged will you please give consideration to the task of uncovering and harnessing the tremendous wealth of information and experience that the

aged have but which we do not at this time have the means of exposing to employees and to the community.

Now, I gather from this group here, we speak of the care of the aged, the medical care, the home care, the housing, but we do not speak—at least I have not heard it here—of the tremendous amount that these people can give back to the community.

And this I would like to recommend—it could be a direction that could be taken—that of readjusting their time, worktime and work schedules and work duties, in order that these disabled people or aged people may be used longer in their lifetime in our community. Thank you.

Senator LONG. Thank you. The next speaker?

STATEMENT OF REV. EDWIN GOODWIN, HONOLULU, HAWAII

Reverend GOODWIN. I am Rev. Edwin Goodwin. I came here 22 years ago as a Baptist minister and I have been doing work here for all these years for the church.

I'm not going to add anything to the fine reports you have had. You have had some wonderful reports on the State of Hawaii, the conditions here, and so forth. But there is just one thing that I would like to say, however, and that is that you in Congress, you Senators come up with a really liberal program for the aged to really provide for them, and I say to soft-pedal some of those who would be conservative enough as one lady, I hear, who is a prominent speaker here, only a week or 10 days ago would repeal much of the progressive legislation that has already been passed. An intelligent lady who had many years of experience in Washington, D.C., made a statement about repealing what we already have because what you gentlemen are doing in Congress is a trend toward socialism and communism.

And I don't stand for any such thing as that because I come from an old New England family and I am an American and have progressive ideas for the betterment of my fellow men, and I believe that we should set up a program which is for the benefit of the aged, a real benefit, not a make-believe, not a halfway job, but do a real job of it.

And you gentlemen should not fear any criticism of politics as regards to being liberal. Be liberal with the aged.

I want to say another thing, gentlemen, something new that hasn't been brought up here this afternoon in this program, and that is that I have a suggestion. I am speaking as a minister. I am speaking very seriously. I am not trying to bring a joke or a gag into this at all; so I want you to take what I say seriously: that you provide in Congress subsidies for big, powerful transportation organizations and so forth; and I say that our Government guarantees life, liberty, and the pursuit of happiness; so let's give some happiness to these aged people by providing entertainment programs that will boost them up and bolster them and make them feel better. And I say that one of the greatest things that can do that is the hula dancing and the island dancing and the island singing that we have from Hawaii and the other islands of the Pacific.

We have an example of what it does to a man right here. Here's Senator Long. We don't have to say his name, but a man stopped me

in Miami, Fla., last winter when he knew that I was from Hawaii, and he said, "How is it that that Senator Long from your State is so frisky and young appearing? He doesn't seem like a man of his age." And I said, "Well, he has the opportunity to observe these dancers and singers from Hawaii. That keeps him young and active."

You could provide—now, I'm serious about this—it wouldn't be much expenditure. I wish you could provide a Hawaiian group and other groups of the Pacific to go through our mainland cities and towns and go before all those citizens groups with this program that I'm speaking about, and you'll find the older will become younger, mentally as well as——

Senator LONG. Thank you for your comments.

Mrs. MAYES. You should join our senior citizens club and——

Senator LONG. I'm glad, Mr. Goodwin, that you said I "observed" rather than participated. I should participate.

We will have to quit, I think, after one more. May I repeat that anyone who wishes to submit a thought, an observation, or a recommendation in writing please do so.

Proceed.

STATEMENT OF MRS. C. BUFFET, HONOLULU, HAWAII

Mrs. BUFFET. My name is Mrs. C. Buffet and I have lived on this island for over 43 years; so I feel that I belong here.

Some of the things that I have heard here today have distressed me very greatly. I have a feeling that we older people are being pushed into Government—whether we like it or whether we don't.

I think that perhaps if the Government would make it possible for us to save some of the money that we earn in our lifetime instead of having it all taken away from us in taxes for things for which we are not prepared, we would be able to take care of ourselves in our old age.

I also have no desire to stick out my hand to Uncle Sam for Uncle Sam to support me in my old age—and I am ready to retire. I have worked practically all my life right here, as a housewife, and if anybody thinks that isn't a full-time job, I'll argue with them. But I think that we have to replan our lives as we go. Taxes and inflation are taking this away from us.

And I would like to state here for the record that I am a widow. My husband died 3 years ago. About 8 years before that, we started saving for the day when we would have taxes to pay, estate taxes to pay on the little income that would be left for me to live on, 8 years before his death. And at the time of his death, we did not have enough saved to pay those taxes. It took 3 whole years' income from his estate to pay the taxes that had to be paid on that small estate, which I have now as my income and which also helps to support a son who was a victim of infantile paralysis in childhood.

So that this is a field, I think, in which you people could do something. This amount of money which is taken in taxes from an estate, on a small estate, could well be used by that family to look after itself.

I have no social security. I have no pension. I expect to look after myself the rest of my days. I hope this. But the way I feel,

that we oldsters are being pushed, I'm not so sure I am going to be able to. But I still hope.

I realize that times and conditions are changing very fast. However, for those of us who have worked and saved all our lives, and invested our savings to take care of us in old age, the income from those savings, being our sole support, should not be taken away from us by taxes.

Future generations will have social security and pensions, but I cannot visualize older people, who have been independent, working citizens all their years, being a happy, healthful, and contented group on Government handouts.

Thank you very much.

Senator LONG. Thank you. When there was a break in the agenda of the day, I referred to it as a change and I stated that I didn't know whether all change is good, but I am certain change is always interesting.

We now come to another change, and we will go back to the regular agenda. And the first two whom I will call upon will be members of the commission on aging: Rev. Dr. Harry Komuro, who is chairman of the commission; and Mrs. Alexander Faye, executive secretary of the commission.

Will you come up to the witness chair?

STATEMENT OF REV. HARRY KOMURO, CHAIRMAN, COMMISSION ON AGING

Reverend KOMURO. Senator Long, Senator Morse, and distinguished members and friends in the audience; I am speaking as Chairman of your Governor's Interim Commission on Aging which was constituted, as reported, in 1959. I would like to make a statement in regard to our total concern of aging as a major social phenomenon of our total civilization, and which demands the attention of mankind. And in one way, the way in which any culture treats its elderly citizens is a reflection of the character of that society.

Your commission on aging is grateful for this hearing by the U.S. Special Committee on Aging, and particularly for having these hearings not only in Honolulu but also in the neighbor islands. The hearings will focus attention on all the concerns of aging, and will be of great assistance in one of the major goals of this commission, that of stimulating the interest of the citizenry of all ages in our State.

So much needs to be done in the area of preparing for retirement, both financially and psychologically. Unless youth as well as those in the middle years plan now to enjoy the retirement years, the impact of the sudden cessation of daily routine of work can be disastrous.

Our main task as a commission has been one primarily of public relations, actually of encouraging people to talk about aging and to look forward to the later years, which is not always an easy job; as a matter of fact, it's a rather difficult job.

Only as an agency, such as this commission, which concentrates solely on the problems of aging stimulates action by public and private groups will the communities be prepared for large numbers of older people. Constant effort must be made to see that activity centers and recreation resources are developed in all areas of the State. This commission is able to bring to the attention of all organizations the needs

of the older people. It is able, through its very existence, to be a common meeting ground where agencies can discuss their activities and plans, thereby avoiding overlapping and also pointing out gaps in services.

The period of discussion and study, it seems to us, is now leading into the area of action, action to be taken at all levels of government, private industry, and private organizations.

I want to say that as a commission we have been appreciative of the cooperating support of the various Government agencies in our State in working with the commission, and also to say that the life of the commission has been carried, not only by Government agencies, but by members of the commission who are a good cross-section of the general public.

As has been reported by certain members who have appeared as witnesses in this hearing, the commission has been active in the area of economic status, with housing, with health. We are now entering into the field of research. We are hopeful for the assistance of the university in development of the whole area of gerontology as a field of information that will be available for our whole State. We have still to constitute a more active program in the field of education and recreation as a commission.

The character of our population in Hawaii is unique and offers, out of its multicultural and multiracial backgrounds, a rich heritage of social concepts, its respect of elders, its family loyalty, its social solidarity now transplanted in the American scene. This may well be our contribution to the total philosophy of aging of our Nation. Hawaii affords a wonderful setting for experimentation and demonstration in living among the elderly.

The commission on aging, more than other single agency, has been responsible for the increased talking about retirement years now going on throughout the entire State. Through such an agency we are free to develop new approaches and explore new possibilities, and it is the hope of this commission that it will become a permanent commission in our coming legislature in order that it can continue to stimulate positive action in the field of aging by all persons and all concerned.

I made this preliminary statement on behalf of our commission on aging, and we will have supplemented remarks by Mrs. Faye, who is our very able and very competent executive secretary of our State commission on aging.

STATEMENT OF MRS. ALEXANDER FAYE, EXECUTIVE SECRETARY, HAWAII STATE COMMISSION ON AGING

Mrs. FAYE. The challenge in the next decade for the commission on aging is to change public opinion with regard to aging, from a negative to a positive concept of the later years as useful and rewarding ones, both to the individual and to the society in which he lives. The commission is succeeding if all of us present are looking forward to our old age. However, we can only look forward to retirement years as we can anticipate being needed and wanted by our community, as we anticipate using the resources offered by our town or city in our leisure hours, as we have no fear of a sudden or crippling illness, knowing of the health services available in our town.

To this end, the commission will stimulate and promote the development throughout the State of the following resources which do not now exist:

(1) Activity centers to assist in the adjustment to retirement years by counteracting loneliness and providing constructive use of leisure.

(2) Increased adult education courses for older persons, to include daytime classes particularly.

(3) Courses in curriculums of schools and colleges to provide training and education of professional personnel to learn total needs of aging and ways of meeting these needs, and to develop more skilled personnel to fill a tremendous lack in Hawaii.

(4) Independent counseling and information centers for older people in all counties to furnish help, advice, and referral to other resources for assistance in housing, health, and legal problems.

(5) Flexible retirement policies geared to the abilities of the individual. In this connection, I should like to offer for the record, a copy of the proceedings of the Institute on the Older Worker, cosponsored by the commission on aging and the University of Hawaii.

(6) Retraining programs combining the planning and resources of adult education, vocational rehabilitation, department of labor.

(7) Homemaker services and home care programs on all islands to enable persons to remain in their own homes.

The commission will also work toward apropriation of adequate State funds to take advantage of the Kerr-Mills bill in which Hawaii is not yet participating fully. It will also work toward a review of a means test to provide a more realistic basis.

The commission recommends that all public buildings and public housing design their facilities to make it easy for older people, the rehabilitated, and the handicapped to enjoy them, and for those in housing projects to live in comfort. Further, that the public housing authority review the ruling in regard to eligibility for public housing which denies admission to one whose income is derived from his own investments, even though this income may be far less than the minimum income requirement. If one's income is from a pension, there is no restriction; if one has made his own investments, it seems he is not eligible.

Perhaps those over 65 cannot now readily change fixed patterns of their lives to enjoy the facilities we hope to develop for senior citizens, but they can be encouraged to do so, with the hope that each day might be more meaningful. Certainly, those of us who anticipate living for many years after retirement must work now to make sure that those resources we want will be in existence when we need them and that through constant public education, the older person will be given the role in his community to which he is entitled.

May I extend the grateful thanks of the commission and its staff for conducting these hearings in Hawaii. This is a tremendous boost to the entire program of aging.

Mr. Chairman, may I say that the education group had to leave and have filed their statements with the committee.

Senator LONG. Thank you.

(The prepared statements of Frank Drees, director of adult education, and Miss Marion King follow:)

PREPARED STATEMENT OF FRANK DREES

In the 1945 session of the territorial legislature, public education in Hawaii was given a new field to cover, adult education. Change was beginning to affect a centuries-old belief that public schools had a responsibility only for the mental development of children.

Although there is always some social lag in the acceptance of change, education has been especially slow in reacting to the pressures of a shrinking world, which is facing innumerable problems of population explosions, political antagonisms, economic adjustments to automation, etc.

Rate of accumulation of new knowledge has meant that persons leaving school 5, 10, 20 years ago are facing severe employment problems in trying to keep pace with the technological advances in all fields (manufacturing, communication, defense, research, and the sciences).

Because of these advances, men who normally would continue doing the same jobs until they were 70, are finding that employment security disappears and retirement is being forced upon them earlier at 60, or 50, or even 40. From this complexity of change has come the necessity for people to recognize that no education is terminal, but needs to be continually pursued through adult life, in one or more lines of study as a means of just keeping abreast of the times. Vocational adjustments call for learning new skills, understandings, and theories; social and political problems call for rethinking and replanning family and community life; employment problems force many to revise retirement plans and too often without study or preparation to meet new conditions.

The community, the State, and the Nation have become acutely aware in the past 10 years that too many retired persons are caught in a precarious dilemma of having too little of personal assets to stretch out an existence over too long a span of years.

Could it have been otherwise? Could education have helped in planning for this period of life? Would different approaches through planned programs have resulted in a happier, healthier retirement period? We can't say, because we haven't tried yet to solve the problem. But one thing we do know. Many of the diseases of aging have been conquered. Man's lifespan is lengthening. Cancer is about to fall victim to medical research, and the retirement years may in the very near future stretch out to 40, 50, or 60 years beyond the end of employment. How will they be spent?

This is society's challenge to provide for readjustment for those who survive the employment period. Education for adults enters into fields of health, housing, income maintenance, and community and family relationship. Education about aging, education for retirement, education by the retired of younger members of society are imperatives we will have to add to our public education programs.

In Hawaii, little has been done to date in this field. Courses now offered by the adult education program are offered to all adults including tuition free courses in citizenship training and basic English language development, but the specific courses organized for retired people have not been accepted. Probably because they have been tuition courses and, as a rule, most retired people are on a minimum income basis. During the past 5 years, a number of attempts have been made to interest an older age group in studying retirement problems, but we have had few registrations. No State funds have been earmarked to subsidize these projects. The pressures created by an expanding need for day schools (elementary and secondary) have left little chance to secure more appropriated money for public education for adults. There are the uninformed both in the community, the school board, and the legislature who feel that adult education is not a program which needs governmental support. "Let adults pay for their own courses," they say, scarcely recognizing that it is the adult who pays all the school bills, at all levels.

The taxpayer can have as much or as little as he wants to pay for in the field of education and, as yet, he is not aware of his own needs, in preparing for retirement.

Education is primarily a local responsibility, and most school districts are local except Hawaii. Hawaii with a State constitution keeping State control of public education, county control of buildings, legislative control of all money for education leaves much to be desired in trying to enter new fields either by experimentation or research. Not until a real crisis occurs will there be a change in State support.

It's a problem the citizen and the public must solve. Such hearings as the one currently being held help to stimulate public discussion and study of this

field. It is fervently hoped the Federal Government will continue its support in research and study.

LIBRARY SERVICE TO THE AGING IN HAWAII

Public library service is available to older persons in Hawaii on all of the principal islands. State-supported systems serve each county through main buildings, branches, deposit stations, and bookmobiles. The combined book collections of these libraries total about 550,000 volumes. In addition they supply over 600 different newspapers and magazines, about 800 films, and over 10,000 phonograph records. On Oahu the bookmobile regularly serves Punchbowl Homes, which supplies housing for senior citizens of limited income.

The Library of Hawaii is a depository of the Library of Congress for talking books and braille and, as such, makes these available free of charge to all readers in the State who qualify for their use. A talking book readers club, composed of persons who use these talking books (mostly older people) meets bimonthly in Honolulu.

The public library is especially useful to the older person because it is the one institution which serves all persons in the community on an *individual* basis. It provides continuing education for anyone who seeks it. It also acts as a subject resource center for the community on aging and its problems both to those who fall in this age group and those who work with them or are engaged in research on it. In addition, it supplies a high type of recreation for the older person, stimulating his imagination and broadening his horizons, whether it be through a historical novel, a book of travel or one which leads him to a new hobby, or his attendance at our weekly educational programs.

TECHNICAL SCHOOLS

Since 1925 Hawaii has participated in the federally supported vocational education programs by providing preemployment training to young adults and part-time in-service training for older adult workers.

Although no specific classes have been organized to date for the retraining of older displaced workers, the vocational program in Hawaii's public schools are well equipped to institute such a retraining program should this become necessary.

PREPARED STATEMENT OF MARION E. KING, MEMBER AND REPRESENTATIVE, STATE ADVISORY COUNCIL FOR ADULT EDUCATION

The advisory council for adult education is a legally constituted group appointed by the board of education to make recommendations and advise the board on matters pertaining to adult education in Hawaii. The council informs itself of changing needs for adult education, local trends in the education of adults, and advises the board on these matters as well as those pertaining to legislation, budget, financial support, and other means necessary to accomplish the adult education program in the department of education. Twenty-six men and women make up the council representing industry, labor, civic, and education fields.

The council is understanding of the points brought out in the report of the director of adult education service, Frank J. Dress, and recognizes that adults must continue to learn because of the accelerating pace of social change and the need of all citizens to adapt to new methods and new patterns.

The council recognizes, too, that elderly persons—as well as younger adults—need a knowledge of the newest developments in medicine, hygiene, and nutrition to maintain maximum physical, mental, and social health; they need economic and consumer education, training in citizenship responsibilities and the worthy use of their leisure.

The council also realizes the importance of putting our program in shape to deal effectively with the needs now and in the future in order that our adult education program can take its proper place in the overall planning for the aging in our State. We know, too, that we must face and solve problems in several categories before we can fully realize our goal of providing adequate adult education services for the aging. Among these considerations are the following:

Development of a plan that takes into account our scattered-island-type of State community—urban as well as rural.

The lack of trained staff for the development of special programs.

The dearth in our State of leaders and instructors skilled in the problems of the aging.

The provision of space (such as community centers) in addition to school buildings where program can be carried on.

The understanding and support of all segments of our State—citizens and governmental agencies responsible for the provision of the finances to accomplish the broadened concept of education for a lifetime.

The thinking of the council is in line with what is generally accepted by educators who have made careful and thorough studies of the problems, that there is a real need in our communities today to continue education throughout our lives. As a council we are committed to an all-out effort to bring this goal into being in our State of Hawaii.

Senator LONG. Now, we have, so far, 17 out of a total of 19 representing different government offices or agencies. It seems to me as though it would be, perhaps, equitable and fair to move on to these few organizations and individuals at the end of the list, because obviously we are not going to be able to get through entirely. The papers that are presented in part will, of course, be published in full; and we wish to express appreciation for all of them.

But we will now proceed with the private agencies working on this and hope that the statements will be brief enough that we can also call on those who represent the retirement system. But I am going to depart at this time and under "organizations and individuals" call upon Dr. Masato Hasegawa.

Mrs. FAYE. Mr. Chairman, I am sorry, but Dr. Hasegawa had to leave also, and I have his statement.

Mr. JOHN C. PIXLEY. As director of the Council of Social Agencies, Senator Long, thank you for the opportunity.

Senator LONG. We will go to Dr. Ah Nee Leong, National Association of Social Workers.

STATEMENT OF AH NEE LEONG, NATIONAL ASSOCIATION OF SOCIAL WORKERS

Mr. LEONG. Senator Long and members of the committee, I would like a correction, Senator Long. I am Mister—not Doctor. I am representing the Hawaii Chapter of the National Association of Social Workers.

Senator LONG. Thank you.

Mr. LEONG. I am appearing here today, sir, as a member of our Public Affairs Committee of the Hawaii Chapter of the National Association of Social Workers, to make a brief statement with regard to the local chapter's endorsement and support of our national organization's stand on certain legislative objectives, and I would like to mention that they are as follows:

First, that we support the national organization's concern that Federal medical care be tied in with the Social Security Act; and also that we support the amendments, which will be considered when Congress reconvenes in January, concerning the amendments to the Social Security Act regarding health care benefits for survivors and the disabled.

We wish to thank you and the committee for allowing us to appear today, and I would like to beg permission to leave a copy of our national association pamphlet on "Goals of Public Social Policy."* from which some of our objectives have been gleaned—and also to mention, Senator Long, that we would like to respectfully refer to

*Pamphlet entitled "Goals of Public Social Policy" adapted by delegate assembly, May 1958 published by National Association of Social Workers, 95 Madison Avenue, New York, N.Y., is in the files of the committee.

you our national director in Washington, Mr. Rudolph Dandstedt, as a resource person.

We in Hawaii certainly stand ready to support the committee and to pledge the support of all social workers in the State.

Thank you very much, Senator Long.

Senator LONG. Thank you, Mr. Leong, very much.

Senator LONG. I understand that Dr. Hasegawa has returned. Doctor, we would be pleased to have you at this time.

STATEMENT OF DR. MASATO HASEGAWA, PRESIDENT, COUNCIL OF SOCIAL AGENCIES

Dr. HASEGAWA. Mr. Chairman, I want to apologize for being absent for a while. I am a baby doctor, but today I am here as a representative—I am also president—of the Honolulu Council of Social Agencies and I am representing them here today.

We are one of the country's 500 citizens community planning organizations, all of which try to balance the available funds with almost unlimited health, welfare, and recreation needs. While I am here to make a speech about our concern for the aging, the organization I represent is, itself, concerned with the total health, welfare, and recreation situation.

As an organization, we have taken the position that there should be an advisory committee in the State of Hawaii and, along with the Oahu Health Council, have recommended to the Governor that there should be an advisory committee of citizens whose primary purpose should be to study the problems of the aging, the available funds, and make representations, when necessary, to obtain the most needed services.

We have not taken a position on any single health, welfare, or recreation need of the aging, nor legislation affecting any need. Therefore, I limit my remarks to recommendations that have to do with advisory groups that will help executive branches at various levels of government or voluntary organizations to determine what problems of the aged should receive highest priority in financing.

We believe the establishment of priorities is essential and must be done by an objective nondepartmental body of citizens and experts who are free to make recommendations to mayors, chairmen, or county boards of supervisors, Governors, and to the President of the United States—or to any organization that they consider needs their suggestions.

We do not believe such organizations can be adequately directed if the advisory committee becomes a service unit of any governmental department.

The need for such a commission or commissions is evident when you look at the total recommendations that have come out of State and Federal conferences on the problems of the aging. It is obvious that there would not be enough money to put all these recommendations into effect, even though we might assume that each proposal is desirable.

We have recently completed an expenditure study on the city and county of Honolulu—hence, the island of Oahu, and have found that from tax sources alone, we spent over $35 million for health, welfare,

and leisure time services in 1960, and this did not include public housing.

I am not saying that this money should not be spent, but I do believe that there must be organizations, such as the Honolulu Council of Social Agencies and the State commission on aging, who stand free to make recommendations to whatever organization is proper so that the most important services are provided first in the best way possible.

Following this point of view, we believe that there should be in Hawaii and in every other State and in the Federal Government a committee or commission of persons, without political commitments, to study the need and services for the aging and make up recommendations they believe are essential to whichever unit of government or voluntary organizations they choose.

Senator LONG. Thank you, Dr. Hasegawa.

At this time, the representative of the Honolulu Chamber of Commerce, Mr. John L. Collis. Is he here?

We will now have the pleasure of listening to Mr. Fred Bennion, director, Tax Foundation of Hawaii.

STATEMENT OF FRED W. BENNION, DIRECTOR, TAX FOUNDATION OF HAWAII

Mr. BENNION. Five-minute limit necessitates rapid, broad generalizations or a quick highlight of one facet of one area.

I choose to discuss under "income maintenance" one prospect for improving the income of persons over 65 years of age by governmental action on the State level and call attention to the need for congressional action.

Hawaii's State personal income tax is patterned after the Federal law with rates ranging from 3 percent on the first $500 of net taxable income to 9 percent on incomes over $30,000. Taxpayers over 65 years of age, who file income tax returns, are granted a double personal exemption of $1,200, the same as under Federal law.

From data compiled on 1959 incomes filed in 1960 for State tax purposes, we know that approximately 8,000 of Hawaii's 65 years or older population filed Hawaii income tax returns. The tax yield from this tax, imposed on this age group, was $1 million. It is estimated that the Federal Government receives about $5,800,000 in income taxes from this same group.

We have prepared a table which is attached to this statement showing that if double exemptions were increased from $1,200 to $3,000, there would be a State tax savings of a quarter million dollars to taxpayers in Hawaii over 65 years of age.

If this $3,000 exemption was granted under the Federal law, the tax savings would be over $1 million.

This amount of $1¼ million is substantial. It is slightly less than the total amount paid annually through Hawaii's State and county liberal retirement system to retired State and county workers.

Now, this tax relief would have an impact upon about 5,500 persons in Hawaii or about one in every five of the total aged in this State. It would not help all who need help, but no single action is likely to benefit all who are most in need.

But this example of how Government can help bring up the point that Hawaii is unique among the States. We still, as a community,

have a great sense of family responsibility. Undoubtedly, this is due to our cultural heritage built upon the Eastern philosophy. For example, 55 percent of those 65 years or over are of Japanese ancestry, but only 19 percent of the old-age assistance recipients are of Japanese ancestry.

We only have 1,400 old age assistance recipients in Hawaii, and 20 percent are living with relatives. Applying this percentage to the total aged population in Hawaii, we estimated that there are over 6,000 persons not receiving old age assistance who are living with relatives.

It seems to me that this type of family responsibility needs to be encouraged by government at both Federal and State levels. Anything that government does to break down family responsibility should be avoided. This encouragement could take the form of extending the double personal exemption, so that taxpayers who support dependent persons 65 years of age or older are permitted to apply the double exemption for such dependents. It could also take the form of extending the medical expense deductions incurred by taxpayers for aged dependents.

My final point is that more and more of us, and more frequently, are looking to Government for the solution to more and more problems. When Government moves to aid, be it nations or individuals, it must take from all of us more and more in taxes. This is inevitable, but not necessarily the best course of action.

I do not pretend to know the limits we can reach in taxing our people, but history tells us that there are limits. Many of us in Hawaii are concerned about the heavy burden placed upon the resources of the State to pay our tax bill.

Last year, total tax collections within the State amounted to $414 million. Three-fifths of this burden is Federal. Tax collections were equal to a payment of $3,000 per family or $686 for each man, woman, and child. Total tax collections were greater than the value of sugar and pineapple production and tourist expenditures combined. These are our three greatest industries.

This reference to the high tax burden might be construed as irrelevant to income maintenance of our elder population. But, I believe it is relevant. Taxes have become one of the highest costs of living as well as a cost of business.

If we can reduce our tax burden, we will be benefiting not only our young and middle age population, who will one day be 65, by providing them with additional income to save or invest, thereby adding to the total economic growth, but, we will also be providing an immediate and substantial benefit to our older citizens.

If the cost of the Federal Government is not reduced, and if we continue to operate each year with deficits, Government is contributing to inflation. Inflation can be the cruelest tax of all upon those with fixed incomes which most often includes our elder citizens.

Why should the Federal and State Governments take nearly $7 million in income taxes from persons in Hawaii who are 65 years or older and at the same time endeavor to legislate plans which would help these people? Before committing ourselves to costly Federal-State aid programs we should do all we can to permit these people to retain their earnings.

(The table earlier referred to follows:)

Estimated income taxes on taxpayers 65 years of age and over.—Changes in State personal income tax receipts if exemptions increased from $1,200 to $3,000

Adjusted gross income class	Single returns				Joint returns				All returns, total tax difference
	Number	Total tax if exemption is—		Difference	Number	Total tax if exemption is—		Difference	
		$1,200	$3,000			$2,400	$6,000		
Returns with losses	25				28				
Under $400	142				163				
$400 to $999	920				287				
$1,000 to $1,999	538	$694		$694	784				$694
$2,000 to $2,999	128	4,160		4,160	190				4,160
$3,000 to $3,999	152	10,242	$328	9,913	164	$2,996		$2,996	12,910
$4,000 to $4,999					195	9,666		9,666	9,666
$5,000 to $5,999	240	36,252	15,202	21,050	273	21,895		21,895	42,945
$6,000 to $7,999	46	9,586	5,446	4,140	97	12,470		12,470	16,610
$8,000 to $9,999	70	25,827	18,267	7,560	149	31,148	$8,022	23,126	30,686
$10,000 to $14,999	62	28,139	21,443	6,696	168	56,624	26,384	30,240	36,936
$15,000 to $19,999	40	31,910	26,870	5,040	55	32,359	21,145	11,214	16,254
$20,000 to $24,999	27	29,747	26,345	3,402	53	45,953	34,505	11,448	14,850
$25,000 to $29,999									
$30,000 to $49,999	33	67,996	63,105	4,891	41	72,842	62,510	10,332	15,223
$50,000 to $99,999	21	80,165	76,763	3,402	25	87,779	80,579	7,200	10,602
$100,000 to $149,999	4	34,764	34,116	648	8	61,359	58,767	2,592	3,240
$150,000 and over	4	78,712	78,064	648	6	111,894	109,950	1,944	2,592
All resident returns	2,452	438,195	365,950	72,245	2,686	546,986	401,862	145,124	217,369
Nonresident returns	89	2,699		2,699	76	2,068		2,068	4,757
Total all returns	2,541	440,894	365,950	74,944	2,762	549,054	401,862	147,192	222,136

NOTE.—From the statistical data compiled on returns on 1959 incomes filed in 1960, the number of exemptions claimed by taxpayers 65 years of age and over is available, by adjusted gross income classes. Total number of exemptions claimed amounted to 2,541 in single returns and 5,516 in joint returns. For computation of the effect of increasing such exemptions from $1,200 to $3,000, the average gross income and average deductions for each adjusted gross income class of all single and all joint returns have been utilized. To compute the effect of the proposed change on joint returns of those 65 years and older, 50 percent of exemptions claimed on joint returns were utilized as the number of joint returns filed by such taxpayers.

Source: Computed by the Tax Foundation of Hawaii from data compiled by the Department of Taxation, State of Hawaii.

Senator LONG. We have one more speaker in this group, and I am very happy to call on Mr. Carl Guntert who represents the National Association of Machinists, District 151.

STATEMENT OF CARL J. GUNTERT, SENIOR BUSINESS REPRESENTATIVE OF THE INTERNATIONAL ASSOCIATION OF MACHINISTS, DISTRICT 151, AFL–CIO

Mr. GUNTERT. Honorable members of the U.S. Senate Special Committee on Aging: Mr. Chairman, my name is Carl J. Guntert. I am the senior business representative of the International Association of Machinists, District 151, AFL–CIO, in Hawaii. There are some 2,500 to 3,000 members in 4 local lodges of this union in this State.

They work for the Federal Government under civil service in the Army, Navy, and Air Force installations here; they keep the early warning aircraft that patrol the barrier between here and the Arctic in repair and constant service; they service the airlines and keep their aircraft safe for you to travel on; they build and repair the sugar mill machinery that refine our sugar; they repair the ships that call at this port; they fabricate and build all kinds of metal and plastic parts, machinery, and devices; they operate, maintain, and repair all kinds of light and heavy equipment, auto trucks, and tractors; they operate missiles tracking stations; repair and rebuild office machines; they belong to clubs and churches; they send their children to public and private schools; they represent nearly all races, colors, and creeds; they are good industrious solid citizens of our great country; they have helped fight its wars, have suffered its depressions, and enjoyed its prosperous times.

They are no different than the rest of the 180 million citizens of the United States of America. Like all of us, each and every one of them will grow old and eventually die—we hope all of old age, and not because in their declining years there were no honorable means of curing the ills that will surely beset all of them.

I say "honorable means" because our members are all prideful people just like the great majority of Americans. Our members do not want to be a burden upon their children or depend upon public charity in their old age.

They want to take care of themselves; they know that the best way to do that is by laying aside a small part of their wages during their working years while they are young, healthy, and strong to take care of their old age and illnesses that most of us face when we are laid off at 65 if not before.

Social security, through payroll deduction, while it is not enough and should be increased, has freed millions of our older American citizens from the dread of spending their declining years in the county poorhouse or as a burden on their children. In fact, it has eliminated many of the county poorhouses which before social security were crowded with older people who had exhausted their lifetime savings, if they had been able to accumulate any, on doctor and hospital bills and pills. Social security was a great step forward toward a better life for the people of America.

Now we have the opportunity to take another great step forward in providing a better way of life for millions of our fellow American citizens. Oh, some will scream that it is socialized medicine, but it is not. There is nothing wrong or socialistic with a person setting aside a small part of his earnings during his productive working years to insure his medical care when he can no longer work. Most commercial and even the so-called nonprofit health and welfare medical group insurance plans are canceled when a person reaches retirement age and if not canceled their benefits are reduced to the bare minimum and the premiums are substantially increased. Just when the person needs it the most he finds that he no longer has it.

There will be some who will try to convince you that the workers will not be paying for their health care under social security, that it will be a burden upon industry. The truth is, if industry does contribute toward the cost it will become a part of the fringe benefits and any thinking person should recognize that all fringe benefits are a part of the wages earned by the employee. In many cases, the less the fringe benefits the higher the cash wage rate; fringe benefits are always counted in the wage-cost package. Therefore, the worker in the end is paying for the fringe benefit received.

There are close to 30,000 people over 65 in Hawaii today and by 1970 it is estimated there will be 49,000 over 65 years of age. For many of them their social security benefits will be their entire source of income to live their aging years on; other will have small pensions and/or savings to supplement their social security income. Few will have enough to pay doctor and hospital bills and maintain a minimum standard of living. Medical care for the aging under social security is the only practical American answer to the problem.

There are many other major problems that face the aging, such as adequate income, housing at reasonable rents and/or payments, recreation facilities, and others that I will not attempt to go into at this time.

We strongly urge this committee to recommend to the U.S. Senate and support the inclusion of an adequate health care program for the aged under social security.

In closing I wish to call this committee's attention to the testimony of the International Association of Machinists president, Mr. A. J. Hayes, and Dr. William A. Sawyer, IAM medical consultant, earlier this year before the House Ways and Means Committee on the subject of health care for the aged under social security. Their statements express the sentiments of our members on this subject far better than I can. For your convenience I have copies of the Machinist August 10 issue which contain excerpts from their testimony.

I wish at this time to thank this Senate committee for the privilege of appearing before it today on behalf of the International Association of Machinists District 151 and its members.

Senator MORSE. Mr. Chairman, I ask unanimous consent that the excerpts from Mr. Hayes' testimony and Dr. Sawyer's testimony be inserted into the record as part of Mr. Guntert's testimony.

Senator LONG. Without objection, it is so ordered.

(The excerpts referred to follow:)

[From the Machinist, Aug. 10, 1961]

WITNESSES FOR HEALTH CARE FOR AGED UNDER SOCIAL SECURITY

Health care for the aged under social security and railroad retirement has long been a goal of the IAM. Last week IAM President Al Hayes and Dr. William A. Sawyer, IAM medical consultant, personally presented the union's views to Congress. Here are excerpts from their testimony before the House Ways and Means Committee:

(By Al Hayes[1])

The problems with which this committee is dealing—the problem of providing a system of adequate medical care for the aged—is one that seriously affects the welfare of the working people of America. It concerns not only the aged and the retired, but their children—and their children's children.

For, when aged parents or grandparents cannot finance care for the inevitable infirmities that come with their later years, the burden falls heavily on their children. When this happens, family funds that should properly be used for the nourishment, education, clothing, housing, and medical care of the young must too often be drained away to provide medical care for the old.

Our population is aging. The aging have a higher incidence of illness than the rest of the population. The aging have low incomes and few savings. And private insurance is inadequate to meet the great social problems involved.

Although the insurance industry has been moved by the controversy over health care for the aged to design special policies for older people, it is obvious that private insurance, by its very nature, will always be inadequate to meet the health care needs of people over 65 years of age.

This is true, because as we have seen, the aged are a high-risk group—so far as illness and accidents are concerned. In the insurance business, a high risk must necessarily carry a high premium. And yet, as we have also seen, most of the aged, on their reduced incomes, cannot even afford normal premiums. No amount of finagling, or working out of special policies by the industry, can overcome these economic realities.

The result is that existing private insurance plans, even those that the industry has tried to tailor to meet the needs of the elderly, are clearly inadequate. The answer is a program of insurance that spreads the cost of high-risk, old-age health insurance over the entire working life of the insured. And that is what H.R. 4222 will do.

These facts, and the statistics that support them, have been placed on the record many times. No matter how you arrange them or add them up, they still come to the same answer. It is an answer that has been accepted by practically every other civilized and industrialized nation in the world.

Not only have such relatively advanced nations as England, France, West Germany, Switzerland, Scandinavia, and Italy brought medical care within the reach of workers through sound principles of social insurance, but even countries whose wealth and resources are far below ours—countries such as Bolivia, Brazil, Burma, Chile, Greece, India, Japan, Portugal, and Venezuela (to name but a few)—have gone much further than we have to remove the financial risks of sickness and accidents through such principles.

We are, in fact, the only major industrial nation in the world that does not do so. In that H.R. 4222 would provide hospital and related services to one significant—and growing—sector of our population, it would, let me repeat, be a step in the right direction.

I want to assure the committee that, despite the propaganda smokescreens that are being laid down by the American Medical Association and the insurance lobby, the American people are with Congress on this issue. Even though doctors are not affected by H.R. 4222, the AMA opposes it on the ground that it is the first step toward what they call socialized medicine. Of course, as someone has said, the AMA seems to define socialized medicine as "a dangerous trend toward health."

[1] IAM President Al Hayes was a member of President Truman's Commission on the Health Needs of the Nation. Mr. Hayes is cochairman with John I. Snyder, Jr., U.S. Industries, Inc., of the Foundation on Employee Health, Medical Care, and Welfare, a joint enterprise.

However, I think H.R. 4222 is more a step toward good sense than toward socialism. It is only good sense to let American workers pay now for the medical care they will need later.

It is only good sense to make it possible for them to stop worrying about how they are going to carry the backbreaking costs of hospitalization for their parents or grandparents. And because it does make such good sense, this issue was very much on the minds of the more than 1,200 delegates that attended the IAM convention in St. Louis last September.

Our convention unanimously approved a resolution supporting the principle of health care for the aged under social security. In testifying this morning, I am, of course, carrying out the desires of our membership—as formally expressed in that resolution. However, on this issue I know that I am expressing more than the sense of a mere formal resolution. I am expressing a heartfelt desire of an overwhelming majority of the members of the Machinists' Union, and of the American labor movement, to see the humane principle of medical care for the aged under social security established in our country.

(By Dr. Sawyer[2])

As I have grown older, I have become acutely conscious of the great need for timely, good quality medical care for older people. I am repeatedly amazed at the many tragic instances of inadequate medical care amongst our industrial workers and their families, especially in the retirement and near-retirement years. And from my experience I know that the reason that so many older folks do not receive the medical care they need is too often because they do not have the money to pay for it.

The barrier of rising medical care costs confronting many workers is of such proportions as to keep many of them from going to the doctor soon enough.

We have no statistics, and the medical profession has little knowledge, of the people who stay away from them. But we do know they exist in large and growing numbers. Too often we learn of these people only when it is too late—when early symptoms have progressed to the critical or incurable stage. We do not see them until it is too late because their means are too little—and their pride is too great.

No one denies that we are going to have an increasing number of older people with medical problems. In fact, advances in medical science have added years to our lives. But these added years will mean little unless they are years of good health and fruitful activity. Without good health our aging population can only be a national liability, placing an unbearable strain on the taxpayers, as their numbers grow greater and their illnesses more serious.

I need not review here the attitude of the American Medical Association. Their opposition is well known to all. In part, this opposition is born of a desire to be sure that anything new in treatment is safe before it is approved. This is good. But much of it springs from less noble motives—from an unadmitted, but nevertheless real fear that a social security approach will endanger the advantageous economic position that doctors now enjoy.

I do not want to be unduly critical of the hierarchy set up in Chicago by the House of Delegates because I do not want to be disloyal to what is good. Actually, I am proud of the medical profession. I am proud of the efforts some within the profession have made to bring better medical care for those in the older age group.

However, I am not proud of the obstructionist tactics that a small bureaucracy within the organization have used against those who are objectively trying to find answers to pressing social and medical problems. We are in a rapidly changing social order and need objectivity and mature judgment if we are to move forward in a constructive way.

It has been said by some AMA spokesmen—especially in their publicity—that adoption of the King-Anderson bill would result in a deterioration of the quality of medical service available. Is it possible that doctors have become so callous to the needs of elderly human beings that they would treat them less well because provision had been made for their care under social security? I don't believe it.

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[2] Dr. William A. Sawyer is the IAM's medical consultant. For 30 years he was medical director of the Eastman Kodak Co., Rochester, N.Y. Dr. Sawyer writes the Machinist's weekly column "Live a Little Longer."

From my observation, a doctor's method and degree of treatment is never determined by the way the patient pays for it. Why should a doctor treat a man who pays out of his own pocket differently than one who pays by means of commercial insurance, Blue Cross, Blue Shield, or social insurance?

The suggestion that doctors would not give as good care to social insurance beneficiaries as to those with private means is a sad reflection—not on the medical profession, but on those who purport to speak for it.

The AMA also makes the claim that with the enactment of the King-Anderson bill, the traditional doctor-patient relationship will be lost.

The method of remunerating doctors has nothing to do with the doctor-patient relationship. If a practitioner is interested in his patient, the quality of care he gives cannot possibly be affected by how he is paid.

Under the program being considered here today—the King-Anderson bill—there would be no interference with the rights of a beneficiary to select his own doctor or of the doctor to treat his patient as he deemed best.

In conclusion, may I re-emphasize that from my contacts with Machinists (through the letters they write), I am convinced that we are confronted with an urgent social problem, and we must do something about it.

Whether the legislation we are discussing today will prove acceptable to Congress we do not know, but for the benefit of the members of the International Association of Machinists, we certainly hope so.

Senator LONG. That brings us down to the last item that we passed over. It is now exactly 5 o'clock, the time we had hoped to be through, but I think we all wish to stay a few minutes longer and have the question of retirement presented to us.

I will call on Harold E. Hill, who will discuss the State retirement system; and, following him, Mr. John DeMello.

Mr. Hill?

STATEMENT OF HAROLD C. HILL, SECRETARY, EMPLOYEES RETIREMENT SYSTEM, STATE OF HAWAII

Mr. HILL. Senator Long, distinguished guests, ladies and gentle men, I believe that a brief statement concerning the employees retirement system of the State of Hawaii may be germane to the deliberations of your committee due to its economic impact upon a substantial portion of the aging population of the State of Hawaii. I have prepared such a presentation and presented it to your secretary for incorporation in your deliberations; and in consideration of your kindness in calling upon me at this late hour, I will merely make a brief extemporaneous statement.

The employees retirement system incorporates in its membership all of the employees of the State and all of its political subdivisions. These members total some 25,300 persons. We have affiliation with the social security plan so that all but 4,000 of our members have coverage by the system and social security, as well.

Our basic benefit for retirement at age 60 is one-seventieth of your final pay for each year of service, and the legislature in the 1961 session increased that benefit to one-sixtieth for persons retiring at age 65. Now, one-seventieth would mean that a person with 35 years of service would retire at 60 or over with a 50-percent pension. And one-sixtieth would mean that it would be 50 percent after only 30 years of service.

For the average worker, or the worker, say, of the $4,200 per year income or $350 a month, this would yield him $175 plus his social security of about $116, which would make a total benefit of about $283 or about 81 percent of his pay at the time he retired.

This is a very good picture, and we think that it is in keeping with the better retirement systems of the States of the Union.

We also have provision for the shrinkage in retirement income due to cost of living after retirement. Our legislature has for many years provided for a pensioners bonus which is paid to all pensioners having 10 or more years of service. This has been supplemented by the last legislature by postretirement benefit consisting of an increase each year after retirement of 1½ percent of the retirement allowance. This is cumulative, meaning that the allowance has increased 1½ percent the first year, 3 percent the second year, 4½ percent the third, and so on. That may not be exactly what the increase of the cost-of-living index shows, but at least it is a step in that direction; and I believe that Hawaii is in the forefront among the States in making such a provision.

As I say, this matter is covered in the written memorandum. I don't wish to take any more of your time. Thank you very much for your patience.

(The statement referred to follows:)

PREPARED STATEMENT OF HAROLD C. HILL, SECRETARY, EMPLOYEES' RETIREMENT SYSTEM, STATE OF HAWAII

Senator Long, distinguished guests, ladies and gentlemen, the membership of the Employees Retirement System of the State of Hawaii is comprised of all the appointive officials and employees of the State of Hawaii and its political subdivisions and such elective officials as may choose to belong. The membership at this time numbers 25,314.

The system was begun on January 1, 1926, for State employees and on January 1, 1928, was extended to include county employees. At this time, membership was optional with the employee and there were about 6,000 members; however, in 1934, membership became mandatory and since that time acceptance of employment with the State or local government is conditioned upon acceptance of membership in the retirement system.

Under authority of Act 284, session laws of Hawaii 1957, the Territory entered into an agreement with the U.S. Department of Health, Education, and Welfare, by which all system members on July 1, 1957, were afforded the opportunity to obtain social security coverage at their option and all new employees after that date were required to accept such coverage in addition to our system membership. As of today, less than 4,000 of our members do not have social security coverage.

The purpose of the system is to provide old-age security for career employees and financial assistance for those who may suffer the misfortune of disability during the working years and to provide a measure of support for the survivors of those who die while in service.

Retirement benefits depend upon length of service and are proportioned to the earnings of the member during his highest paid 5 years of employment. This is a joint contributory system, meaning that both the member and his employing government contribute to the system, thereby funding the ultimate cost of retirement benefits during the employee's working years. The benefit consists of a pension payable from the employer's contributions and an annuity purchased by the employee's accumulated contributions with interest at 4 percent compounded annually. The law contemplates a benefit at age 60 of one-seventieth of average final compensation for each year of service.

Thus, a career employee having 35 years of service should receive a retirement benefit of thirty-five seventieths or one-half of average final compensation. Act 175, session laws of 1961, increased the basic benefit from one-seventieth to one-sixtieth for persons retiring at age 65 or older. This change in formula increases the basic benefit by 16⅔ percent and would provide retirement at half pay after 30 years of service. However, under either formula, the benefit is proportioned to the years of service. Those members who accepted social security coverage will receive the total OASI old-age benefit in addition to the foregoing system benefits except that at age 65 there is an offset based upon the amount and years of coverage under social security since January 1, 1956; the maximum of such offset being $15 per year or $1.25 per month for each year of service since that

date. These rather involved statements may be clarified by the following example:

> An employee retires on December 31, 1961, after 30 years of service at the age of 65 and with an average final compensation of $350 per month, or $4,200 per year. His retirement allowance would be thirty-sixtieths (one-half) of $350, or $175 per month, less social security offset of $7.50 ($1.25 per month multiplied by the 6 years from January 1, 1956, to December 31, 1961) making a net allowance of $167 from the retirement system. He would also be entitled to a social security benefit of about $116 per month, making a total retirement pay of $283.50. This is 81 percent of his average final compensation and is probably as much as his take-home pay prior to retirement. If this individual also has a wife of approximately his age, who does not have a social security benefit in her own right, he will receive an additional social security benefit of approximately $58.

This glowing picture is not distorted and applies to a great majority of the employees within the average salary range and it is our experience that retirants with 30 or more years of service find little cause for complaint. However, our difficulties arise in two areas. The first is that a great majority of retirants have lesser periods of service and therefore receive an inadequate retirement benefit to support them in the manner to which they are accustomed. The second occurs after a period of years when the retirement allowance of the individual loses its purchasing value through increase in cost of living. There is little that can be done to increase the benefit of the individual who retires after a comparatively short period of service. The concept of a retirement plan is based upon a benefit measured by service rendered and cannot be the ultimate solution of individual economic problems under all circumstances.

However, recognition has been given to the second point of maintaining the purchasing power of the retirant's dollar after retirement, in two ways. First, the legislature has seen fit to grant pensioners' bonuses which still apply to all persons not having social security coverage and second, the 1961 legislature established the postretirement benefit, which provides an automatic annual increase of 1½ percent of the basic retirement allowance of all pensioners, present, and future, each year after retirement. This benefit is cumulative—1½ percent the first year, 3 percent the second year, 4½ percent the third year, etc., indefinitely so long as the pensioner survives.

On June 30, 1961, we had 2,258 pensioners on our monthly rolls. During the 12 months preceding that date, we paid these retirants over $4.5 million. The average payment per individual is about $169 per month but this figure is of little value in evaluating the retirement problem of this group as a whole because the payments range from a few dollars to over $550 per month per individual depending upon length of service and salary range.

As is the case in acquiring any article, service, or commodity where the quality to be obtained depends in large measure upon the price to be paid, the benefits which the retirement system can pay depend upon the amount of money made available for its support. In the case of this system, the support is derived from two sources—the employing governments and the employee-members. The overall cost of retirement and pension benefits to the State and county governments of Hawaii is approximately 10.47 percent of their combined payrolls. The average cost to the individual members is approximately the same percentage of their earnings. These percentages are in line with the cost concept accepted by the leading State and local government retirement plans now in effect.

In conclusion, it would appear that our benefits are adequate when judged by the national trend and, for the career employee, provide a retirement income adequate to maintain an acceptable standard of living. We are in advance of the national trend in making provision for retaining the purchasing power of the pensioner's dollar to offset, at least in part, the shrinkage due to steadily increasing cost of living.

Senator LONG. Thank you, Mr. Hill.

It is rather appropriate, isn't it, to have as the last member on the agenda of the day one dealing with retirement. That is also suggestive of the end of activity.

Senator Morse, do you have any further comment?

Senator MORSE. Mr. Chairman, Senator Fong, and ladies and gentlemen, as an old professor, let me say, this has been one of the best seminars I have attended on this subject—either here or in Washington.

I was very much interested and found myself in favorable agreement with some of the suggestions made by Mr. Fred Bennion, director of the Tax Foundation of Hawaii. The committee, Mr. Chairman, is going to have to give some consideration to some tax problems in connection with the problems of the aged.

There has been considerable comment today about taxes. Freedom comes high—but it is worth it. I would suggest that we give thought to that great historic statement of Thaddeus Stevens, the father of the public school system in Pennsylvania, years and years ago when he was bitterly attacked because he thought the State had a responsibility in establishing free public schools paid for by all the taxpayers. He, too, was charged with being a—not a "creeping" Socialist in those days—but just a downright Socialist. And he made that historic comment that he hoped that the people of Pennsylvania would come to fear ignorance more than taxation.

I would suggest, paraphrasing him, that I hope the people of the United States will fear the loss of freedom more than taxation because I would have you remember that, out of a national budget of between $76 and $77 billion, in round numbers you pay $47 billion for the defense and security of your country. I would like to suggest someone come forward with some program that would make it safe to greatly reduce that tax at the present critical hour.

And I would also suggest, particularly to the businessmen present, that you keep in mind the fact that you are not living in a free economy. We must hope to return to it as fast as we can, but we are living in a defense economy. When we have more, and substantially more, than 50 percent of our national budget going to defense costs, what makes you think you are living in a free economy? You can't plow fields with a tank. You can't establish civilian airlines with jet fighters. Keep in mind that so much of the defense costs go to noncivilian production and, really, non-tax-producing production. But we have to produce it and we have to support those costs with taxes.

What a great day it will be if mankind ever reaches the point that we can eliminate a substantial part of that 47 billions of dollars cost for defense and start pouring a little bit of that into civilian production that will create the new wealth out of which new tax dollars at reduced rates can be paid.

It's very easy to take the position, "As free men and women, let's cut the taxes." Well, start telling me within the costs of government outside of the defense program just what those programs are that you think you ought to cut.

Of course, if you hold to the point of view that we shouldn't have a social security system, let me say as a politician—and there's nothing wrong in being a politician; it's a highly honorable profession—that, after all, our democracy is based upon the system of majority rule. That is the essence of freedom. If you think that there is a majority in this country that wants to do away with the social security system, try to offer that bill in the Congress of the United States and see how many votes you will get. And yet, when it was established, there were powerful economic forces in this country that attacked those who favored it as Socialists.

And the same went for unemployment insurance. That takes taxes, too. At that time the business community of the country generally

was against unemployment insurance, and I am perfectly willing to put unemployment insurance now before the chambers of commerce of the United States for the termination of its continuance because the businessmen now have come to recognize that this great service is the great stabilizer of the cash registers on the main streets of the United States.

So may I say that, of course, we want to eliminate waste and unnecessary expenditures, but I close, Mr. Chairman, by saying that my attendance at this seminar today has intensified my determination to do what I can to see to it that in this democracy of ours, based upon the principle of majority rule, we see to it that social justice and economic fairness is extended to the aged of this country.

Senator LONG. Senator Fong, we would like to call on you at this time for your remarks.

Senator FONG. Mr. Chairman, Senator Morse, Mr. Miller, the minority staff member of this committee, advised me that he has attended 15 meetings of this subcommittee and that this is one of the largest attended meetings that he has witnessed. It shows the intense interest of our citizenry in the problems on the aging. It certainly has given me a better insight into the problem.

I note that most of the speakers have spoken in favor of financing this medical insurance under social security. And yet, listening to some of the applause that has been given to members of this audience who stood up and spoke for individual freedom and for voluntary plans, I seemed to sense also that there is quite a large group here that is not for social security financing.

After being here and listening to the various presentations, it is clear we all agree that something must be done for the aged. We have to attack these problems. We've got to give them medical care. The question is the path by which we may reach that goal—whether it should be by voluntary contributions or by compulsory contributions or by Federal-State matching.

And I would like to say again, that, after listening to the excellent presentations, I have a much better understanding of the problems of our senior citizens.

Thank you.

Senator LONG. Senator Morse, Senator Fong, members of the staff, and my neighbors in Hawaii, I want first of all to say that I have never been lacking in pride in regard to the human side of Hawaii. I used to say in talking to children in the schools and to other groups that Hawaii is never going to make any outstanding contributions to the Union in relation to wealth. We have considerable wealth but it's not comparable to that of many of the States on the mainland. It will never be comparable in its potential to the 49th State, Alaska. But Hawaii has one thing that I think is worthy of its place in the Nation—and that's the spirit that we have been able to maintain here. I don't know where it came from—possibly from the oldtime Hawaiians. That's the best answer that I have ever heard as to its source.

I think that this afternoon, throughout the entire day, we have had an example of what the people of Hawaii are capable of. I was impressed by the turnout. Members of the staff made the same statement to me that Mr. Miller made to Senator Fong—that this was unusual from the standpoint of turnout.

One of them—and this is echoed by Senator Morse—made another statement. That is that, from the standpoint of the content, the preparation of the papers, this is outstanding. I am proud of that.

I am particularly proud of that group of senior citizens who came and made their contribution, and it was a contribution in some ways more impressive than the more formal presentation.

I am proud of it also because it shows that Hawaii has been aware of this problem and has been doing something about it. It is a vast step forward, isn't it, from that period in human history when they exposed the aged to the elements. We are not going to do that. And anyone who decries the forward steps that have been taken or feels that we must halt them is just not realistic, because this trend is in the best keeping, the best tradition of our Nation and it is certainly in keeping with the spirit of America.

I thank you all for coming today. You have made an outstanding contribution. And I am certain that among the 30 records that will go to the Members of the Senate, ours is going to constitute a real contribution. Thank you for coming. The meeting is adjourned.

(Whereupon, at approximately 5:30 p.m., Monday, November 27, 1961, the subcommittee hearing was adjourned.)

APPENDIX

Population Background and Health Needs for the Older Persons of the State of Hawaii

I. POPULATION BACKGROUND

Hawaii's population of 632,772 (including 52,916 Armed Forces personnel) reported in the final U.S. census bureau report for April 1, 1960, is distributed over an area of 6,451 square miles, including the 20-odd islands and many islets and reefs. The population is still a youthful one, with over one-half under 25 years of age, but the population of those over 65 is expected to increase by 70 percent in the next 10 years from 29,000 in 1960 to 49,000 by 1970.

The eight main islands spread in a slight arc about 373 miles long from northwest to southeast. Hawaii, known as the "Big Island" covers an area just over 4,000 square miles. The other six which are permanently inhabited—Kauai, Lanai, Maui, Molokai, Niihau, and Oahu—are each about as large as a small or averaged sized county in the eastern United States. Kahoolawe is but 45 square miles in area, is uninhabited and is used as a target ground by military planes. But the people of the new State are living in five counties, with 79 percent in Honolulu, 9.7 percent in Hawaii, 6.7 percent in Maui (including 0.8 percent on Molokai and 0.3 percent on Lanai), 4.4 percent in Kauai, and with less than 0.1 percent in Kalawao. While the principal islands are separated by bodies of water of the Pacific, six are quickly and easily reached by airplane services.

The people are mainly American-born (87 percent) of United States citizenship. Over half are of Oriental ancestry; some 38 percent Japanese, 7 percent Chinèse, 2 percent Korean and 13 percent Filipino. In 1950, only 12,206 unmixed Hawaiians (Polynesians) remained.

Using the census bureau figures of 1960 there was an increase of 42.8 percent since 1950 in the over 65 population in Hawaii, compared to an increase of 34.7 percent on the mainland. In the 52 jurisdictions, Hawaii's percentage increase is exceeded only by Florida, 132.9 percent; Arizona, 103.9 percent; Nevada, 65.4 percent; New Mexico, 55.1 percent; California, 53.8 percent; and Texas, 45.2 percent.

The 65 years and over population in Hawaii is only 4.6 percent of the total population and compared to the national figure of 9.2 percent, but the percentage is expected to increase at a rapid rate. Only two jurisdictions, Puerto Rico and Alaska, had a lower percentage of older population.

In the 1950 census there were 20,411 persons 65 years and over in Hawaii—12,619 on Oahu, 7,792 on the neighbor islands. The 1960 census reports that there were 19,584 persons 65 years and over on Oahu on April 1 of that year. Figures on the population 65 years and over for the neighbor islands are given in table 1.

According to the Hawaii Health Survey, about 6.5 percent of persons 65 years and over on Oahu were living alone (see table 2).

Table 3 reports population distribution by military status as of April 1, 1960. This summary includes final 1960 census data on total population and State Planning Department data on military personnel and their dependents.

Table 4 indicates the civilian population of each county, island and major city as of April 1, 1940, 1950, 1960. Unlike the U.S. Census totals on which these estimates are based, they exclude military personnel but include their dependents.

Table 5 presents projection of the civilian population of the State of Hawaii, by geographic area, from 1960 to 1980.

TABLE 1.—*Population of Hawaii and the United States, Apr. 1, 1960*

Geographic area	Population	65 years and over		Median age
		Number	Percent	
United States	188,000,000	16,559,580	9.6	29.5
State of Hawaii, total population	[1] 632,772	29,162	4.6	24.3
Hawaii County	61,332	4,587	7.5	27.4
Honolulu County—total population	500,409	19,584	3.9	23.8
Kalawao County	279	23	8.2	44.5
Kauai County	28,176	2,002	7.1	29.6
Maui County	42,576	2,966	7.0	31.4
Maui Island	35,717	2,670	7.5	----
Molokai Island (excluding Kalawao)	4,744	219	4.6	----
Lanai Island	2,115	77	3.6	----

[1] Includes approximately 52,916 servicemen and 60,057 military dependents.

TABLE 2.—*Civilian population by family relationship and sex, persons 65 years and over, Island of Oahu: Estimated from Hawaii health survey, October 1958 and September 1959*

Family relationship	Both sexes		Male		Female	
	Number	Percent	Number	Percent	Number	Percent
Total persons	18,599	100.0	9,714	100.0	8,885	100.0
Living alone	1,211	6.5	556	5.7	655	7.4
Living with other than relatives	1,230	6.6	925	9.5	305	3.4
Living with relatives:						
Married persons	9,437	50.8	6,352	65.4	3,085	34.7
All other	6,721	36.1	1,881	19.4	4,840	54.5

TABLE 3.—*Population, by military status for Hawaii by geographic area, Apr. 1, 1960*

Geographic area	Total population	Military personnel	Civilian population		
			All civilians	Military dependents	Other civilians
The State	632,772	52,881	579,891	60,057	519,834
Hawaii County	61,332	132	61,200	204	60,996
City of Hilo	25,966	----	25,966	----	25,966
Remainder of county	35,366	132	35,234	204	35,030
Honolulu County [1]	500,409	52,570	447,839	59,661	388,178
City of Honolulu	294,179	9,486	284,693	28,079	256,614
Remainder of county [1]	206,230	43,084	163.146	31,582	131,564
Kalawao County	279	----	279	----	279
Kauai County	28,176	140	28,036	134	27,902
Island of Kauai	27,922	140	27,782	134	27,648
Island of Niihau	254	----	254	----	254
Maui County	42,576	39	42,537	58	42,479
Island of Lanai	2,115	----	2,115	----	2,115
Island of Maui	35,717	20	35,697	34	35,663
Island of Molokai [2]	4,744	19	4,725	24	4,701

[1] Includes French Frigate *Shoal* (15 persons, all military personnel), legally part of the city of Honolulu.
[2] Excludes Kalawao County.

Source: Total population from U.S. Bureau of the Census, "1960 Census of Population, Advance Reports, Final Population Counts," PC (A1)-13, Nov. 10, 1960, table 2. Military personnel and dependents from data supplied by Armed Forces (except Honolulu, from number of household heads and average military household size reported by the Honolulu Redevelopment Agency, "Redevelopment and Housing Research," No. 17, April 1960, pp. 13-14).

TABLE 4.—*Civilian population of the State of Hawaii by geographic area, 1940, 1950, and 1960*

Geographic area	Apr. 1, 1940 [1]	Apr. 1, 1950 [2]	Apr. 1, 1960 [2]
The State	396,537	476,938	579,891
County of Hawaii	73,276	68,307	61,200
City of Hilo	23,353	27,187	25,966
Remainder of county	49,923	41,120	35,234
County of Honolulu	231,463	330,251	447,839
City of Honolulu	174,743	241,836	284,693
Remainder of county	56,720	88,415	163,146
County of Kalawao	446	340	279
County of Kauai	35,818	29,885	28,036
Island of Kauai	35,636	29,677	27,782
Island of Niihau	182	208	254
County of Maui	55,534	48,155	42,537
Island of Kahoolawe	1	----	----
Island of Lanai	3,720	3,135	2,115
Island of Maui	46,919	40,088	35,697
Island of Molokai [3]	4,894	4,932	4,725

[1] Total population exclusive of soldiers, sailors, marines, and coast guards.
[2] Total population exclusive of military personnel.
[3] Excluding Kalawao County.

Source: "1940 U.S. Census, Population, Second Series, Hawaii," table 13; "1950 U.S. Census of Population," Bulletin P-A52, table 5, Bulletin P-B52, tables 19 and 28, and Bulletin P-D62, table 2; present study, table 1.

TABLE 5.—*Civilian population of the State of Hawaii by geographic area, 1940–80*

Series and date	The State	Hawaii County	Honolulu County	Kauai County	Maui and Kalawao Counties	
					Islands of Lanai and Molokai	Island of Maui
Enumerated (Apr. 1):						
1940	396,537	73,276	231,463	35,818	9,061	46,919
1950	476,938	68,307	330,251	29,885	8,407	40,088
1960	579,891	61,200	447,839	28,036	7,119	35,097
Projections without program (July 1):						
1965	709,921	62,613	569,377	30,291	9,555	38,085
1970	801,072	68,276	638,761	34,139	10,566	49,330
1975	893,990	74,518	711,764	39,162	11,562	56,984
1980	993,007	82,773	784,938	44,651	12,613	68,032
Projections with program (July 1):						
1965	774,816	84,589	586,670	40,749	11,515	51,293
1970	945,332	122,629	664,823	61,231	15,064	81,585
1975	1,096,745	150,570	748,304	79,038	17,282	101,551
1980	1,257,420	178,406	838,454	97,329	19,739	123,492

NOTE.—The "projections without program" assume no major governmental assistance to tourism and transportation programs; the "projections with program" assume active governmental assistance to tourism and transportation programs.

Source: Present study, table 2; "A Study of the Economic Potential of the Hawaiian Islands," pts. I, II, and IV (by John Child & Co., for the Hawaii State Planning Office), pp. 195–206 and 210.

II. HEALTH NEEDS OF OLDER PERSONS

A. Mortality

The estimated population of Hawaii, by military status and age groups, is shown in table 1. From these data the age-specific mortality rates shown in table 2 have been calculated.

It will be noted that the order of leading causes of death differs from that given in the "Guide for State Surveys on Aging." In fact this reflects the younger population of Hawaii.

B. Morbidity

A preliminary report[1] is now available from the Hawaii health survey conducted from October 1958 to September 1959. This was a survey of 3,300 households, comprising 12,500 persons in the resident civilian, noninstitutional population of the island of Oahu. The total population of the island of Oahu, according to the preliminary figure from the 1960 census, is 500,409 out of the total State population of 632,772. Thus the survey represents a sample of approximately 2.5 percent of the Oahu population. It was carefully done, and we believe the sample is adequate.

The remaining tables and charts in this section are taken from the report cited.[1] These tables in the original report are grouped: All ages, under 5, 5 to 14, 15 to 24, 25 to 44, 45 to 65, and 65 plus. Only the first and the last two groups will be used in this report. The figures in parentheses indicate the table number and page in the printed report. Note that (*) in the tables indicates that "magnitude of the sampling error precludes showing separate estimates."

Table 3 (p. 1219) shows hospital discharges and hospital days, per 1,000 population, excluding (as in other tables) patients who died during the year, and those who did not remain overnight. The figure 98 for patients over 65 compares with 121 on the mainland.

As expected, the rates of hospital days to discharges are highest in the older age groups (all ages, 7.5 to 1; 45–64, 13.7; 65 plus, 22.1).

Table 4 (p. 1220) shows average length of stay in "short stay" hospitals. Here also the time for older groups is considerably more than the average. "It should be noted that sampling errors for days of hospital stay are relatively large." Table 5 (p. 1220) shows rates per 100 persons of acute conditions, and table 6 (p. 1220) shows similar rates for chronic conditions. As expected, rates for older people are less in acute conditions, more in chronic ones.

Tables 7 and 8 (p. 1221) show rates of chronic limitation of activity and mobility. These also increase greatly with age, as expected. It should be borne in mind that patients in institutions are not included.

Tables 9 and 10 (p. 1221) show restricted activity and bed disability days per person per year; here the age differences are less than might have been expected. The exclusion of patients in institutions is probably an important factor here.

Table 11 (p. 1222) shows rates of "persons who received injuries that were of enough consequence to require medical attention, or to cause the person to cut down on his activities for at least a day." The highest rate was in males in the 15- to 24-year group.

Other findings of the survey for the age group 65 and over are given as follows:

(1) As judged by factors considered in this report, the health level of persons 65 years and older on the island of Oahu appeared remarkably high when compared to that of the same age group on the mainland as a whole.

(2) Among this oldest segment of the population, the average number of disability days due to illness or injury per person per year was only 16.5 on Oahu and 42.6 on the mainland.

(3) About 58 percent of the population 65 and over on Oahu and 77 percent on the mainland had one or more chronic conditions.

(4) On Oahu, about 27 percent and on the mainland, 42 percent of the population 65 and over had some degree of activity limitation due to chronic conditions.

(5) Among these older people, prevalence rates for heart conditions, peptic ulcer, arthritis and rheumatism, hernia, asthma-hay fever, chronic bronchitis, visual impairments and hearing impairments ranged from 21 percent to 69 percent lower on Oahu than on the mainland. For high blood pressure, the difference in rates was less pronounced.

(6) Rates for diabetes and for paralysis of major extremities and or trunk were higher on Oahu than on the mainland.

(7) The incidence rate for acute conditions among persons 65 and over was 15.9 percent lower on Oahu than on the mainland.

(8) For the 65 and over group, the average number of physician visits per year was 4.5 on Oahu and 6.8 on the mainland.

(9) On Oahu, 78 percent and on the mainland, 81 percent of the population 65 years and older had not visited a dentist during the past year.

[1] Health Statistics; the Hawaii Health Survey, description and selected results; Department of Health, Education, and Welfare, Public Health Service, publication 584–C3.

(10) Among those 65 and over, the rate of patient discharge from short-stay hospitals per 1,000 population was 23 percent lower on Oahu than on the mainland.

(11) The average length of stay for the Oahu patients in short-stay hospitals was longer—22.1 days compared to 14.7 days for the mainland patients.

(12) Among persons 65 and over on Oahu who were discharged from short-stay hospitals, only 14.6 percent were reported with hospital insurance.

TABLE 1.—*Population of Hawaii by age and military status, Apr. 1, 1960*

Age group	Total	Military status	
		Military	Civilian
Total	632,772	52,916	579,856
Under 5	80,962		80,962
5 to 17	169,951		169,951
18 to 44	255,364	51,096	204,268
45 to 64	97,333	1,820	95,513
65 and over	29,162		29,162

Source: Estimates by Hawaii State Planning Office, Staff Research Memorandum 29, table 3, and U.S. Bureau of the Census: 1960, Final Report PC (1)-13B, "General Population Characteristics. Hawaii," table 27.

TABLE 2.—*Deaths and rate for the leading causes of death for resident civilians, age groups 45 and over, Hawaii, 1960*

Cause of death	Age 45 to 64 years		Age 65 years and over	
	Number	Rate per 100,000 population	Number	Rate per 100,000 population
All causes	969	1,014.5	1,682	5,767.8
Heart diseases	369	386.3	737	2,527.3
Cancer and other malignant condition	233	243.9	289	991.0
Cerebral hemorrhage [1]	96	100.5	191	655.0
Accidents (all forms)	55	57.6	45	154.3
Cirrhosis of liver	24	25.1	14	48.0
Diabetes mellitus	26	27.2	60	205.7
Influenza and pneumonia	14	14.7	58	198.9
Suicide	16	16.8	11	37.9
Tuberculosis (all forms)	3	3.1	7	24.1
All other causes	133	139.2	270	925.9

[1] Includes other intracranial lesion of vascular origin.

TABLE 3.—*Number of hospital discharges and number of hospital days per 1,000 population by age and sex: Short-stay hospitals, Oahu, Hawaii, October 1958 to September 1959*

Age	Hospital discharges per 1,000 persons			Hospital days per 1,000 persons		
	Both sexes	Male	Female	Both sexes	Male	Female
All ages	105.5	73.6	133.7	791.2	765.9	813.6
45 to 64	103.5	96.0	112.7	1,401.5	1,430.9	1,365.3
65 and over	98.1	103.8	92.0	2,164.5	2,129.5	2,202.8

TABLE 4.—*Average length of stay per discharge from short-stay hospitals by age and sex: Oahu, Hawaii, October 1958 to September 1959*

Age	Average length of stay in days		
	Both sexes	Male	Female
All ages	7.5	10.4	6.1
45 to 64	13.5	14.9	12.1
65 and over	22.1	20.5	24.0

TABLE 5.—*Annual incidence of acute conditions according to condition group by age: Oahu, Hawaii, October 1958 to September 1959*

Condition group	Rate per 100 persons		
	All ages	Age 45–64	Age 65+
All conditions	273.7	180.3	112.6
Infectious and parasitic	15.9		
Upper respiratory	112.1	74.8	23.3
Other respiratory	50.8	37.6	23.3
Digestive system	16.7	14.2	9.2
Fractures, dislocations, sprains, and strains	6.0	7.1	19.1
Open wounds and lacerations	14.0	12.9	(1)
Contusions and superficial injuries	9.1	7.0	9.2
Other current injuries	7.2	6.9	
All other acute conditions	41.8	19.7	24.1

[1] Magnitude of the sampling error precludes showing separate estimates.

TABLE 6.—*Number of chronic conditions and rate per 1,000 persons per year reported in interviews according to condition group by age: Oahu, Hawaii, October 1958 to September 1959*

Condition group	Rate per 1,000 persons		
	All ages	Age 45–64	Age 65+
Heart conditions	12.2	33.7	52.4
High blood pressure	23.9	86.1	122.3
Asthma-hay fever	77.5	45.5	27.7
Chronic bronchitis	10.4	8.0	(1)
Chronic sinusitis	31.9	40.1	20.2
Hernia	4.8	10.5	16.8
Peptic ulcer	6.8	11.7	16.3
Diabetes	10.6	45.0	58.3
Arthritis and rheumatism	22.0	68.1	139.0
Hearing impairments	22.4	36.4	135.3
Visual impairments	9.8	26.3	66.6
Impairment,[2] back or trunk	23.8	53.7	59.4
Impairment,[2] upper extremity, shoulder	6.7	18.2	(1)
Impairment,[2] lower extremity, hip	12.3	21.7	35.7

[1] Magnitude of the sampling error precludes showing separate estimates.
[2] Not including absence or paralysis.

TABLE 7.—*Number and percent distribution of persons according to limitation of activity due to chronic conditions by age: Oahu, Hawaii, October 1958 to September 1959*

Limitation of activity	Percent distribution		
	All ages	Age 45–64	Age 65+
All persons	100.0	100.0	100.0
With no chronic conditions	67.1	51.7	42.3
With 1+ chronic conditions	32.9	48.3	57.7
No limitation of activity	27.7	37.7	30.9
Limited but not in major activity	1.5	2.0	5.0
Partially limited in major activity	2.8	6.2	13.8
Unable to carry on major activity	.8	2.5	8.0

TABLE 8.—*Number and percent distribution of persons according to limitation of mobility due to chronic conditions by age: Oahu, Hawaii, October 1958 to September 1959*

Limitation of mobility	Percent distribution		
	All ages	Age 45–64	Age 65+
All persons	100.0	100.0	100.0
With no chronic conditions	67.1	51.7	42.3
With 1+ chronic conditions	32.9	48.3	57.7
No mobility limitation	31.6	45.3	45.3
Trouble getting around alone	.7	1.7	6.3
Confined or needs help	.6	1.4	6.2

TABLE 9.—*Number of restricted-activity days and number of restricted-activity days per person per year by age and sex: Oahu, Hawaii, October 1958 to September 1959*

Age	Number of restricted-activity days			Restricted-activity days per person per year		
	Both sexes	Male	Female	Both sexes	Male	Female
All ages	5,380,700	2,310,800	3,070,000	11.7	10.7	12.5
45 to 64	769,800	436,800	333,100	12.2	12.5	11.8
65+	307,100	156,300	150,800	16.5	16.1	17.0

TABLE 10.—*Number of bed-disability days and number of bed-disability days per person per year by age and sex: Oahu, Hawaii, October 1958 to September 1959*

Age	Number of bed-disability days			Bed-disability days per person per year		
	Both sexes	Male	Female	Both sexes	Male	Female
All ages	2,299,100	1,023,700	1,275,500	5.0	4.7	5.2
45 to 64	309,300	178,300	131,000	4.9	5.1	4.6
65 plus	123,600	66,300	57,300	6.6	6.8	6.5

TABLE 11.—*Number of persons injured and rate per 1,000 persons by age and sex: Oahu, Hawaii, October 1958 to September 1959*

Age	Rate per 1,000 persons		
	Both sexes	Male	Female
All ages	347	463	246
45–64	269	384	127
65+	282	179	395

EXCERPTS OF REPORT ON NURSING HOMES AND CARE HOMES, STATE OF HAWAII*

UNMET NEEDS

(1) Development of additional small care homes for specialized care (mental retardate, ex-mental hospital patients, diabetics, blind, etc.).

(2) Improved standards of patient and resident care in all homes relative to medical supervision and nursing care, employing rehabilitative concepts.

(3) Development of training programs for nursing and care home administrators and staffs.

(4) Closer supervision by the licensing agency in assisting homes to comply with prescribed standards.

(5) Establishment of central index in licensing agency for better control of patient movement, counseling, and placement.

(6) Closer coordination with all standard-setting agencies which have jurisdictions in these areas.

(7) Development of a planning committee for hospitals and auxiliary medical facilities, including nursing homes, care homes, outpatient facilities, home care and housekeeping programs, with the objectives of:

(*a*) Proper and orderly planning.

(*b*) Development of resources and adequate financing for the future construction.

(*c*) Provision for a plan for coordinated progessive patient care by placement of residents in proper type of facility for his particular disability or need for care—to be developed on area and regional bases as well as statewide basis.

As the result of recent passage of Public Law 87–395 (H.R. 4998) some of these problems will be partially resolved in the near future. A total of $40,000 has been made available to Hawaii and out of these funds a consultant coordinator, occupational therapy consultant, and physical therapy consultant will be added to the hospital and medical facilities branch of the department of health.

The coordinator will assist in the recruitment of small care homes and assist in setting up a registry of all patients in nursing and care homes throughout the State, in conjunction with the licensing agency for these homes. Some effort will be made to classify the homes as to type of patients and care they will provide.

The occupational therapy consultant will assist the various nursing home and care home administrators in developing an activity program going beyond those generally ascribed to the field of occupational therapy per se. For those showing physical handicap, the physical therapy consultant will assist in educating the administrators in the need for and usefulness of rehabilitation physical therapy techniques on a demonstration and educational basis.

At the present, part-time consultative services are available in the way of sanitation and nutrition, but these services are presently inadequate. There is also a need for services from a health educator, research analyst, and extended architectural services for advice and for review of structural details which are particularly applicable to the nursing home field.

*Figures and tables submitted by Dr. Lee can be found in their proper place in the contents of the full text of "Nursing Homes and Care Homes in Hawaii" which appears on pages 1395 to 1439 in the appendix.

Although alcoholism is not necessarily a problem of the aging, it is a segment of chronic care and a field neglected which needs development insofar as halfway houses and aggressive activity programs are concerned, especially as they relate to reorientation of psychological forces which may have led to the disability.

Diabetic and dietetic problems are not exclusively problems of the aging but the trends increase as age progresses. For example, more than 40 patients in one particular chronic-care institution are known diabetics receiving minimal attention, both medical and dietary. At least half of these patients might be better cared for in less complex facilities with more personal attention.

Greater emphasis for the future may have to be placed in day care centers for the elderly, and efforts by the Commission on Aging will undoubtedly be directed to this area.

Of some concern is the legislative proposal for 180 days of care in the nursing home under the Social Security Act. Perhaps the intent could be misunderstood, but with an average stay of over 5 years, in 40 percent of the residents of nursing and care homes, it raises the question as to who is going to finance the care for the other 185 days of the year?

INTRODUCTION

The existence in the State of single elderly men in considerable numbers without close family connections constitutes a special problem in Hawaii. Many of these men immigrated to the islands as plantation laborers without wives and never married.[1] Some have a limited educational background and are frequently handicapped by language difficulties. A considerable number are already retired.

Indications are that our aged population of the not distant future will be more subject to the diseases and infirmities of old age. The Hawaii Health Survey conducted in 1958 and 1959 showed the health of our present population 65 and over remarkably good compared to the same age group on the mainland and to younger ages in Hawaii. On the other hand, the age group 45 to 64 years and younger groups appeared relatively less well off healthwise. Upon reaching 65 and over, they may be expected to show less stamina and resistance than our aged population of today.[2]

Considered as medical care facilities, nursing homes, and to a lesser extent care homes are being used more widely for post-hospital convalescent care and for the care of the long-term and chronically ill patient. Thereby, the load on hospitals of all types is reduced and they can concentrate to a greater extent upon the more acute conditions of the short-term stay patient. In this way also, the cost of illness in the community may be reduced. Amendments to the Federal Hospital Survey and Construction Act recognizes this supplementary function of nursing homes by making matching funds available to assist in the construction of nonprofit homes.

For all of these reasons, the nursing and care homes program of the future is bound to be extensive and constantly expanding. Although we are now faced with a shortage of homes and serious defects among some of these which exist, a few years from now without some planning the problem could be even greater.

Definitions of what constitutes a nursing home and a care home as used in this report are as follows:

Nursing home.—This type of home provides as its primary and predominant function skilled nursing care for adults. Skilled nursing care includes those procedures employed in caring for the sick which require some technical nursing skill beyond that which the ordinary untrained person can adequately administer. These may include full bed baths, enemas, irrigations, catheterization, application of dressings or bandages, administration of medication by whatever method the physician orders (oral, rectal, hypodermic, intramuscular), and carrying out other treatments prescribed by the physician which involve a similar level of complexity and skill in administration. They may be provided by either professional or practical nursing personnel, so long as they extend beyond personal care as described below.

Care home.—This type of home provides personal care with little or no skilled nursing care. Personal care includes such personal services as help in walking and getting in and out of bed, assistance with general bathing, help with dressing or feeding, preparation of special diet, supervision over medications which can be

[1] Lind, A. W., "Hawaii's People," University of Hawaii Press, Honolulu, 1955.
[2] "Health Characteristics of Persons 45 Years and Older." Hawaii Health Survey Report No. 2, Office of Health Statistics, Hawaii State Department of Health, 1960.

self-administered, and other types of personal assistance of this order. Minimum services of a domiciliary nature, such as laundry and personal courtesies are, of course, also included.

I. DISTRIBUTION AND CHARACTERISTICS OF HOMES

Number of homes and bed capacity.—At the time of the survey, 15 nursing homes and 32 care homes were operating in the State. They had a combined bed capacity of 1,057 beds or 1.8 beds per 1,000 population.

This rate is well above the minimum standard of 1 bed per 1,000 population specified in the Hill-Burton hospital and medical facilities construction program, but probably below the existing national average. A national survey in 1954, indicated an estimated 2.8 beds per 1,000 population in nursing homes and related facilities.[3]

Occupancy rates.—Although bed capacity reported from the two types of homes was 1,004,[4] the number of patients reported was 833. Thus, the overall occupancy rate was 83 percent at the time of the survey. For nursing homes, it was 92 percent; for care homes, it was 70 percent.

Size of homes.—Measured by bed capacity, nursing homes were generally much larger than care homes. The bed capacity average for nursing homes was 43.5 compared to only 12.6 for care homes (table 1).

Type of ownership.—Considering the two types of homes as one group, 80 percent were privately operated and 17 percent by a nonprofit organization other than religious (Table 4); one home was church related.

Using bed capacity rather than number of homes, proportions appeared quite different. In this case, homes of nonprofit organizations had 56 percent of the beds and privately operated homes only 40 percent. This, of course, reflects the larger capacity of the nonprofit organization establishments.

Staffing.—Nursing homes had an average of 21.2 patients to each registered professional nurse. This average in care homes was negligible since only two part-time registered nurses were employed.

Considering all categories of nursing help as a group, the ratio was 4.3 patients to each nurse in nursing homes and 11.8 patients to each nurse in care homes.

II. CHARGES FOR CARE AND PATIENT FINANCING

Sources of funds.—An outstanding fact relative to patient financing in nursing homes and care homes is the extensive part played by public welfare funds. In nursing homes, 57 percent, and in care homes, 67 percent of the patients were financed wholly or in part by the welfare department (table 11 and fig. 2). In both types of homes, welfare funds paid the full bill, rather than only part, in the majority of cases.

In nursing homes, 39 percent had a private source of income and 14 percent some form of pension. In care homes, only 7 percent had private sources of income while 28 percent had pensions. In both categories of homes, the most usual type of pension was old-age retirement.

III. PERSONAL CHARACTERISTICS OF PATIENTS

Age and sex.—In line with a lower median age, nursing homes of Hawaii had a higher proportion of younger people than care homes. For example, 13.6 percent in nursing homes and only 3.5 percent in care homes were under 50 years of age. About 63 percent in nursing homes and 67 percent in care homes were 70 and over (table 13 and fig. 3).

Patients in nursing homes were far more nearly and evenly divided between the sexes. About 51 percent were males and 48.6 percent females. Only 9.2 percent of those in care homes (26 patients) were females. In the nursing homes, females averaged slightly older than males, while in care homes, the males were slightly older.

Marital status.—In nursing homes, 29.2 percent of all patients were widowed females. Single men were next in importance, constituting 24.1 percent of all patients (table 14).

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[3] Solon, J., Dean, W., Baney, A. M., "Nursing Homes, Their Patients and Their Care," Public Health Service and the Commission on Chronic Illness, Public Health Monograph No. 46, 1957.

[4] From this point, data for one nursing home which failed to report for survey purposes are omitted.

In care homes, single men were by far the predominant group, constituting 53.2 percent of all patients. Widowers were second in importance, 22.3 percent.

A major difference between homes of the country as a whole and of Hawaii is the much higher proportion of single men in Hawaii. No doubt this is due to the considerable numbers of immigrant laborers who came to the islands in the past without wives and who never married. Many of them are now retired from work on the sugar and pineapple plantations.

Racial groups.—Caucasians were the largest group in nursing homes (38.5 percent) followed by Japanese (28.1 percent) and Filipinos (13.2 percent). A concentration of Caucasian females was especially noticeable. About one in four patients was in this category (table 15).

Only 10.6 percent of the patients in care homes were Caucasian. The most numerous groups were Japanese and Chinese (table 17). Filipinos, Hawaiians, and those in the "all other" classification were in more or less equal numbers. Most of the females were either Caucasian or Hawaiian.

Residence before admission.—About 87 percent of the patients in nursing homes resided in the same county before admission; about 11 percent came from another county of the State; and less than 2 percent (10 patients) came from another State or county. Females were more likely to come from outside the State than males (table 16).

Home and family status.—Home and family status were obtained for about four-fifths of the patients in nursing and care homes combined. About 19 percent of those for which the information was obtained had homes and more than half had families; 18 percent had both homes and families. As indicated in table 17, nearly all of those with homes also had families.

IV. MEDICAL CONDITION OF PATIENTS

Walking status.—In nursing homes, 62.6 percent of the patients could walk alone or with no more help than a cane or crutch. Others (18.5 percent) needed personal assistance or some mechanical device for getting about. About as many (18.9 percent) could not walk or get about to any extent.

The situation was quite different in care homes. More than 85 percent could walk alone or with cane or crutch; less than 2 percent were unable to get about at all; and 13.1 percent needed major assistance (table 22).

Bed status.—In nursing homes, 28.3 percent of the patients and in care homes 22 percent where in bed part or most of the time. The greatest contrast appeared for patients in bed all of the time—11.1 percent in nursing homes and only 1 percent (three patients) in care homes (table 22).

Mental condition.—More than two-thirds of nursing home patients and only one-third of care homes patients were disoriented at least part of the time. About 1 in 4 in nursing homes and 1 out of 25 in care homes were confused most or all of the time (table 23).

Continence.—About 71 percent of nursing home patients and 90.1 percent of care home patients were continent. In nursing homes, about 1 patient in 5 was incontinent with respect to both urine and feces (table 23).

As indicated in table 23 showing patients in nursing and care homes as a single group, continence tends to decrease with age. Of those under 50, 91.9 percent were continent; at ages of 80 and over, only 71.9 were continent.

V. PATIENT CARE

Length of stay.—As of the time of the survey, 33 percent of the nursing home patients and 42 percent of those in care homes had resided there for 5 years or more. Relatively few in either type of home had come so recently as less than 1 year ago (table 24 and fig. 8). The median length of stay in nursing homes was 3.4 years and 4.1 years in care homes. In care homes, the small number of females included (19) averaged a much shorter stay than males; on the contrary, females in nursing homes stayed somewhat longer than males.

These data indicate that both types of homes are definitely establishments for long-term care. The characterization "home" is not misplaced in the sense that patients reside there for long periods.

Such lengthy care frequently imposes great financial strain on the patients and their families. It is, therefore, not surprising that public welfare funds wholly or in part must be used to support a high proportion of patients.

Level of nursing care needed.—About one out of five (19.2 percent) in nursing homes required mainly boarding care, whereas well over one-half (57.5

percent) in care homes needed only this kind of care. It would appear then that a considerable number of nursing home patients needing mainly boarding care might be transferred to care homes without ill effect.

In care homes, it is striking that at least 93.8 percent of those 80 years of age and over were judged to need only boarding care or care that might have been given in their own homes.

Activity participation.—Table 27 shows a selected list of activities in which patients of nursing homes and care homes do or do not participate. About 1 out of 4 (24.1 percent) in nursing homes and 1 out of 10 (10.8 percent) in care homes did not take part in any of the activities listed.

It is of particular note that 32.5 percent of those in nursing homes and 58.9 in care homes did not have visitors. This may indicate an opportunity on the part of appropriate volunteer agencies to arrange occasional social visits to nursing and care homes.

Services rendered.—Thirty and seven-tenths percent in nursing homes and only 7.4 in care homes required a special diet.

Only 2.6 percent (22 patients) were receiving physical therapy.

Physician or clinic visits.—About 60 percent of the patients in each type of home had a physician or clinic visit within the past 30 days (table 32). In nursing homes, 1 out of 4 patients had seen a physician 5 or more times during this period; in care homes, only 1 out of 17 had seen a physician so many times. This, of course, reflects the better condition of care home patients healthwise.

Resources for Meeting Health Needs of Older Persons

A. STATE ORGANIZATION

Introduction

The organizational unit of the Hawaii Department of Health which deals with problems of the health of aging is the adult health branch. The branch works in cooperation with the hospital and medical facilities branch, the office of research, planning, and statistics, and the division of mental health.

1. Financing

State funds are supplemented by Federal categoric grants for heart, cancer, and chronic illness and aging.

2. Full-time staff members and specialties

Chief, assistant chief (position vacant), cancer control physician, cancer and chronic disease nursing consultant; for cancer register: coordinator, stenographer and clerk; office and clerical staff, rehabilitation nursing consultant (assigned to independent living project of division of vocational rehabilitation).

The health educator, nutritionist, and research analyst have been assigned to other units of the department, but the service is still available to the branch.

3. Advisory committee: Composition and functions

The Committee on Chronic Illness and Aging of the Hawaii Medical Association, of which the chiefs of the adult health and hospital and medical facilities branches, and the executive officer of the medical health services division are members, cooperates with the branch and gives advice when requested. Heart and cancer committees of the Hawaii Medical Association are established as advisory committees. These three committees consist of physicians who are members of the Hawaii Medical Association. The Hawaii Cancer Commission is composed of six members, two representing the Hawaii Medical Association, two the American Cancer Society, Hawaii Division, and two the State department of health. Currently all members are physicians and members of the Hawaii Medical Association. This commission is a policymaking body for, and advisory to, the Hawaii Cancer Register.

The branch works in cooperation with, and is advised by, the Governor's interim commission on aging, which has 17 members appointed by the Governor. The director of health serves as vice chairman. The branch chief serves as an ex officio member. He also represented the State of Hawaii on the National Advisory Committee to the White House Conference on Aging, and attended the conference in January 1961.

4. Defined objectives

Promotion of positive health in the aging members of the community; cooperation with other social and health agencies to alleviate some of the problems of

aging; study of prevention, alleviation, and patient rehabilitation in chronic diseases associated with the aging process.

5. Current activities

(*a*) *Grants for local programs.*—Funds of the branch have been used to purchase services of the Rehabilitation Center of Hawaii, in promoting educational programs for physicians, nurses, occupational therapists, and physical therapists, and for direct evaluation of patients in need of rehabilitative care and recommendations for their treatment.

The services of the physiatrist have been purchased from the Rehabilitation Center of Hawaii, to serve the independent living project of the division of vocational rehabilitation. The rehabilitation nursing consultant of the branch staff is assigned to this project full time. The chief serves as a consultant and resource person to this project.

(*b*) *Assistance in equipment and supplies for local programs.*—Cooperates with the American Cancer Society (Hawaii Division), Hawaii Heart Association, and others in providing educational materials and in conducting educational programs.

(*c*) *Consultation to communities, groups, and agencies.*—Members of the staff of the branch, as well as workers in health education, nursing, etc., work with local official and voluntary organizations as directors, committee members, and consultants. Major service is in programs of heart, cancer, and rehabilitation.

(*d*) *Training.*—The chiefs of the adult health and hospital and medical facilities branches, and the cancer control physician, hold the degrees of A.B. and M.D. The chief of the adult health branch has the degree of M.P.H., is a diplomate of the American Board of Preventive Medicine in Public Health, and is a fellow of the American College of Preventive Medicine and of the American Public Health Association. The chief of the hospital and medical facilities branch is a fellow of the American College of Pathology and the American College of Hospital Administrators. Other professional workers have degrees in their respective fields. Frequent use is made of postgraduate conferences, institutes, etc., both here and on the mainland, for further training of workers.

(*e*) *Inspection and licensure.*—Regulations which have been established for inspection and licensure of nursing homes and care homes are administered by the hospitals and medical facilities branch.

(*f*) *Development of health education and training aids.*—A health educator is assigned part time to the adult health branch to work in promoting health education in the fields with which the branch is concerned, including aging, and in the production and dissemination of training aids, both through the department of health and through the voluntary organizations.

(*g*) *Case finding.*—A diabetes survey was completed about 2 years ago. Further case finding in this direction is desirable, but is limited by lack of funds and personnel.

We cooperate with the department of social services in glaucoma testing clinics, and with other agencies in cancer and heart programs.

(*h*) *Direct services to patients.*—The nutrition branch, using funds provided by the adult health branch, advises individuals and groups (including nursing homes and hospitals) in the carrying out of routine or special diets as indicated by physicians.

In the rehabilitation programs, a certain amount of direct service is given as demonstration in nursing homes and elsewhere.

(*i*) *Program planning for personnel utilization.*—It has not been possible to secure a trained assistant chief for several years, largely because the available salary range is not attractive to workers who can obtain higher salaries elsewhere. We are still trying to find such a person; when we do he will be assigned to programs of heart and rehabilitation in the aging program, leaving more of the time of the chief available for administration and planning.

6. Local programs to which current activities are related

(*a*) *Geriatric units or clinics.*—None at present; we are studying the question of whether it is advisable to develop a well oldster clinic.

(*b*) *Rehabilitation programs.*—We cooperate with the division of vocational rehabilitation in their independent living program. The hospital and medical facilities branch will be using the new Federal funds to improve and develop rehabilitation programs in nursing and care homes.

(*c*) *Organized home care programs.*—The St. Francis Hospital is applying for a Federal project for development of home nursing in Honolulu. If this project is granted, the entire department of health will have a cooperative part in it.

(*d*) *Home nursing programs.*—In addition to the above, demonstration service and a limited amount of direct care are given by the public health nurses.

(*e*) *Case finding.*—A special study of heart disease in Hawaiians and others is being conducted by the Hawaii Heart Association, with the assistance of an officer of the public health service who is working under the direction of the chief of the adult health branch.

We cooperate with the American Cancer Society, Hawaii Division, in their program of cytologic examinations for detection of early cancer.

(*f*) *Preventive services.*—We cooperate with the Hawaii Heart Association in the program of providing penicillin at cost to patients who require this assistance in carrying out prophylaxis of rheumatic fever.

(*g*) *Homemaker services.*—The only ones now available are limited service from the department of social services.

(*h*) *Central informational services.*—Help is given as indicated by the medical staff, the nursing consultant, the health educator, and the nutritionist. Consideration is being given to establishing a program of this type in the American Cancer Society office.

7. Liaison with other organizations

(*a*) *Nature of relationships.*—The chief, assistant, and cancer control physician, serve as members of numerous committees of the Hawaii Medical Association, including the committees on chronic illness and aging, cancer, and heart. The chief and cancer control physician are the representatives of the department of health on the Hawaii Cancer Commission. The chief is a board member of the American Cancer Society, Honolulu unit, and serves as chairman of the unit service committee. The chief or assistant serves on the Rehabilitation Committee of the Oahu Health Council, of which the chief was chairman for 1 year. The nursing consultant is a member of, and works with, the Mental Health Association of Hawaii.

(*b*) *Activities of voluntary organizations.*—The voluntary health organizations concerned with programs of aging are: Blood Bank of Hawaii; American Cancer Society, Hawaii Division, and four county units; Hawaii Association to Help Retarded Children; Hawaii Heart Association; Mental Health Association of Hawaii; National Foundation; National Society for Crippled Children and Adults; Tuberculosis and Health Association of the State of Hawaii, with four county units; Oahu Health Council.

The following facts are pertinent to all:

(1) They have no programs or activities specifically geared to aging groups.

(2) While certain activities give emphasis to the aging group, all age groups receive equal treatment.

(3) Some of the agencies have indicated that programs for the aging are in their plans for the future.

(4) The majority of the programs are designed to include the aging.

(5) All of the organizations usually augment State health programs, or cosponsor programs with the State and other organizations, or support State health programs by supporting them in the legislature. This may be by providing personnel, funds, or other services.

The Senior Citizens Club and the Honolulu Council of Social Agencies also cooperate with the department of health and others.

B. PREVENTIVE SERVICES

1. Glaucoma detection clinic

This is a service of the department of social services, in cooperation with the Lions Clubs of Hawaii, with which the department of health cooperates.

2. Tuberculosis

(*a*) *Services provided.*—Case finding, diagnosis, referral to private physicians where indicated, followup. Free hospitalization is available in State-supported institutions, but this is not a function of the department of health. Case finding is by photofluorography, which is available to any adult at three centers on Oahu and by a mobile unit. Pulmonary and cardiac abnormalities are also noted.

(*b*) *Auspices.*—Tuberculosis Branch, Hawaii Department of Health, cooperating with local and State tuberculosis and health associations.

(*c*) *Financing.*—State funds for tuberculosis branch; voluntary collections by Tuberculosis Association; and limited decreasing Federal grants.

(*d*) *Program objectives.*—Early diagnosis of tuberculosis, with adequate treatment and followup, and epidemiologic investigation of sources of infection.

(e) *Personnel employed.*—Staff of the tuberculosis branch, headed by two physicians, with cooperation of the Tuberculosis and Health Association.

(f) *Eligibility.*—Open to all residents of the State.

(g) *Estimated number of persons reached annually.*—131,068 adults had chest X-rays in the X-ray survey program of the State during the calendar year 1960.

(h) *Results.*—Death rate 1930, 102; 1950, 24.4; 1960, 2.2. New case rate 1930, 289; 1950, 158.9; 1960, 77.6.

3. Diabetes

(a) *Service provided.*—Little direct service at present, but it is hoped to improve this situation. The service when given includes case finding, education, reference to private physicians, and followup.

(b) *Auspices.*—Adult Health Branch, Hawaii Department of Health.

(c) *Financing.*—Only those funds which can be spared from other programs are now available.

(d) *Program objectives.*—To locate previously undiagnosed cases of diabetes mellitus; to determine whether there are significant differences in the prevalence of diabetes among the various ethnic groups in Hawaii; to study reasons why such differences may be present; and to follow up on doubtful cases, and members of diabetes families.

(e) *Personnel employed.*—At present only the staff of the branch.

(f) *Eligibility.*—Not restricted.

(g) *Number of persons reached.*—38,000 were screened in a former survey; no current figures available.

(h) *Results.*—The previous survey yielded 2.15 percent of those screened found to have diabetes; 60 percent of these were previously undiagnosed. Rates were higher than average among patients of Hawaiian, Filipino, and Puerto Rican ancestry.

4. Cervical cytology

(a) *Service provided.*—Casefinding.

(b) *Auspices.*—Free service has been provided for the past 12 years in a laboratory sponsored by the cancer society.

(c) *Program objective.*—Determination of previously undetected cases of carcinoma, especially of the cervix uteri.

(d) *Facilities.*—Hospitals and private laboratories in the State are increasing their cytology laboratory service so that any physician or clinic will be able to obtain this diagnostic assistance.

(e) *Eligibility.*—Any physician may send a smear from any patient and receive this service on either a private or an indigent basis.

5. Diagnostic geriatric clinics and well-oldster conferences

None exists as such. We are exploring the possibility of developing a clinic of this type, but prospects are remote. The following services are available:

(a) Outpatient departments at the Queen's, St. Francis, Kauikeolani Children's, and Kapiolani Hospitals provide complete medical service to indigent and medically indigent. General and special clinics are provided.

(b) The city and county of Honolulu provides an outpatient department at Maluhia Hospital for emergency cases and for welfare patients, in addition to Maluhia's function as a chronic disease hospital.

(c) Government physicians in rural Oahu and on other islands care for indigent and medically indigent patients.

(d) Medical plans of sugar and pineapple plantations care for retired workers, providing comprehensive medical and surgical coverage.

(e) Some private business enterprises have contracts with various medical groups for preemployment and annual physical examinations, and for industrial injuries.

6. Nutrition services

(a) *Services provided.*—Monthly nutrition newsletter emphasizing diets for the elderly; pamphlet, "Fun in Food for the Senior Citizen"; consultation to the monthly senior citizens group for informal discussion; consultation to nursing homes; personal instruction on special diets on request and prescription of physicians.

(b) *Auspices.*—State department of health.

(c) *Program objectives.*—Assisting older people to plan and use adequate diets.

(*d*) *Personnel employed.*—Three full-time nutritionists of the nutrition branch give service part time, so that the equivalent of one full-time worker is available for the programs of the adult health branch.

(*e*) *Eligibility.*—Not limited.

7. Lectures and discussion groups

(*a*) Series by the YWCA on preparation for retirement.
(*b*) Classes by Red Cross on preparation for retirement.
(*c*) Talks by individual members at the adult health branch and others.
(*d*) A State conference of aging was held.

8. Required examinations

Schoolteachers, barbers, food handlers, beauticians, masseurs, and foster parents are required to have annual chest X-rays.

9. Accident prevention programs

The health department is developing an intradepartmental safety council, and has an accident prevention committee for community service. Both of these programs are still being developed.

C. HOW THE FEDERAL GOVERNMENT CAN HELP

1. There are always unmet needs in a community. The extent to which these should be met by local, State, or Federal funds is often hard to determine.

(*a*) *Rehabilitation.*—The concept of "independent living," as opposed to strict "Vocational Rehabilitation," is rightly gaining ground. A permanent governmental organization is needed to develop and extend this concept.

Further study is needed of patients who have received maximum benefit from physical rehabilitation programs and have returned to their homes. More intensive effort is needed in finding employment for handicapped persons.

(*b*) *Diabetes.*—Blindness, crippling, and death may be postponed or prevented by early diagnosis and treatment. It is certain that much diabetes remains undetected.

(*c*) *Glaucoma.*—The productive results from a few clinics make it clear that much more should be done in this field.

(*d*) *Chronic illness in general.*—The concept of "well oldster clinics" merits careful consideration.

(*e*) *Cancer and heart.*—Current level of Federal funds for these programs is adequate but present method of distribution makes maximum use difficult as explained below.

2. Costs of medical care

The Kerr-Mills Act represents an adequate means of providing assistance where it is needed, provided the States do their share.

3. Use of Federal funds

It is impossible for the State to make optimum use of Federal categoric grants under the present method of distribution, in which grant amounts are determined in September (or near that time) and funds must be spent within that fiscal year. It is suggested that:

(*a*) Appropriations made in the latter half of a calendar year be extended to the end of the following calendar year.

(*b*) More latitude be granted in use of funds, as for hospitalization for diagnosis (now limited to 3 days for cancer suspects), and payment for treatment in cases of catastrophic expense (e.g., intracardiac surgery).

(*c*) That the use of funds of cooperating agencies be permitted for matching in all categoric grants (as now in heart disease).

MENTAL HEALTH

1. Mental health needs of older persons

Because Hawaii has essentially a "young" population, community agencies other than parks and recreation and Hawaii Housing Authority have not considered the needs of the aging a problem. The proportion of aged (over 65) admitted to the State hospital is about 13 percent as against 20 percent in the other States. Our culture here, although it is slowly changing, tends to keep older people in their children's homes when parents become dependent or ill. Because of our emphasis on preventive treatment (of the young, to prevent spread or

increase of the illness), Hawaii may have neglected, somewhat, the needs of older people.

2. Resources for meeting needs

(A) State mental health programs: At the present time the Hawaii State Hospital has separate facilities for those older patients who have concomitant physical illness. However, a new convalescent unit is under construction and, when completed, the present convalescent unit will be utilized for a geriatric service. These facilities are fairly well designed for this function.

The seven clinics of the Division of Mental Health offer a variety of consultative services to the communities of the State. There has, as yet, been no programed consultation specifically in the area of problems of aging.

Several older patients have been rehabilitated and returned to the community. However, a more effective program will be implemented with the use of the above-mentioned geriatric facility.

Many older patients have been transferred from the State mental hospital to their homes and convalescent and nursing homes and to tuberculosis hospitals on their home islands. There is presently no foster home program for older people.

The Division of Mental Health has a convalescent center in Honolulu for patients conditionally discharged from the hospital. There are a variety of programs including a day hospital program in which many older persons are effectively treated. Referrals are also made to appropriate community agencies.

(B) Significant developments under other auspices: There has been no development of services to the aging as a special group.

In terms of private overall care, in the last year, a new outpatient clinic was opened at St. Francis Hospital in June 1959. Queen's has expanded its inpatient service for 19 beds to 25.

There is no veterans facility here, but veterans are hospitalized at the State hospital through contract agreements with the State government.

(C) Trends in number of older patients in hospitals for the mentally ill: More recent data is needed and evaluation of it is important because of new treatment methods, earlier case finding, growth of outpatient facilities, etc. Admissions to the Hawaii State Hospital are decreasing as well as the length of stay.

The committee agreed that the extension of OASI and the increase in amount of payment has helped many aged into boarding and nursing homes who otherwise might have had to go to the State Hospital. Many have also been able to remain with children who find it easier to keep their parents when some money is available.

(D) Provision of aftercare services: As mentioned above in II, (A) many older patients conditionally discharged to Oahu get excellent care. The referrals to community agencies such as the senior citizens' organizations carry over following discharge.

Special programs to facilitate adjustment in the community are scarce—the convalescent center available to the conditionally discharged and Lanakila crafts available for work hardening and rehabilitation. A few nursing homes have organized occupational therapy programs.

(E) Preventive services are not specifically designed for the older person. Due to staff shortages in all mental health agencies, emphasis is placed on young children and their parents. If the principles of mental health are learned early, then the onset of illness should be prevented in the older age groups.

(F) There has been recognition of the need for planning for the increase in the older age group population and all agencies are moving with specific programs.

(G) How Federal Government can help: Would like the old-age and survivors insurance law to be changed so that funds would not be cut off when patients enter tuberculosis or mental hospitals.

Mental Health Services in Hawaii

Hawaii is unique in that all public facilities and services for the mentally ill are administered by the mental health division which is part of the Hawaii State Department of Health. These facilities consist of a 1,200-bed State hospital located in rural Oahu; a convalescent center and day hospital facility located in the city of Honolulu; and seven regional mental health centers, four

of which are on the island of Oahu and one each in the neighboring county islands.

Additionally, on the island of Oahu, one private general hospital, the Queen's Hospital, has a 25-bed psychiatric inpatient unit and a part-pay outpatient clinic. There is also a very active mental health association which currently operates only on the island of Oahu.

MISSION, ORGANIZATION AND PROGRAMS OF THE MENTAL HEALTH DIVISION OF THE HAWAII STATE DEPARTMENT OF HEALTH

The Hawaii State Health Department as the State mental health authority is charged with the promotion of good mental health, the prevention of mental illness, the early detection and treatment of individuals with emotional and mental disorders, and the rehabilitation of the mentally ill. The responsibility for programs to carry out this mission are delegated to the mental health division which is one of seven line divisions of the health department.

The mental health division is organized into three branches and two staff services. The three regional mental health centers on the neighbor islands receive administrative direction from the district health office on that island but receive technical consultation from the mental health division.

1. Research and planning services

This service is headed up by the assistant to the executive officer of the mental health division (psychiatrist) and has on its staff the chief psychologist and the chief psychiatric social worker for the division, plus a research analyst and a statistical clerk. This service is responsible for the stimulation, coordination and carrying out of both basic and applied research and for the assessment of current programing and plans for the future. At the present time major effort is in the area of current program assessment which will be accomplished primarily around the development of a public health tool, the central case registry. With considerable assistance from the National Institute of Mental Health and the research, planning and statistics office of the health department, we are beginning on November 1, 1961, a trial run of the central case registry. This will become formalized on July 1, 1962. This will include reporting not only from all facilities of the mental health division, including the neighbor islands, but also from the Queen's and St. Francis Hospitals.

2. Training services

The training services is at present responsible only for the approved 3-year psychiatric residency program, financed by the National Institute of Mental Health, which utilizes facilities and staffs not only of the mental health division but also the Queen's Hospital and community psychiatrists. Future planning calls for the central coordination of the additional training programs listed below which are currently the responsibility of subordinate units of the mental health division.

A. An approved psychology internship program financed by the National Institute of Mental Health at the Hawaii State Hospital for individuals seeking the doctorate in clinical psychology.

B. A 4-month affiliation at Hawaii State Hospital for professional nurse students from the Queen's and St. Francis Hospitals and at the convalescent center for students from the University of Hawaii College of Nursing.

C. Psychiatric social work sequences at various facilities for graduate students from the University of Hawaii School of Social Work.

D. An affiliation with the Hawaii State Hospital for practical nursing students from the department of education school of nursing.

E. An internship program at the Hawaii State Hospital for occupational therapy students.

F. A practicum and fieldwork experience for University of Hawaii psychology students in counseling.

3. Services to mentally troubled people

This is the area of secondary prevention which is the early detection and amelioration of emotional problems before they become more severe or chronic. During the past 5 years an increasing emphasis has been placed upon providing training, consultation, and support to individuals and groups outside the mental health division who are in a position to directly utilize mental health principles and who need to be able to recognize possible emotional symptoms for appropriate referral. Priority of consultation is given first to other healthworkers in

the health department, such as public health nurses; to general practitioners and to pediatricians in the community; clergymen; personnel in the schools and courts; and to workers in social and welfare agencies. The division has conducted workshops and institutes to train these people and has also participated extensively in educational programs sponsored by other agencies, public and private, such as the Mental Health Association.

4. Immediate care of acutely disturbed mental patients

Present emergency and immediate care services are inadequate. On Oahu most acutely ill persons are provided service by the Honolulu City and County Emergency Service, St. Francis Hospital, or the Queen's Hospital. The Queen's Hospital is the only one of these which has psychiatric residents on call for emergencies in connection with the psychiatric training program. The convalescent center provides some emergency care for patients conditionally discharged from the Hawaii State Hospital or former patients. The four regional mental health centers also provide emergency services during the working day.

The counties of Hawaii and Maui provide 24-hour emergency coverage through its regional mental health centers and general hospitals. The island of Kauai does not yet have a resident psychiatrist so that emergencies on that county are inadequately handled. There is a request in the 1962–63 departmental budget request for a full-time resident psychiatrist for the island of Kauai.

A proposed 6-year plan requests funds for the fiscal year 1965–66 to provide mobile emergency services for Honolulu.

5. Intensive treatment of acutely ill mental patients

This group of patients requires intensive treatment from highly skilled professional mental health workers and, provided they receive adequate care, have a good chance to recover, thus preventing the development of a chronic condition.

A. *Community mental health clinics.*—The Hawaii State Health Department operates seven regional mental health centers which, in addition to community services, provide diagnostic services and treatment for children and adults. In addition, two private general hospitals in Honolulu, the Queen's Hospital and St. Francis Hospital, operate psychiatric outpatient clinics. These 9 clinics (6 on Oahu) provide services for a population of approximately 605,336 or 1 clinic for each 67,258 of population. To meet the standard of 1 clinic for each 50,000 population, Hawaii needs 3 additional clinics. Several private psychiatrists devote time on a part-pay basis to both public and one private clinic as consultants and therapists.

B. *General hospital psychiatric units.*—Hawaii provides general hospital psychiatric service for all of its population, except the county of Kauai and the small islands of Molokai and Lanai which use facilities on Maui and Oahu. On Oahu the Queen's Hospital has a 25-bed psychiatric unit and the county general hospitals on Maui and Hawaii accept psychiatric patients in the medical services. Similar services will be offered on Kauai when a full-time psychiatrist position is established for the mental health service on that island. The State provides $50,000 a year for hospitalization of the indigent and medically indigent mentally ill in these facilities, and psychiatric services are provided by the health department.

While the short-term, intensive treatment of acutely ill mental patients in regional clinics and general hospitals is a program still in its infancy in Hawaii, some of the preliminary results have been encouraging. The indications are that more than 75 percent of the patients so treated can be discharged, without need for admission to the Hawaii State Hospital. To the extent that these patients formerly would have been admitted to the Hawaii State Hospital, this represents a considerable saving to the taxpayer, both in terms of reducing treatment costs and in keeping the patient economically productive.

C. *Intensive psychiatric treatment centers.*—The Hawaii State Hospital of 1,200 beds has both an intensive treatment program for patients with major mental illness in the acute stages with a good prospect for improvement and also a section for chronic patients. This hospital has been fully accredited by the Central Inspection Board of the American Psychiatric Association and by the Joint Commission on Accreditation of Hospitals (1 of only 26 State hospitals to be accredited by the Joint Commission on Accreditation of Hospitals.) With the expansion of the chronic care program described below, the Hawaii State Hospital will gradually become an intensive psychiatric treatment center.

Approximately 70 percent of all first admissions to the Hawaiii State Hospital leave within a few months. Some may be readmitted later. This dis-

charge rate suggests that the prognosis for mental illness compares favorably with other illnesses, and like other illnesses it should have early treatment.

In keeping with the international trend to reduce the size of mental hospitals, it is planned to hold the hospital population at its present capacity of 1,200 patients. In order to do so, the hospital must increase its level of intensive treatment to bring about quicker recovery and minimize later relapses requiring readmission. The expected population increase in Hawaii makes necessary improved service at the hospital and general expansion of other nonhospital mental health services (convalescent day-care service, mental health center activities, rehabilitation, and nursing home services, etc.) if the number of patients at the hospital is to be kept constant.

D. *Day-care program.*—The 1962–63 departmental budget requests funds for a day-care program for emotionally disturbed children as a pilot study emphasizing the education aspects of the child's life. The present belief in Hawaii is that a day-care program will give better service than a residential treatment center and at less cost.

6. Care of chronic mental patients

Hawaii is pioneering in this field in a direction which may prove useful to other States. A small number (36) of very long term chronic patients have been transferred to 2 tuberculosis sanatoriums, Samuel Mahelona Hospital on Kauai, and Kula Sanatorium on Maui. These patients originally were residents of the island to which they were returned.

A new plan for hospitalization directly to the chronic care hospital located in the county in which the patient resides has been proposed to these sanatoriums In this way, certain chronic patients who do not require the intensive treatment offered by the State hospital can be hospitalized directly on their home islands without first having to be sent to Kaneohe. The vacant sections of these hospitals are being converted to the care of chronic disease, including mental illness. Considerable training and orientation of hospital staff preceded this transfer. Additional patients will be transferred to these hospitals as they are able to receive them.

In this program, which is less than a year old, the results have been encouraging. The patients have shown marked improvement in their own care and the care of fellow patients. For example, on Maui at the Kula Hospital, two of them have been discharged after more than 20 years' hospitalization; two chronic patients have also been discharged from Mahelona Hospital. On both islands, the public accepted this program and has aided in its development.

7. After-care, intermediate care, and rehabilitative services

A Convalescent Center was established in Honolulu in 1958 which provides after-care services for all patients conditionally discharged from the Hawaii State Hospital to residence on Oahu. It has a day hospital program for about 60 patients. The day hospital now accepts patients from facilities and services other than the Hawaii State Hospital and receives some self-referrals of former patients. In the 6-year plan this facility will be expanded to provide night hospital services in the fiscal year 1963–64. A day hospital program is being planned on Maui and is under discussion on Hawaii.

Oahu has a sheltered workshop for various handicapped persons including the mentally ill and retarded. The islands of Maui and Kauai also have similar multipurpose sheltered workshops.

Public health nursing services have been used extensively on the neighbor islands and a major program on Oahu is beginning. Nursing homes are used extensively, particularly on Oahu, and standards for facilities and services have been established following recommendations made by the hospital, the medical society, and the department of health. A mental health nursing consultant would greatly advance this program.

The health department is planning a family care program for various handicapped persons including the mentally ill.

8. Public education

Hawaii continues to expend a large proportion of its mental health professional time in providing mental health education to various community lay and professional groups. In this area, the division has been able to work closely with the Hawaii Mental Health Association. We feel that continuing efforts must be made to help people understand and accept mental illness. The success of mental health programs depends on public support and a mental patient's re-

covery is dependent upon community acceptance of him. Also, it is believed that the learning and application of good mental health principles while a person is young will go far in preventing mental disturbance in himself or his children in the future. An adequate number of trained health educators in the department of health will aid considerably in the program.

MORE EFFECTIVE UTILIZATION OF COMMUNITY TREATMENT RESOURCES

The Hawaii State Health Department believes strongly that a major responsibility of a public health program is to provide leadership and assistance to the existing community agencies to improve, expand, or to develop new treatment programs. This may need to include financial assistance where appropriate. As an example, discussions have already been held with the administrators of the Queen's and St. Francis Hospitals to explore the possibilities for expanding the Queen's unit and at developing a 40-bed psychiatric inpatient unit at St. Francis Hospital by 1967 or 1968.

Other gaps in our services to the mentally ill, such as ex-patients' clubs and a halfway house, can be established by such community agencies as the mental health association. This has been done in other States and in some the State's mental health authority has taken over operation after they had been well established.

We urge that you study the statement submitted by Dr. Robert Felix, Director of the National Institute of Mental Health, which was included for consideration by the policy committee. We strongly concur with the concepts emphasized by him, particularly as they apply to Hawaii's integrated program in mental health.

Submitted to:

RICHARD K. C. LEE, M.D., D.P.H.,
Director of Health.

RESOLUTION ADOPTED BY SPECIAL GOVERNORS' CONFERENCE ON MENTAL HEALTH, NOVEMBER 10, 1961

Whereas medical and social scientists find that patients suffering from mental disease and tuberculosis need to be near their families and home communities while undergoing treatment and rehabilitation for these disorders; and

Whereas community care for these patients depends in many instances on adequate public assistance benefits; and

Whereas expensive and inappropriate public institutional care for these patients may be prevented or terminated by provision of such social security benefits; and

Whereas the Social Security Act in its present form specifically precludes patients in public and private institutions for mental disease or tuberculosis as well as patients in community nursing and foster homes from receiving Federal public assistance; and

Whereas the Senate Advisory Committee on Public Assistance recommended a review and study of this subject (S. Doc. 93, January 1960): Now therefore, be it

Resolved by the Governors' Conference on Mental Health, meeting in Chicago, Ill., November 10, 1961. That concern be expressed over the lack of Federal participation in public assistance programs that would facilitate early, less expensive, and more humane forms of community care for mental disease and tuberculosis, and implications of these public assistance exclusions to determine what basis may exist for considering further amendments to the Social Security Act on behalf of these patients.

MENTAL HEALTH

I. MENTAL HEALTH NEEDS OF OLDER PERSONS

Because Hawaii has essentially a young population, community agencies other than the City and County of Honolulu Parks and Recreation Department, and the Hawaii Housing Authority have only recently initiated programs for the aging. The proportion of aged (over 65) admitted to the Hawaii State Hospital is about 13 percent compared to 20 percent in the other State. Our culture here, although it is slowly changing, tends to keep older people in their children's

home when the older people become dependent or ill. Therefore, emphasis has been on the preventive treatment of the young to prevent spread or increase of mental illness.

II. RESOURCES FOR MEETING NEEDS

A. State mental health programs

The seven regional mental health clinics of the mental health division, department of health, offer a variety of consultative services to the communities of the State, including consultation specifically in the area of problems of the aging.

At the present time the Hawaii State Hospital has separate facilities for those older patients who have concomitant physical illness. However, a new convalescent unit is under construction and when completed, the present convalescent unit will be utilized for a geriatric service. These facilities are fairly well designed for this function.

Several older patients have been rehabilitated and returned to the community. However, a more effective program will be implemented with the use of the above geriatric facility.

Many older patients have been transferred from the Hawaii State Hospital to their homes and convalescent and nursing homes and to tuberculosis hospitals on their home islands. There is presently under discussion a foster home program for older people.

The mental health division has a convalescent center in Honolulu for patients conditionally discharged from the hospital. There is a variety of programs, including a day hospital program, in which many older persons are effectively treated. Referrals are also made to and by appropriate community agencies.

B. Significant developments under other auspices

A new outpatient mental health clinic was opened at St. Francis Hospital in June 1959. The Queen's Hospital has expanded its inpatient psychiatric service from 19 to 25 beds.

Veterans receive short-term care only at Tripler Army Hospital but are hospitalized at the Hawaii State Hospital through contract agreement with the Federal Government.

C. Trends in number of older patients in hospitals for the mentally ill

More recent data is needed and evaluation of it is important because of new treatment methods, earlier case finding, growth of outpatient facilities, etc. Admissions to the Hawaii State Hospital of older persons are gradually increasing.

The Mental Health Association of Hawaii, Committee on Aging, agreed that the extension of OASI and the increase in amount of payment has helped many aged persons move into boarding and nursing homes who otherwise might have had to go to State hospitals. Many have also been able to remain with children who find it easier to keep their parents when some money is available.

D. Provision of aftercare services

As mentioned in above II, A, many older patients conditionally discharged from the Hawaii State Hospital get adequate care. The referrals to community agencies such as the senior citizens' organizations carry over following discharge.

The convalescent center is available to the conditionally discharged and Lanakila Crafts is available for work hardening and rehabilitation. A few nursing homes have organized occupational therapy programs. Additional special programs to facilitate adjustment in the community are needed.

III. PLANNING

There has been recognition of the need for coordinated planning for the increase in the older age group population and most agencies are moving with specific programs.

IV. HOW FEDERAL GOVERNMENT CAN HELP

Study the possibility of amending the Social Security Act which now precludes patients in public and private institutions for mental disease and tuberculosis as well as patients in community nursing and foster homes from receiving Federal public assistance. The Senate Advisory Committee on Public Assistance recommended a review and study of this subject (S. Doc. 93, January 1960).

HAWAII DEPARTMENT OF PUBLIC WELFARE STAFF MANUAL

Part IV Public Assistance Programs
Standards of Assistance 4300 - 4310

4300 STANDARDS OF ASSISTANCE

The Public Welfare Board establishes the standards governing the amount of assistance for all programs. The following sections have been approved by the Public Welfare Board.

4310 DETERMINING THE AMOUNT OF ASSISTANCE PAYMENT

An individual or family is eligible for an assistance payment equal to the difference between monthly requirements and monthly resources. To arrive at this:

1. Compute the cost of the total family or individual requirements according to prescribed standards.
2. Compute the cash value of all resources readily available to meet these requirements.
3. Subtract the cash value of the resources from the cash cost of the requirements.
4. Plan payments so that maximum federal matching will be secured.

A. Basic individual requirements always needed by all people for which a standard cost figure has been determined are:

1. Food
2. Clothing
3. Utilities
4. Household Supplies
5. Personal Essentials

B. Basic requirements for which a standard cost figure has not been determined is: shelter.

C. Requirements sometimes needed by some people because of their individual circumstances are:

1. Special food requirements
2. Transportation of individual and household furnishings
3. Education and school supplies
4. Household equipment
5. Laundry

HAWAII DEPARTMENT OF PUBLIC WELFARE STAFF MANUAL

Part IV — Public Assistance Programs — Standards of Assistance — 4310 - 4321

4310 DETERMINING THE AMOUNT OF ASSISTANCE PAYMENT - cont'd

6. Insurance
7. Telephone
8. General hospital care
9. Housekeeper service
10. Convalescent, nursing, or boarding home care
11. Fees and other costs

D. In cases of proven hardship, county administrator's approval may be given for requirements not listed or described in the Department's standards.

E. When an individual's age places him in the next age bracket of Individual Basic Requirements Schedules, his allowance shall be adjusted at the time of the Eligibility Review nearest to his birthdate.

4320 BASIC FOOD REQUIREMENTS (10/1/58)

The following food allowance, unless modified by special need, shall be provided in each financial plan. This allowance is the minimum which will purchase food needed to maintain health, based on June 1958 prices.

4321

MONTHLY FOOD ALLOWANCE
AT JUNE 1958 PRICES

Family Composition	Less Than 4 Years	4 - 7	8 - 12	13 - 19		20 and Over
				Boy	Girl	
Individual living alone	$18.75	$25.25	$32.50	$42.25	$34.00	$34.75
2-member family	16.50	22.50	28.75	37.25	30.25	31.00
3-member family	15.00	20.25	26.50	34.00	28.00	28.25
4-member family	13.75	18.75	24.00	31.25	25.25	25.75

HAWAII DEPARTMENT OF PUBLIC WELFARE STAFF MANUAL

Part IV — Public Assistance Programs — Standards of Assistance — 4322 - 4322.1

4322 SPECIAL FOOD REQUIREMENTS

4322.1 Restaurant Food Allowance

Restaurant food allowance may be allowed for recipients who are unable to cook for themselves because of any of the following reasons:

1. Physical handicap
2. Inability to handle cash or a food purchase order.
3. No cooking facilities, providing cost of shelter and utilities does not exceed $20

The full restaurant allowance shall be allowed if two or more meals per day are eaten in restaurants.

RESTAURANT FOOD ALLOWANCE
AT JUNE, 1958 PRICES

	Children Under 12			Persons 12 and Over		
	Daily	Weekly	Monthly	Daily	Weekly	Monthly
Breakfast	$ .30	$ 2.00	$ 8.75	$ .40	$ 2.75	$12.00
Lunch	.50	3.50	15.00	.60	4.50	19.00
Dinner	.65	4.75	19.25	.90	6.25	26.25
Total	$1.45	$10.25	$43.00	$1.90	$13.50	$57.25

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Part IV — Public Assistance Programs — Standards of Assistance — 4322.2 - 4322.4

4322.2 Restaurant Food Allowance - Special Diet

Use the table for Restaurant Food Allowance - Section 4322.1 and add cost of any extra items recommended by the physician.

4322.3 Employment Diet

The following shall be allowed the employed individual if he eats lunch at a restaurant:

MONTHLY FOOD ALLOWANCE FOR EMPLOYED PERSONS
AT JUNE, 1958 PRICES

Family Composition	16-20 Years		Over 20 Years	
	Boy	Girl	Man	Woman
Living alone	$47.25	$41.75	$48.75	$43.00
2-member	44.00	39.27	45.50	40.50
3-member	41.75	37.75	43.25	38.50
4-member	40.00	36.00	41.00	36.75

4322.4 Pregnancy Diet

As soon as pregnancy is diagnosed by a physician, $8.50, in addition to the regular monthly food allowance, shall be allowed for the pregnant mother. This allowance shall be discontinued when the child is born. Refer to Appendix B Food page 11 for items and quantities.

4322.5 Tuberculosis Diets

a. Pulmonary: All individuals diagnosed by a physician as having active pulmonary tuberculosis shall be allowed $8.50, in addition to the regular monthly food allowance. Persons with arrested or inactive tuberculosis shall be allowed $8.50, in addition to the regular monthly food allowance, for one year following hospital discharge. Refer to Appendix B Food page 8 for items and quantities.

The special diet for pulmonary TB patients shall be allowed for more than a year following hospital discharge only on the basis of a physician's written recommendation or official clinic or hospital statement.

b. Other TB: Individual with other kinds of tuberculosis who may need a tuberculosis diet shall also be allowed the extra $8.50 only on the basis of a physician's written recommendation for the length of time necessary.

c. TB Contacts:

Definition: A TB contact is an individual who has a positive Mantoux reaction or who has had prolonged or intimate exposure to an active TB case within a two-year period preceding discovery of the active case.

Only the following contacts shall be given the tuberculosis diet allowance:

(1) Children under 20 years of age who have a positive Mantoux regardless of when the TB patient leaves home or his condition becomes inactive.

(2) All individuals living with an active pulmonary TB patient--until the TB patient leaves home or becomes an inactive case.

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4322.6 All other Diets

On the basis of a physician's written recommendation, the following amounts shall be allowed to individuals, regardless of age and size of family. Refer to Appendix B - Food - pages 9 - 12 for items and quantities.

SPECIAL DIET ALLOWANCES
AT JUNE, 1958 PRICES

Name of Diet	Specifications	Cost Per Month
Diabetic Diet A	Protein 70, Fat 60, Carbohydrate 120	$26.00
Diabetic Diet B	Protein 70, Fat 70, Carbohydrate 150	27.75
Diabetic Diet C	Protein 70, Fat 90, Carbohydrate 180	29.50
Diabetic Diet D	Protein 90, Fat 100, Carbohydrate 250	33.25
800 Calories		14.50
1000 Calories		19.25
1200 Calories		20.50
1500 Calories		23.50
Low Fat, High Protein High Carbohydrate		38.50
Low Residue		34.75
Meulengracht Diet, Modified		31.00

A person convalescing after a severe illness or a malnourished individual shall be allowed the same amount as that for an individual living alone providing the physician makes a written recommendation.

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4323 Household Supplies 12/1/58

The following monthly allowances for household supplies shall be provided in each financial plan, except for residents in institutions or boarding homes where regular monthly rates are paid.

STANDARD MONTHLY ALLOWANCES FOR HOUSEHOLD SUPPLIES

Family Composition	Less than 4 years	4-7	8-12	13-19	20 & Over
Individual living alone	2.25	2.25	2.25	2.25	2.25
2-member family	1.50	1.50	1.50	1.50	1.50
3-member family	1.25	1.25	1.25	1.25	1.25
4 or more members*	1.00	1.00	1.00	1.00	1.00

*A maximum of $8 is allowed for families of 8 or more.

4324 Utilities

4324.1 Allowance for the cost of utilities when paid by the recipient shall be made in accordance with the Standard Monthly Utilities Schedule.

The allowance shall be figured by:

1. Determining the kind of utilities in use.
2. The purpose or purposes for which the utility is used.
3. Identifying the cost of each utility according to the purpose, size of family, and geographical location.
4. Totaling the costs identified.

Exception to the above policy shall be made in cases in which the combination of utilities used by families is such that the standard cannot be applied. In these cases, payment shall be made on an as-paid basis.

If two recipient families are residing together, the total number of individuals living in the household shall be used to determine the cost of utilities. The allowance may be prorated between the families or charged to one recipient family, providing that maximum Federal matching is secured. If a recipient family is residing with a non-needy family, the cost of utilities as charged by the non-needy family may be allowed, providing it is not more than the maximum allowed according to the standards schedule.

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STANDARD MONTHLY UTILITIES SCHEDULE

HONOLULU COUNTY

ELECTRICITY
Hawaiian Electric Company

	Number of Persons				
	1	2	3-4	5-6-7	8 or More
Lighting	$1.40	$2.10	$2.30	$2.80	$3.20
Light and Refrigeration	1.85	3.00	3.85	4.55	5.00
Light, Refrigeration, and Cooking	3.85	5.40	6.75	7.40	7.90
Water Heater*	4.00	4.10	4.45	5.05	5.80

GAS
Honolulu Gas Company

	Number of Persons				
	1	2	3-4	5-6-7	8 or More
Cooking	$2.15	$2.65	$3.05	$3.45	$3.85
Water Heater*	1.00	1.75	2.45	2.85	3.25

WATER
Honolulu Board of Water Supply

	Number of Persons				
	1	2	3-4	5-6-7	8 or More
	$1.90	$2.80	$3.70	$4.30	$5.20
Suburban Water System	1.90	2.75	3.60	4.20	5.05

KEROSENE

	Number of Persons				
	1	2	3-4	5-6-7	8 or More
Cooking, water heating	$1.40	$1.95	$2.80	$3.65	$4.20
Light, cooking, water heating	1.70	2.25	3.10	4.20	4.75

*If water heater is used, add amount shown under water heater to the total of all other allowance for utilities.

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STANDARD MONTHLY UTILITIES SCHEDULE

HAWAII COUNTY

ELECTRICITY

Hilo Electric Light Company

	Number of Persons				
	1	2	3-4	5-6-7	8 or More
Lighting	$1.50	$2.10	$2.45	$3.15	$3.75
Light and Refrigeration	1.75	3.50	4.75	5.75	6.50
Light, Refrigeration and Cooking	4.75	7.25	9.50	10.50	11.50
Water Heater*	6.75	6.75	6.10	6.25	6.40

Kona Light and Power Company

	Number of Persons				
	1	2	3-4	5-6-7	8 or More
Lighting	$1.95	$3.70	$4.15	$5.05	$5.95
Lighting and Refrigeration	3.25	5.50	7.75	8.95	9.85
Light, Refrigeration and Cooking	7.75	10.75	13.25	14.25	15.25
Water Heater*	7.50	8.50	10.00	12.00	14.00

GAS

Honolulu Gas Company - Hilo Gas Division

	Number of Persons				
	1	2	3-4	5-6-7	8 or More
Cooking	$2.15	$2.90	$3.50	$4.10	$4.70
Water Heater*	1.55	2.60	3.60	4.20	4.80

WATER

Hawaii Board of Water Supply

	Number of Persons				
Rates apply to:	1	2	3-4	5-6-7	8 or More
Hilo proper, Paukaa-Honolii, South Kohala, and North Kohala	$1.85	$2.70	$3.50	$4.10	$4.90

*If water heater is used, add amount shown under water heater to the total of all other allowance for utilities.

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STANDARD MONTHLY UTILITIES SCHEDULE

HAWAII COUNTY - Cont'd.

WATER

Hawaii Board of Water Supply

Rates apply to:	Number of Persons				
	1	2	3-4	5-6-7	8 or More
Papaikou, Pepeekeo, Honomu, North Hilo, and Kau	$1.70	$2.45	$3.15	$3.65	$4.35

Rates apply to:	Number of Persons				
	1	2	3-4	5-6-7	8 or More
Olaa - Mt. View	$2.40	$3.30	$4.20	$4.80	$5.70

Rates apply to:	Number of Persons				
	1	2	3-4	5-6-7	8 or More
Honokaa	$2.55	$3.60	$4.65	$5.35	$6.40

Rates apply to:	Number of Persons				
	1	2	3-4	5-6-7	8 or More
North Kona	$3.50	$5.00	$6.50	$7.50	$9.00

KEROSENE

	Number of Persons				
	1	2	3-4	5-6-7	8 or More
Cooking, water heating	$1.40	$1.95	$2.80	$3.65	$4.20
Light, cooking, water heating	1.70	2.25	3.10	4.20	4.75

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STANDARD MONTHLY UTILITIES SCHEDULE

KAUAI COUNTY

ELECTRICITY

Kauai Electric Company

	Number of Persons				
	1	2	3-4	5-6-7	8 or More
Lighting	$1.20	$2.25	$2.50	$3.00	$3.50
Lighting and Refrigeration	2.00	3.25	4.50	5.50	6.05
Light, Refrigeration and Cooking	4.50	6.50	8.00	8.75	9.50
Water Heater*	5.00	6.00	7.50	9.00	10.50

Waiahi Electric Company

	Number of Persons				
	1	2	3-4	5-6-7	8 or More
Lighting	$1.20	$2.25	$2.50	$3.00	$3.50
Lighting and Refrigeration	2.00	3.25	4.50	5.50	6.05
Light, Refrigeration and Cooking	4.50	6.50	8.00	8.75	9.50
Water Heater*	5.00	6.00	7.50	9.00	10.50

WATER

Kauai County Water Works Board

Number of Persons				
1	2	3-4	5-6-7	8 or More
$1.55	$2.10	$2.62	$3.00	$3.50

KEROSENE

	Number of Persons				
	1	2	3-4	5-6-7	8 or More
Cooking, water heating	$1.40	$1.95	$2.80	$3.65	$4.20
Light, cooking, water heating	1.70	2.25	3.10	4.20	4.75

*If water heater is used, add amount shown under water heater to the total of all other allowances for utilities.

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STANDARD MONTHLY UTILITIES SCHEDULE

MAUI COUNTY

ELECTRICITY

Maui Electric Company

	Number of Persons				
	1	2	3-4	5-6-7	8 or More
Lighting	$1.55	$2.55	$2.75	$3.10	$3.50
Lighting and Refrigeration	2.20	3.30	4.20	4.95	5.40
Light, Refrigeration and Cooking	4.20	5.80	7.15	7.85	8.35
Water Heater*	4.15	4.65	5.40	6.30	7.35

Maui Electric Company, Lanai Division

	Number of Persons				
	1	2	3-4	5-6-7	8 or More
Lighting	$1.55	$2.60	$2.80	$3.20	$3.60
Lighting and Refrigeration	2.25	3.40	4.40	5.15	5.65
Light, Refrigeration and Cooking	4.40	6.10	7.55	8.30	8.85
Water Heater*	4.45	5.10	6.00	7.00	8.15

Lahaina Light and Power Company

	Number of Persons				
	1	2	3-4	5-6-7	8 or More
Lighting	$1.05	$1.80	$1.95	$2.35	$2.75
Lighting and Refrigeration	1.60	2.55	3.50	4.10	4.50
Light, Refrigeration and Cooking	3.50	4.95	6.10	6.55	7.00
Water Heater*	3.50	3.85	4.50	5.40	6.30

Maui Ranch Company

	Number of Persons				
	1	2	3-4	5-6-7	8 or More
Lighting	$1.90	$3.20	$3.50	$4.20	$4.85
Lighting and Refrigeration	2.40	4.50	6.10	7.40	8.25
Light, Refrigeration and Cooking	6.10	9.00	11.50	12.75	13.50
Water Heater*	7.40	7.50	8.00	9.00	10.50

*If water heater is used, add amount shown under water heater to the total of all other allowance for utilities.

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STANDARD MONTHLY UTILITIES SCHEDULE

MAUI COUNTY - Cont'd

ELECTRICITY - cont'd.
Molokai Electric Company

	Number of Persons				
	1	2	3-4	5-6-7	8 or More
Lighting	$1.65	$3.05	$3.35	$3.95	$4.55
Light and Refrigeration	2.75	4.25	5.75	6.95	7.45
Light, Refrigeration and Cooking	5.75	7.75	8.75	9.25	9.75
Water Heater*	4.00	4.00	5.00	6.00	7.00

WATER
Maui County Water Works Board

	Number of Persons				
	1	2	3-4	5-6-7	8 or More
	$1.75	$2.50	$3.25	$3.75	$4.50

KEROSENE

	Number of Persons				
	1	2	3-4	5-6-7	8 or More
Cooking, water heating	$1.40	$1.95	$2.80	$3.65	$4.20
Light, cooking, water heating	1.70	2.25	3.10	4.20	4.75

*If water heater is used, add amount shown under water heater to the total of all other allowances for utilities.

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4325 Shelter

Shelter is a basic requirement which shall be included in all financial plans.

4325.1 Rent

1. Actual rent, excluding utilities shall be allowed for furnished or unfurnished units, not to exceed the amounts in the following tables:

Hawaii, Kauai & Maui		Honolulu	
Rental	Size of Family	Rental	Size of Family
$50.00	6 or less	$50.00	1 person
52.50	7	65.00	2 - 4
55.50	8 or more	70.00	5 & 6
		75.00	7 or more

Suitable shelter shall be secured at the lowest rental available.

2. Rents in Hawaii Housing projects shall be allowed according to the established rates.

4325.11 Rentals Above the Maximums Allowed (Special Circumstances)

Rentals, as paid, may be allowed for a period of three months to enable the recipient to locate housing within the maximum. Evidence must be provided to prove the attempts of the individual to locate cheaper quarters. The County Administrator may approve payment for more than three months on a month-to-month basis if the failure to secure quarters is due to lack of available housing in the community.

4325.12 Hotel Accommodations

Hotel accommodations may be provided for:

1. Recipients as an emergency plan only with the approval of the supervisor.

2. Single individuals on a regular plan, providing the cost of shelter and utilities does not exceed $20.00.

4325.13 Sharing of Living Quarters

a. Recipient Family with Non-needy Family: The rent allowed shall be the rent agreed upon prior to the date of application for public assistance, provided the charge to the recipient does not exceed the maximum allowed in the table of rental

4325.13 Sharing of Living Quarters - cont'd

schedules, Section 4325.1. In the absence of a previous agreement, the rent cost to the recipient shall be figured by prorating the rental according to the number of people in each family or by dividing the rental equally between the two families.

b. Two Recipient Families: The maximum rental allowed shall be determined by the total number of persons occupying the home.

Rental may be budgeted for one or both families, depending on the plan made by them for payment of the rental.

c. ADC Children with Non-needy Relatives: Rental costs may be allowed if either or both of the following situations occur:

1. The cost of rent incurred by the relatives increases because of the presence of the children in the home, or net income is lost because the space occupied by the children would otherwise be rented.

2. The relatives are not legally responsible for support of the children and are unable or unwilling to contribute shelter.

4325.14 Home Ownership Costs

Shelter costs for home ownership shall be included in the financial plan in lieu of rental payments. These shelter costs may include:

1. Taxes, including special tax assessments when they cannot be deferred. (Taxes will not be recognized as a requirement unless home exemption has been claimed.)

2. Necessary and reasonable repairs.

3. Fire insurance.

4. Payments on a home or farm home loan including interest payments and payments on the principal (adjusted to the lowest possible rate).

The total monthly shelter cost figure shall be determined by prorating all costs over a twelve months' period and shall not exceed the maximum for rentals. If such prorated costs equal or exceed $5 per month, they shall be included in the regular monthly cash payment. If they are less than $5 per month, they may be allowed in lump sum as due.

4325.14 Home Ownership Costs - cont'd

Home Ownership Costs in Excess of Maximum: It shall be the responsibility of the applicant to attempt to secure a payment rate within the maximum allowed within thirty days after date of application. If an adjustment cannot be made, the County Administrator may approve payment over the maximum for six months. During this time, the applicant shall continue to make efforts to adjust the payment or to sell his equity and reinvest in home property on which monthly payments will be within the maximum allowed.

Pending Sale of Property: If the applicant is planning sale of his property, payment should be adjusted to the lowest possible rate or to cover interest charges only, when such plan is acceptable to the mortgagor.

4325.2 Room-and-Board Arrangements

a. ADC Children with Non-needy Relatives: Room and board may be provided at the existing foster board rates if the relatives who are not legally responsible agree to have the children only on a board rate basis.

If non-needy relative payee becomes needy, the child's board payment shall be discontinued and his needs met as part of a needy family group.

b. Child with Needy Foster Parents. If foster parents become needy the child's board payment shall continue and shall not be considered a resource in determining foster parents' needs.

c. Adult Recipient with Non-legally Responsible Relatives: Room and board shall be allowed on an as-paid basis to a maximum of $60.00 monthly:

1. If such care is necessary to the health and welfare of the recipient.

2. If no other living arrangements are suitable to his needs.

4326 Convalescent or Nursing Home Care

Payment for care in a convalescent or nursing home may be allowed as paid if the care is prescribed by a practicing physician. The physician's statement shall include:

1. The diagnosis

2. Prognosis

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4326 Convalescent or Nursing Home Care - cont'd

3. The reason why special care is needed.

4. The probable length of time it will be needed.

The worker shall reevaluate the need of the patient for convalescent or nursing home care at such intervals as indicated by the physician's report, or at least once a year.

4327 Education and School Supplies

4327.1 Children Regularly Attending School

The monthly cost of school supplies shall be provided as shown in the following schedule:

Children 4 - 12 years	25¢
Children 13 - 19 years	50¢

4327.2 Vocational Education or Training

Expenditure necessary to secure vocational education or training may be allowed if additional training will result in higher earning power for the individual. Supervisor's approval is necessary to include this item as a special requirement.

4328 Household Equipment

Supervisor's approval is needed for the purchase of initial equipment or for repair or replacement of equipment necessary for household operation.

4329 Transportation of Household Goods

Moving expenses may be provided for transportation of household goods, with Supervisor's approval.

4330 Personal Essentials 12/1/58

The following allowances for personal essentials shall be provided in each financial plan:

STANDARD MONTHLY ALLOWANCES FOR PERSONAL ESSENTIALS

Less than 4 years	4 - 7	8 - 12	13 - 19		20 & Over
			Boys	Girls	
.75	1.25	1.25	2.25	2.00	2.00

NURSING HOME CARE Section 4326

POLICY	*PROCEDURE*
Nursing Home Care	
1. Payment for care prescribed by a physician in a nursing home may be allowed at the going rate, provided that the cost of the care required by the recipient shall be the lowest available. Exceptions to the minimum cost may be allowed with county division administrator's approval in order to avoid undue hardship and/or isolation.	To determine a "nursing home," use the definition contained in Chapter 12A, 'Convalescent or Nursing Homes," Department of Health's Public Health Regulations. See copy on file at CDA's office.
2. The need for nursing home care shall be determined by a licensed physician.	The physician's statement shall include: a. Diagnosis; b. Prognosis; c. Type of nursing care required; d. Reason why nursing care is needed; e. Probable length of time care will be needed; and f. Intervals when need should be reviewed.
3. A review of the patient's need for nursing care is required at the following times: a. At such intervals as indicated on the physician's statement, or b. At least once a year.	The social worker shall review with the physician: a. The patient's need for nursing care. b. Type of nursing care required. c. Any questions regarding where such care can be obtained.

POLICY	PROCEDURE

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Part IV — Public Assistance Programs — Standards of Assistance — 4330.1 - 4332.1

4330.1 Modifications for Special Needs

4330.11 Laundry

The cost of laundry may be provided in the regular assistance payment for a recipient who is:

1. Unable to do his own laundry because of illness, infirmity, or other handicap.

2. Living in quarters without adequate facilities for laundering and it is not practical to move to other quarters solely to provide laundering facilities.

An amount not to exceed $3 per month may be allowed. Unusual circumstances that require service costing in excess of $3 may be allowed with supervisor's approval.

4330.12 Public Baths

If there are no bathing facilities in the home and the family is using public baths, $1.40 per person per month shall be allowed.

4330.13 Supplies for Infant

Supplies for the care of an infant up to a $7 maximum cost shown may be provided according to the list in Appendix B.

4331 Clothing

4331.1 The clothing items listed in the Clothing Replacement Standards may be allowed as needed in the quantity and up to the costs listed in the guide. Supervisor's approval is required when:

1. Amount per individual totals $25.00 or more within a year.

2. When amount per case totals $100.00 or more a year.

4332 Transportation (Special Circumstances)

4332.1 Actual costs within a maximum of $10 monthly per individual may be allowed to cover the expense of the use of commercial facilities or privately owned automobiles, motorcycles, or motor scooters to cover:

1. Visits to clinics for diagnosis or treatment.

2. Visits to hospitals to visit immediate family members.

3. Attendance at rehabilitation projects or training classes.

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CLOTHING REPLACEMENT STANDARDS

	Stock	Annual Replacement	Cost
	(If a person has amount of clothing listed here; no replacement can be allowed)	*(Items indicated by the fraction ½ can be replaced only once in 2 years)*	*(Max. Amt. of money DPW will allow for each item)*
Infant, 0 - 1 Year			
Diapers	4 doz.	0	$3.23 per doz.
Shirts	4	0	.38
Nities	4	0	.94
Pre-school Child, 1 - 4 Years			
Raincoat	1	½	2.53
Sweater	1	½	3.50
Dress or shirt and pants	1	1	3.06
Underwear	6	1	.54
Pajamas	3	1	1.63
Shoes	1	1	3.65
Anklets	6	1	.82
Slippers	1	1	1.26
Shirts and trousers	4	1	1.85
Boys, 4 - 12 Years			
Raincoat	1	½	2.76
Jacket	1	½	3.77
Trousers (khaki, gabardine)	3	1	3.08
Shorts	3	1	.75
Pajamas	2	1	2.37
Shoes	1	1	3.42
Socks	4	1	.33
Belt	1	1	.75
Handkerchief	6	1	.18
Dress shirt (aloha)	1	1	1.95
Sport shirt	4	1	1.71
Slippers	1	1	1.23
Girls, 4 - 12 Years			
Raincoat	1	½	2.53
Jacket	1	½	4.04
Dress	2	1	2.62
Skirt	2	1	3.27
Blouse	2	1	1.89
Brassieres	2	1	.88
Panties	6	1	.34
Slips	2	1	.96
Pajamas	2	1	2.15
Anklets	2	1	.34
Shoes	1	1	3.42
Slippers	1	1	1.23

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CLOTHING REPLACEMENT STANDARDS

	Stock	Annual Replacement	Cost
	(If a person has amount of clothing listed here, no replacement can be allowed)	*(Items indicated by the fraction ½ can be replaced only once in 2 years)*	*(Max. Amt. of money DPW will allow for each item)*
Boys, 13 - 20 Years			
Raincoat	1	½	$2.94
Jacket	1	½	5.02
Trousers (khaki, gabardine)	3	1	3.64
Shorts	4	1	.66
Pajamas	2	1	3.06
Shoes	1	1	6.43
Socks	4	1	.40
Belt	1	½	.96
Handkerchief	6	1	.18
Dress shirt (aloha)	1	1	2.68
Sport shirt	4	1	2.29
Slippers	1	1	1.80
Underwear - shirts	2	1	.68
Girls, 13 - 20 Years			
Raincoat	1	½	2.55
Jacket	1	½	4.77
Dress	3	1	3.79
Skirt	2	1	3.87
Blouse	3	1	1.98
Brassiere	3	1	.95
Panties	4	1	.53
Slip	2	1	1.77
Pajamas	2	1	3.09
Anklets	4	1	.36
Shoes	2	1	4.53
Slippers	1	1	1.53
Stockings	2	1	1.10
Jeans	1	1	3.62
Men			
Raincoat	1	½	3.35
Jacket	1	½	6.30
Trousers, wool	1	1	9.77
Work trousers, dung	3	1	3.42
Dress shirt (aloha)	2	1	3.20
Work shirt	4	1	1.68
Underwear, shorts	3	1	.77
Underwear, shirt	3	1	.68
Shoes	1	1	6.88
Handkerchief	6	1	.20
Socks	4	1	.38
Suspenders or belt	1	½	1.07
Slippers	1	1	1.80
Pajamas, cotton	2	1½	3.41

Section 4381.11
Hawaii DPW Staff Manual

December 1 , 1955

CLOTHING REPLACEMENT STANDARDS

	Stock	Annual Replacement	Cost
	(If a person has amount of clothing listed here, no replacement can be allowed)	*(Items indicated by the fraction ½ can be replaced only once in 2 years)*	*(Max. Amt. of money DPW will allow for each item)*
Women			
Raincoat	1	½	$2.63
Sweater	1	½	4.34
Street dress	2	1	5.78
House dress	3	1	3.18
Slips	2	1	2.14
Panties	4	1	.54
Brassieres	3	1	1.00
Girdle/garter belt	1	½	1.89
Nightgown	2	1	2.52
Shoes	1	1	4.37
Slippers	1	1	1.68

HAWAII DEPARTMENT OF PUBLIC WELFARE STAFF MANUAL

Part IV	Public Assistance Programs	4332.1 - 4332.14
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4332.1 Transportation - Cont'd.

4. Essential marketing if the recipient lives in an area in which markets are not within walking distance.

Allowances to cover the cost of commercially operated transportation shall be for the cheapest facility available. Taxi fare may be provided for individuals upon medical recommendation that they are too handicapped to board a bus.

Special needs that may require allowances over the maximum or which are not included in this list may be included in the payment plan after supervisor's approval is secured.

4332.12 School Children

The actual cost of school transportation shall be provided for children who are attending public or private schools with the following exceptions:

No transportation shall be allowed for children:

1. Who live within a reasonable walking distance of school.

2. Who live in areas served by free school buses.

3. Who are eligible for transportation from the Bureau of Crippled Children or the Health Education Division of the Department of Public Instruction.

The item for school transportation shall be removed from the financial plan during the summer months if the total monthly amount budgeted for the family is more than $2.50, regardless of the number of children in the family.

4332.13 Employed and Employable Persons

Actual cost may be allowed for transportation for:

1. Regularly employed persons.

2. Temporary Labor Force workers.

3. The initial registration at Bureau of Employment Security and such other interviews as the Bureau may request.

4. Registration at the Unemployment Insurance Division, Department of Labor, to meet the requirements for benefit payments.

4332.14 Transportation - Out of County

The actual cost of transportation at minimum rates may be allowed with special approval:

1. For recipients to move between islands.

2. For recipients to be returned to their place of residence.

4332.14 Transportation - Out of County - Cont'd.

Minimum cost may include:

1. Expenses of shipping essential household goods and personal belongings.

2. Expenses of a non-needy person if he is required as a guardian or escort for a recipient:

   a. Who is a minor.

   b. Who is so physically or mentally disabled that he is unable to travel alone.

3. Cost of minimum subsistence and shelter enroute if these are necessary to the journey.

Out-of-county transportation includes transportation between the counties, from the Territory to other jurisdictions of the U S. and its territories, and from the Territory to foreign countries.

Transportation shall not be allowed unless the recipient's plan to travel is approved by the County Administrator and his return is authorized by the jurisdiction to which he is travelling.

4333 Telephone

4333.1 Payment for telephone may be included as a requirement at minimum party-line cost (see Appendix B) if an individual or family member:

1. Is dependent on a telephone for his employment, providing income from such employment equals or is greater than expenses.

2. Is chronically ill, handicapped, and living alone in an isolated area.

4334 Insurance Premium Payments

4334.1 Life Insurance Premium Payments

Provision can be made for recognition of life insurance premium payments as a requirement if the insured recipient has verification that he has:

1. A terminal illness.

2. A physical or mental disability which would disqualify him from obtaining new insurance.

3. Membership in a group life insurance plan which is a requirement of employment.

Premium payments in the above cases shall be allowed only if the insured:

1. Has borrowed the full loan value of his policy.

4334.1 Life Insurance Premium Payments - cont'd

2. Applies all benefits of the policy to keep his insurance in force.

3. Assigns and deposits his life insurance policy with the DPW to reimburse the Department in an amount equal to the amount of public assistance received.

The county administrator's approval shall be required if the policy has a face value of $10,000 or more.

4334.2 Insurance on Property

Public liability and property damage insurance premiums shall be allowed as paid if the recipient owns a car and the expense of its upkeep has been approved.

Fire insurance on real or personal property owned by individuals on assistance shall be allowed if the property ownership is recognized as a requirement according to the standards in relation to shelter. Premium rates to be allowed are those determined on individual dwellings by the Hawaii Rating Bureau and applied by the insurance companies.

4334.3 Private Health Insurance Premiums (7/1/59)

If an employed recipient is insured or carries an industrial policy because of his employment, additional premiums to cover other members of his family may be allowed up to the amount of the individual premium payments by category listed in Section 4335. If a recipient is eligible for health insurance coverage under a non-needy person's policy, premiums may also be allowed in the same amount.

A person allowed health insurance premiums under this section shall not be insured under the Department's Hospital Insurance Plan with the Department of Health.

STANDARDS OF ASSISTANCE--Payment for Physical Examinations Section 4334.4
Page 1

POLICY	*PROCEDURE*
Payment for Physical Examinations	
1. The Department shall pay for the following types of physical examinations when given by an out-patient clinic or government physician:	Physical examinations shall be charged to administrative expense. They are not considered medical care payments.
a. Examinations to determine eligibility for a particular category.	
Examples	
1) Age for OAA or MAA	
2) Blindness for AB	
3) Permanent and total disability for AD	
4) Employability for GA	
b. Preplacement examinations for children before placement in foster care.	
c. Annual physical examinations for children in foster care.	
d. School health exams for children entering school in Hawaii for the first time.	
2. a. The Department shall not pay for examinations which are available from other sources.	
Example	
School health examinations for children entering kindergarten or first grade.	Refer such children needing school health examinations to Department of Health's child health conference for free examination.
	Arrange appointment through public health nurse.

POLICY	PROCEDURE
3. Payment a. The Department shall allow the following payment: Up to $5 for the examination, plus up to $5 for further tests and x-rays necessary for diagnosis. b. Payment for treatment or medication shall not be included with payment for examinations.	Authorize payment by purchase order. Identify type of physical examination on purchase order. IN HONOLULU For Queen's and St. Francis Hospitals only: Use form DSS-HON 26 instead of individual purchase order. For payment to other vendors, issue individual purchase order.

POLICY	*PROCEDURE*
1. Eligibility for Medical Payment	
a. All persons who are unable to pay for the cost of medical care as defined in Section 4335.4 shall be eligible for payments.	
b. Such payments shall be made under one of the following categories: 1) Old Age Assistance (OAA) 2) Aid to Dependent Children (ADC) ADC-UP ADC-FC 3) Aid to Blind (AB) 4) Aid to Disabled (AD) 5) Child Welfare Services (CWS) 6) General Assistance (GA) 7) Medical Assistance for the Aged (MAA) 8) Medical Assistance for Others (MAO)	See Manual Section 4335.2 See Manual Section 4335.3
Exceptions: Persons in the above categories shall not be eligible for medical payments to the extent that they have medical care available from other resources, such as: 1) Care available to certain state and county pensioners. (Sec. 6 - 4, RLH 1955) 2) Health, accident, and group insurance policies. 3) Veterans' Administration medical care. 4) Red Cross disaster relief.	Refer to Manual Sections 3700 - 3790 for details on: a. Medical care available from private and public sources. b. Referral procedures.

POLICY	*PROCEDURE*
5) Employers' benefits. 6) Workmen's Compensation. 7) Other government and private programs.	
2. Controlling Factors	
a. The Department shall pay for the cost of medical care when it is determined necessary to the patient's well-being.	
b. The Department shall make direct payment to the vendor.	
c. Payments shall be made only to those vendors legally authorized under State laws to provide medical care.	
d. The Department shall pay for only standard and accepted methods of diagnosis and treatment. No payment shall be made for unproved drugs or procedures, nor for anything of an experimental nature.	
e. The Department of Social Services may reject payment in situations where the above policies are violated.	
3. Application	
a. All persons wishing to apply shall have opportunity to do so within the Department's established policies and procedures.	Follow Manual Sections 3310-3335, 4054-4070 for application procedures, opening and closing cases. a. Write in appropriate category on DSS-47.

POLICY	*PROCEDURE*
b. Applications for MAA and MAO shall be processed as promptly as possible but no later than 2 weeks after receipt.	b. Send Form DSS-1003 to notify recipient of decision. c. DSS-5 is not required for MAA and MAO cases.
4. Determination of Eligibility The social worker shall: a. Determine eligibility for medical payments. b. Authorize the vendor to submit a bill for each approved case.	See Manual Sections 4335.1 - 4335.6 for eligibility requirements and authorization procedures. Sign Form DSS-1001 for applicants determined eligible.

POLICY	*PROCEDURE*
1. Eligibility for Medical Payments Under OAA, ADC (including ADC-UP, ADC-FC), AB, AD, GA, and CWS. Medical payments shall be made under the above categories if: a. The recipient is receiving assistance for basic living requirements (food, shelter, etc.); b. The recipient requests assistance to meet the cost of medical care only, and his resources are equal to or less than his requirements in accordance with the Department's Standards of Assistance for the above categories.	Cases Receiving Financial Assistance a. Follow regular payment procedures. b. Use Form DSS-1001 to authorize medical payment. c. It is not necessary to send Form DSS-1003 to recipient. Cases Receiving Medical Payments Only a. Use Form DSS-5 and Form DSS-1001 to authorize medical payment. b. Send top portion of Form DSS-5 to notify recipient of decision. Enter reason under Section 4. c. It is not necessary to send Form DSS-1003 to recipient.

POLICY	*PROCEDURE*
1. Eligibility for MAA Medical payments shall be made under the Medical Assistance for Aged category (MAA) if the applicant is: a. In need according to the Standards of Assistance for MAA and MAO. b. 65 years of age or over. c. Not an inmate of a public institution, except a public medical institution. d. Not in a medical institution by reason of tuberculosis or mental illness. e. Not in a medical institution primarily established for tuberculosis or mental illness; and f. If the resources determined available to him within 12 months after date of application are insufficient to pay the cost of medical care.	See Manual Section 4335.6 for Standards. a. Use Form DSS-1001 to authorize medical payment. b. Notify recipient by sending Form DSS-1003. Computing Payment a. Use Standards of Assistance for MAA and MAO. b. Compute family's total requirements. c. Compute cash value of all resources. d. Subtract requirements from resources. e. Multiply balance by 12 to determine amount family can pay on a 12 months basis.

POLICY	*PROCEDURE*
2. The Department shall pay the difference between the cost of authorized medical care and the amount of resources available to meet such cost.	
3. Residence	
a. There shall be no residence requirement for receipt of MAA.	
b. A Hawaii resident temporarily out of the state may be eligible for MAA from DSS to cover expenses incurred in another state.	Refer correspondence regarding such applicants to State Office.
4. No enrollment fee, premium or similar charge shall be required of the applicant.	
5. Liens and Recoveries	
a. No lien or encumbrance of any kind shall be required from or be imposed against the property of an applicant for or a recipient of MAA as a condition of eligibility.	
b. There shall be no adjustment or recovery of MAA correctly paid during the lifetime of the recipient and his surviving spouse.	
6. Nursing Home Care	
a. For MAA cases only. The cost of nursing home care shall be included in the Definition of Medical Care.	a. See Section 4326 for policy requiring physician's recommendation for such nursing home care.

POLICY	*PROCEDURE*
b. For OAA cases. If the payment in behalf of a needy person 65 years of age or over is more than $90 a month, payment shall be made to vendor under MAA category -- not OAA.	b. See Section 4335.4 for definition of medical care.
c. The recipient's personal essential allowance shall be included in the vendor payment to the nursing home operator with the understanding that his allowance shall be given to him in cash. Exception shall be made for incompetents.	c. Follow regular payment procedure for vendor payment as stated in Section 4335.5.
	d. Request nursing home operator to submit monthly bill to Department on Form DSS-1006.

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POLICY	*PROCEDURE*
1. Eligibility for MAO Medical payment for part or all of the cost of medical care shall be made under Medical Assistance for Others (MAO) category if the applicant: a. Is under 65 years of age; b. Is not eligible for medical payments under categories other than MAO; c. Is in need according to the Standards of Assistance for MAA and MAO, and	See Manual Section 4335.6 for Standards.
d. Has insufficient resources available to him within 12 months after date of application to pay the cost of medical care.	See Manual Section 4335.2 (f) for procedure.
2. The Department shall pay the difference between the cost of authorized medical care and the amount of resources available to meet such cost.	

POLICY	*PROCEDURE*
1. Definition of Medical Care Medical care shall include: a. Hospital Care as follows: 1) Ward accommodations including bed and meals. 2) Regular nursing care. 3) Drugs, antibiotics, dressings, diagnostic tests, and therapeutic tests, and therapeutic procedures as prescribed and ordered by the attending physician. 4) Cost of air transportation when necessary care is available only in another county. 5) All other necessary expenses connected with hospital care within certain limitations. Payments for "hospital care" shall not include: 1) Care of patients hospitalized because of T.B., mental illness, mental deficiency, and/or Hansen's disease. 2) Care in an institution established for T.B., mental illness, mental deficiency, or Hansen's disease. 3) Domiciliary and other non-medical care.	

POLICY	*PROCEDURE*
4) Observation in connection with mental conditions which are responsibilities of the county government. (Sections 81-25, 81-26, RLH 1955)	
5) Hospitalization beyond the first 15 days without special approval of the Department.	
Exception: There is no time limit on medical care of non-T.B. cases in segregated sections of T.B. institutions.	The hospital shall use Form DSS-1002 to request extension of hospitalization.
b. Out-Patient & Allied Services as follows:	
1) Drugs 2) Antibiotics 3) Dressings 4) Diagnostic tests 5) Therapeutic procedures as prescribed by the attending physician, including special eye care, prosthetics, physio-therapy, x-ray therapy and opticals.	
c. Dental Care as follows:	
1) Emergency dental services, including examinations, x-rays, fillings, extractions, and caps.	
2) Drugs prescribed by attending dentist.	

POLICY	*PROCEDURE*
2. Payment by Vendor	
a. All payments for medical services shall be made directly to vendors providing services.	
b. The Department shall make payments for the above services to:	
1) General and specialized hospitals.	See listing of authorized vendors circulated to staff periodically.
2) Out-patient clinics of general and specialized hospitals in the City of Honolulu.	
3) Government physicians in Rural Oahu and in Hawaii, Maui, and Kauai Counties.	
4) Dentists authorized by the Department.	
5) Other vendors authorized by the Department.	

POLICY	*PROCEDURE*
1. Prior Authorization Required a. Authorization in advance is required for all items included in the Definition of Medical Care. Prior authorization shall be made in all situations in which the doctor believes the service could be provided at a later date. Examples: Elective surgeries, glasses, and prosthetics. b. Exception: In an emergency when there is neither time nor opportunity to secure advance approval, authorization must be requested within 72 hours of the day in which the service was provided, excluding Saturdays, Sundays, and holidays. A situation shall be considered an emergency when the doctor determines that immediate service is necessary.	Required Authorization Form Form DSS-1001, "Request for Authorization for Payment of Medical Care" a. When to use Vendor or Department may originate form. Vendor - To request authorization. DSS - To notify vendors that an individual is eligible for medical payment. b. When required Hospital Care. A separate authorization Form DSS-1001 is required for each and every admission, regardless of the number of times the patient is hospitalized during the same month. Out-Patient Care (including clinic visits, drugs issued on out-patient basis, special EENT care, dental care, and other care requiring a series of out-patient visits). One authorization on Form DSS-1001 is required at time of first visit for each month. Approval at time of first visit constitutes approval for the whole month unless otherwise cancelled in writing. When Used by Vendor: 1. Patient goes to vendor for service and indicates he cannot pay for his care. Vendor refers patient on Form DSS-1000 if patient has never been known to DSS.

POLICY	*PROCEDURE*
	2. Vendor submits 3 copies of Form DSS-1001 to the Department. 3. DSS determines whether patient is eligible and whether he has medical care resources. 4. DSS returns to vendor 2 signed copies of Form DSS-1001, indicating approval or disapproval. 5. If approved, vendor bills DSS for the services, returning the 2 copies of Form DSS-1001 with the bill as evidence of authorization. When Used by DSS: 1. Patient goes to DSS requesting approval for medical services. 2. DSS determines patient's eligibility. 3. If approved, patient is given 2 copies of approved Form DSS-1001 and referred to vendor. 4. Vendor bills DSS and attaches the 2 copies of Form DSS-1001 to bill. Authorization for Hospitalization 1. Vendor shall submit Form DSS-1001 to DSS as soon as possible, giving estimated length of stay as determined by attending physician. 2. DSS shall review Form DSS-1001 and return it to the hospital, authorizing a stated number of hospital days.

POLICY	*PROCEDURE*
	3. Extension of hospitalization. If the attending physician determines that a patient will need to be hospitalized beyond original estimate, vendor shall submit Form DSS-1002, "Request for Extension of Hospital Stay," at least 24 hours before the expiration of the originally authorized hospital stay. 4. DSS shall notify the hospital of its decision on Form DSS-1002. 5. Hospitals shall notify the Department of patient's discharge on Form DSS-1004.
2. Payment a. If the patient has resources to pay part of the cost of service, the vendor shall be responsible to bill the patient for his share of the expense and to collect payment.	Payment Procedure 1. The vendor shall submit a bill to DSS as soon as possible but no later than the 5th government working day after the end of the month in which service was provided the patient. 2. Form DSS-1001 and, if necessary, Form DSS-1002 shall be attached to each bill. 3. There shall be a bill for each patient provided service and, for hospitalized patients, a bill for each admission. 4. Billing shall be made on the following forms and sent to the county office: a. Hospital services - Form DSS-1005. b. Out-Patient & Allied Services (other than hospital services) - Form DSS-1006. 5. For hospital care, charges may include either day of admission or day of discharge but not both.

POLICY	*PROCEDURE*
	6. County Division Responsibilities a. Review bills for completeness. b. See that required documents are attached. c. Send to ADS office daily. 7. ADS Responsibility a. Process payments to vendors. b. Maintain individual ledger cards on Form DSS-1007.
3. Case Recording a. Recording shall clearly establish financial eligibility. b. Extensive and detailed narrative recording is not required.	Case Record See Manual Sections 3403 for establishment of case; 3413 for case recording.
4. Required Reports a. A monthly report on Form DSS-1008 is required of the county division by the 5th working day of the month.	a. Include following cases on DSS-1008: 1) MAA 2) MAO 3) OAA, ADC, ADC-UP, ADC-FC, AB, AD, GA, and CWS. b. Do not count item a-3) above in regular monthly report - DSS-RS-1. c. Establish separate section in kardex file for each of above categories.

POLICY	*PROCEDURE*
1. Standards of Assistance for MAA and MAO The requirements and resources in the Department's Standards of Assistance for non-medical as well as medical requirements shall be used to determine eligibility for MAA and MAO with the exceptions listed below.	See Manual Sections 4300 - 4348.3.
2. Food a. Diabetic - $8.50 per month in addition to basic food requirement may be allowed. b. For persons requiring high protein, low fat and high carbohydrate diet, or any combination of these, $8.50 per month in addition to basic food requirement may be allowed.	
3. Shelter Allowance for rental or home ownership costs shall be as paid, up to the following maximums: No. of Persons — Maximum Allowance 1 — $ 50.00 2-5 — $ 75.00 6-9 — $100.00 10 or more — $125.00	See Manual Section 4325.14
4. Laundry For persons who cannot do their own laundry, allowance for laundry services shall be: $3.00/month for non-employed persons and $7.00/month for employed persons.	

POLICY	PROCEDURE
5. Clothing Monthly clothing allowance shall be as follows:	

Less than 4 yrs.	4-12	13-19 Boys	13-19 Girls	20 & Over
1.25	1.75	2.25	3.00	3.00

6. Debts	
a. Payments being made by the patient or his immediate family on the following items shall be considered essential requirements:	Monthly payments, according to Table in 6-b, shall be included in determining family's regular expenses.
1) Medical bills, including professionally prescribed dental, optical and orthopedic appliances.	
2) Hospital bills.	
3) Kitchen appliances, such as refrigerator, stove and dinette set.	
4) Washing machines and heaters.	
5) Bedroom sets and living room sets.	
6) Automobiles up to $50 a month for families residing in rural areas where public transportation is non-existent or extremely poor, provided:	

POLICY

a) the automobile is four years or older and

b) the applicant and/or spouse are the registered owners.

8) Loans on automobiles (auto put up as security) if loans were for allowable items.

9) Insurance premiums.

10) Garnishes and overdue payments on unpaid loans, provided loans were for purchase of essential items as listed in this section.

11) Other items with supervisory approval.

b. Maximum monthly allowance for installment payment of allowable debts shall be as follows:

Bal. of Total Allowable Debts	Maximum Mo. Allowance Debts Combined	Single Debts
$ 1 - 49	None	None
50 - 99	$ 8.25	$ 8.25
100 - 149	12.50	12.50
150 - 199	16.60	16.50
200 - 249	20.75	18.00
250 - 299	25.00	20.00
300 - 349	29.00	22.00
350 - 399	33.25	24.00
400 - 449	37.50	26.00
450 - 499	41.50	28.00
500 - over	45.75	30.00

Exceptions may be made with supervisor's approval.

PROCEDURE

POLICY	*PROCEDURE*
c. The following items shall be considered non-essential and monthly payments being made on them shall not be included as regular requirements of the family in determining their ability to pay: 1) Payments on TV sets. Exceptions: a) Families living in rural areas where recreational facilities are very limited. b) Situations where legally responsible relatives give TV sets as gifts and meet the payments on installments. 2) Payments on pianos, phonographs, extra radios, silverware, and encyclopedias. 3) Payments on freezers. Exception: Rural families if they produce much of their food for family consumption, such as from backyard gardening, poultry, and fishing. 4) Payments on automobiles for all applicants living within the city limits or suburban districts where public transportation is fairly satisfactory.	

POLICY	*PROCEDURE*
5) Payments on expensive living room sets and rugs. 6) Payments on loans if they were obtained for recreational or non-essential purposes. 7) Support of non-related persons or relatives who have legally responsible persons to assume complete support. Exception: "Hanai" relationships. 8) Garnishees for being a co-signer to a loan. d. Reapplication When a person reapplies, the Department shall determine if he and his family had been given prior consideration for payment on essential items. If he had made no effort to meet payments and his debts remain essentially the same, allowances for payments on debts shall not be included as a requirement unless the patient can prove he had additional essential expenses which prevented him from meeting existing debts.	

POLICY	*PROCEDURE*
B. Resources	
1. Bank Savings of Unemancipated Minors Savings over and above the first $50 shall be considered resource.	See Manual Section 4345.4 for definition of unemancipated minors.
2. Real Property Used as a Home Home property which has a tax-appraised value of $14,000 or over shall be considered a resource.	
3. Automobile Sale value of automobile manufactured not more than 4 years ago shall be considered a resource. Retention of such an automobile may be allowed with supervisory approval.	

An outpatient, private or government physician can do the examination. Referral can be to the doctor (or clinic) who will be following up with treatment. The private doctor shall be informed of the department's inability to pay for more than the diagnostic work-up.

4336 Housekeeper Service (Special Circumstances)

The cost of housekeeper service may be allowed if such service is necessary to keep the family together during a period when the mother is acutely ill, or absent from the home for confinement, or other temporary hospitalization or imprisonment.

Costs for this service may be allowed up to $1 an hour.

4337 Fees and Other Costs

Taxes, court fees, legal fees, and other costs which cannot be waived or postponed may be allowed. These costs may be:

Taxes, other than withholding taxes. Most taxes can be paid in installments.

Bankruptcy petitions. With written verification of the attorney representing the recipient, the filing fee of $50 for petitions in bankruptcy may be allowed. This fee may be paid in installments on petition to the U. S. District Court. In Honolulu County, the services of the Legal Aid Society, 813 Alakea Street, are available to individual needy petitioners.

Naturalization costs. $3 for filing of declaration of intention, $8 for petition for certificate of naturalization.

Photographs. $1 may be allowed for photographs for petitions for citizenship, passport, or certificates of identity.

Costs necessary to carry out an approved plan for the development of property as a resource, such as recording fees at the Bureau of Conveyances.

Marriage license fees, $5.

Court fees and publication of notices required in certain legal proceedings such as divorce, adoption, legal separation, or change of legal name may be allowed with the written verification of the attorney representing the recipient.

Motor vehicles. Registration of motor vehicles, drivers' and chauffeurs' licenses may be allowed.

Deposits. Deposits, up to a maximum of $25, may be allowed to secure shelter with Hawaii Housing Authority.

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State of Hawaii
DEPARTMENT OF SOCIAL SERVICES

Honolulu

Honolulu County Manual Supplement No. 9
July 19, 1961

Effective July 1, 1961

To: HONOLULU STAFF

From: Honolulu County Division Administrator

Subject: Medical Payments -- Dental Services

A. Explanation:

This is to confirm the policy and procedure put into effect July 1, 1961. Until further notice, the Department will authorize payment for dental services through the City & County Department of Health as follows:

Within city limits -- C&C Department of Health, Dental Clinic at Maluhia Hospital

Rural Oahu -- City & County Department of Health Mobile Units

Emergency - Dental Clinic at Maluhia Hospital.

B. Action to be taken:

If there are no other resources available, refer needy persons to City & County Health Department following procedures stated in Manual Section 4335.4.

C. Filing Instruction:

1. File attached after Manual Section 4335.4, page 11.

HAWAII DEPARTMENT OF PUBLIC WELFARE STAFF MANUAL

Part IV Public Assistance Programs
Standards of Assistance 4340 - 4340.2

INCOME AND RESOURCES

4340 INCOME IN DETERMINING THE ASSISTANCE PAYMENT

All resources, available to an individual now or in the immediate future, affect his eligibility for public assistance. Income and resources must be evaluated:

1. In studying an application for public assistance,

2. In redetermining the recipient's continuing eligibility.

Vague or incomplete information shall be verified through means agreed upon with the applicant.

All immediately available resources must be used to meet the individual's or family's current living expenses.

Real and personal property which the applicant owns may have to be converted to cash and used before he is eligible for assistance.

4340.1 Refusal to Permit Verification

Refusal to provide needed information on resources makes an applicant and his legal dependents in the home ineligible for assistance. E.g.--refusal to establish eligibility through determination of resources would disqualify for assistance both parents and their minor children living in the same household. The applicant's refusal would not affect the eligibility of other household members who are entitled to apply for assistance on their own.

4340.2 Budgeting

The social worker shall discuss with each applicant the method of determining assistance payments, including:

1. Discussion of requirements and consideration of resources now available or soon to be available to him,

2. Explanation of current agency policies and assistance standards as they apply to the individual's particular situation.

4340.2 Budgeting - Cont'd

All resources regularly available to the person or family shall be shown on the Resource Evaluation Form, DPW-3, and the Financial Plan, DPW-4 and 4A. His employment record, often a key to potential resources such as unemployment insurance, shall be shown on the Employment History Sheet, DPW-12.

Resources known to be available to the recipient within a given month must be taken into full account in determining the assistance payment for that month. Only those resources available for a recipient's use shall be budgeted.

4340.3 Conservation of Resources

Conservation of readily available resources may be allowed in exceptional circumstances with director's approval.

4341 Credit

A. Loans Against Income

An applicant or recipient shall attempt to establish credit for his current living expenses if he expects to receive a resource at a known time in an amount at least equal to the credit he will require. The social worker shall explore the possibility of credit with the applicant, who establishes his own credit.

B. Farm Loans

An applicant or recipient whose farm is not producing sufficient income to meet his requirements and that of his dependents shall be referred to the Federal Farmers Home Administration for a federal loan.

The Federal Office and the University of Hawaii Agricultural Extension Service will evaluate and advise whether the recipient can become self-sustaining on the farm. The federal loan and (the evaluation of the possible productivity of the farm) shall be considered a resource.

HAWAII DEPARTMENT OF PUBLIC WELFARE STAFF MANUAL

4342 Life Insurance

Full loan value of an insurance policy shall be considered a resource. Financial assistance shall be paid an otherwise eligible applicant until the cash becomes available. The time period required to convert the insurance shall be determined by contacting the insurance company's representative who handles the transaction.

Burial or group life insurance has no loan value.

Any insurance policy on which premiums have lapsed shall be studied to determine the current value of the policy. (See Glossary, Appendix C-5, Insurance.)

4343 Stocks and Bonds

Stocks and bonds shall be considered a resource if currently registered on an exchange. The applicant shall be required to sell them.

4344 Resources in Cash

All cash income received by a recipient shall be considered a resource.

Monthly income shall be determined as follows:

1. Lump sum, if received only once;
2. Current monthly income, if regular and constant in amount;
3. Average of past 3 months' income if irregular, variable, and not likely to continue throughout the subsequent year;
4. Average of the past year's income if it has been irregular but there is reasonable assurance it will be about the same amount in the subsequent year.

HAWAII DEPARTMENT OF PUBLIC WELFARE STAFF MANUAL

Part IV — Public Assistance Programs — Standards of Assistance — 4344.1 - 4344.14

4344.1 Sources of Cash Income

4344.11 Savings

All savings, as soon as they become available, shall be considered a resource.

Savings include:

1. Cash on hand
2. Bank accounts
3. Building and loan accounts
4. Credit union accounts
5. Postal savings
6. U. S. savings bonds and stamps
7. All other accounts or deposits available in cash on demand or within 30 days.

4344.12 Pensions

Monthly cash benefits or lump-sum payments may be available to former employees in government or private industry. Such persons or their beneficiaries shall be referred to retirement or personnel offices of their former place of employment to determine their benefits.

4344.13 Old-Age and Survivors Insurance

All insured persons who may qualify for Retirement, Survivors and Disability benefits or the Disability Freeze shall be referred to the Bureau of OASI to make application. Use DPW 25 in duplicate for referral. See Section 3712 for eligibility statement of all benefit and freeze provisions.

4344.14 Unemployment Insurance Benefits

Unemployed workers shall file claims for bi-weekly unemployment insurance benefits with the Bureau of Employment Security.

Claimants for unemployment insurance benefits may receive financial assistance up to 4 weeks only if there are delays, except for interstate claimants who may receive assistance until the first benefit is received.

4344.15 Workmen's Compensation

All individuals unemployed because of injury or disability sustained on the job shall be referred to Bureau of Workmen's Compensation.

4344.16 Servicemen's Dependency Benefits

Dependents of servicemen shall be referred to Hawaii Chapter, American Red Cross, to apply for government benefits, allowances, and allotments, and for Red Cross assistance pending receipt of such benefits.

4344.17 Veterans' Benefits

Veterans, or dependents of surviving veterans, shall be referred to U. S. Veterans Administration, or the Territorial Council on Veterans Affairs, to determine possible claims for pensions, compensation, or other allowances.

4344.18 Income for Education or Training

Scholarships or other income specifically designated for educational or training purposes shall not be deducted as a resource if such education or training is likely to increase the recipient's earning power. Such other income includes items provided by any approved vocational training or rehabilitation agency, such as bus fare and lunch money. Other subsistence allowances provided trainees shall be considered a resource.

4345 Income from Employment

All earnings must be considered a resource, and the net pay shall be budgeted.

4345.1 Income from Self-employment

Net income from self-employment such as farming, yardwork, taxi driving, operation of rooming or boarding houses, or other business or occupation shall be considered a resource in the same manner as other net earnings. The monthly Gross Income Report, prepared for tax purposes, shall be used to verify the individual's income from this source.

HAWAII DEPARTMENT OF PUBLIC WELFARE STAFF MANUAL

4345.2 Income from Exchange of Goods

The value of food or other goods produced by the recipient which is regularly traded for other items for home consumption shall be considered income from self-employment and shall be considered a resource. The price the recipient would get if he sold his produce shall be the amount budgeted.

4345.3 Determining Earned Net Income

Net income shall be determined as follows:

1. Gross income from salaries and wages, less those deductions required:

   a. by law, excluding garnishments
   b. as conditions of employment

2. Gross income from self-employment less operational costs of own business, including: rent, tools, taxes, insurance, utilities, licenses, reasonable repairs, interest on mortgage, goods and labor.

   If there is a net loss, the monthly deficit can be met with approval of County Administrator up to three months.

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Part IV Public Assistance Programs
Standards of Assistance 4345.31

4345.31 Earned Income of Employed Blind Persons

A. Income Which is Not a Resource In Determining Need

The first $50.00 of a blind person's earned income shall not be considered as a resource in determining his eligibility for financial assistance. It is also not to be considered in determining need of any other person who is eligible for assistance under the Federally matched categories.

Exclusions:

Excluded from "earned income" of a blind person is income which requires no activity on the part of the blind person to produce the income such as:

1. Benefits, pensions, unemployment or workmen's compensation.

2. Insurance paid as a result of accident or illness.

3. Returns on capital investment, dividends or interest.

B. Definition of Earned Income of Blind Persons

1. Earned income is income only in the month in which it is earned. It can be in cash, in kind or as net profit from self-employment.

2. Any accumulation of money becomes a resource in determining need.

3. It is the blind person's gross pay less expenses which he must meet as a requirement of the job.

Examples: uniforms
tools
business telephone
transportation to perform the work
operating expenses of own business, if self-employed

Personal expenses such as transportation to and from work, income tax, lunches, are requirements which the agency meets.

4. In cases of lump sum payments for work performed for more than one month, disregard $50.00 for each month person works.

HAWAII DEPARTMENT OF PUBLIC WELFARE STAFF MANUAL

4345.4 Income of Minors

A. Income of Unemancipated Minors (1/1/57)

Generally, net income, including earnings, of an unmarried, unemancipated minor is subject to his parents' control and management. Net income shall be considered a resource, except that portion used to meet expenses for:

1. School fees, such as shop fees, athletic fees, vocational class fees.

2. Expenses incidental to graduation, such as rental of a cap and gown when required, special clothing, class ring, expenses of class dance, banquet expenses, school annual, etc.

4345.4 Income of Minors - Cont'd

3. Community activities (costs of participation in group activities), such as club dues, scout dues, uniform and equipment required by clubs, church offering, etc.

4. Dentures

Need for these items shall be individually determined by the social worker.

The social worker shall decide the period of time the income will be budgeted, based on a plan worked out with the family and child. For example, a school child may earn sufficient money between school sessions to be self-supporting, but it may be decided that it is best for him to save his earnings for special requirements for the next school year.

B. Earnings of Emancipated Minors

1. Married minors

A married minor child is emancipated. He has the same responsibility as an adult child for the support of his needy parents. Parents are not legally responsible for the support of a needy married child.

A minor whose marriage is terminated during his minority does not revert to the status of an unemancipated minor, but retains his freedom from control and is not the responsibility of his parents. His legal status is that of an adult.

HAWAII DEPARTMENT OF PUBLIC WELFARE STAFF MANUAL

Part IV — Public Assistance Programs — Standards of Assistance — 4345.4

4345.4 Earned Income of Minors - Cont'd

2. Unmarried minor in the home. A minor is considered emancipated if:

   a. He has reached the age of 16, and is no longer subject to compulsory school attendance;

   b. He has made his own arrangements for his job and is working;

   c. He has sufficient mental ability to plan the use of his earnings;

   d. He and his parents (or those relatives or hanai parents caring for him and acting as his parents) have agreed that he may work and that he may use his earnings as he sees fit while emancipated;

   e. He understands that with emancipation, he will have the same responsibility as an adult child for the support of his parents;

   f. He is earning more than his total requirements. He is paying for his total requirements according to the Department's current level of payments and including his prorated share of shelter and utilities.

   If all the above conditions are met, the Department will consider his earnings are his own property and his financial responsibility toward his parents is the same as that of an adult child. If he does not meet his obligations as an adult child, then he shall lose his status as an emancipated minor.

3. Unmarried minors out of the home. A minor is considered emancipated if:

   a. He is serving in the armed forces, or

   b. He has left his parents' home, established himself in a separate household, and meets the first six of the criteria in Paragraph 2 above.

   c. He is out of the home and under the control and supervision of a Juvenile Court or the Department of Institutions. In this instance, he is subject to their regulations concerning use of his earnings and contributions to his parents' support.

HAWAII DEPARTMENT OF PUBLIC WELFARE STAFF MANUAL

Part IV Public Assistance Programs
Standards of Assistance 4345.5

4345.5 Employment Opportunities

Employment opportunities which exist in the community are available resources.

A. Recipients for Whom Employment May Be Available

An individual able to work in gainful employment shall be required to determine if there is employment in the community suitable to his physical and mental capacities, unless he is:

1. A minor over 16 in school who has not completed high school, and the school recommends continuation.
2. An individual who is successfully attending a vocational or commercial school or university, if the securing of the additional education will mean higher earning power.
3. An individual whose presence is required in the home to care for children or handicapped household members.

When an individual states he cannot work, the social worker and the supervisor shall evaluate his ability to use available rehabilitation and work opportunities on the basis of:

1. His medical, and/or psychiatric and psychological examinations,
2. Social and occupational history,
3. His statements concerning his disability.

If it is decided that the individual can work, he shall comply with the requirements of this section.

In determining an individual's availability for employment, these factors shall be considered:

1. Transportation problems to and from the job,
2. Location of the job if it requires a change in his living arrangements or would adversely affect the welfare of dependents.

Wages cannot be considered a criterion in determining the suitability of the work opportunity unless the wage offered is an illegal one.

B. Procedures for Developing Employment Opportunities

All citizens available for employment shall be referred to Federal, Territorial, and County Civil Service Commissions to apply for Civil Service jobs.

HAWAII DEPARTMENT OF PUBLIC WELFARE STAFF MANUAL

4345.5 Employment Opportunities - Cont'd

All persons available for employment shall be referred, on Form DPW-11, to the Territorial Employment Service to register for employment. TES registration shall be kept active according to a plan agreed upon by the social worker and the recipient which considers location, coverage, and recommendations of the TES Office. Frequency of TES registration shall be recorded on the back of Form DPW-12.

The individual shall use other sources in seeking suitable employment such as applying for work directly to employers and following up on newspaper advertisements. He shall also try to be reinstated in his last job if it is still available.

4345.6 Financial Assistance Pending Employment

An otherwise needy individual who is diligently seeking employment according to the requirements of this section shall be entitled to financial assistance. A recipient who has found a job is eligible for financial assistance until his resources, including earnings, are suficient to meet his requirements.

An employable person who is not diligently seeking work shall be ineligible for assistance on the basis that he is failing to determine whether such a resource is available. He, and those household members legally dependent on him, shall be ineligible for assistance as long as he refuses to accept referral, register for, or search for job opportunities, or refuses to accept or remain in suitable employment.

4345.7 Employment as a Resource to Persons Involved in Labor Disputes

Applications for assistance from strikers or families of strikers will be accepted on the same basis as other applications.

The assistance available from a labor union to a member or his dependents shall be considered a resource. Such persons shall be referred to TES in accordance with normal practice. The Department recognizes the standards of the TES which prohibit referral to a position vacant because it is involved in a labor dispute.

If persons involved in a labor dispute apply to this Department for assistance and if they refuse referral to TES or refuse job referral offered by the Department or TES, they are considered as refusing work and are ineligible.

4345.8 Borderline Cases

Cases, in which application of departmental policy leaves doubt as to eligibility, shall be referred to the Director.

4345.9 Securing Employment Record

Form DPW-14 may be used, with the applicant's knowledge, to secure information about his past employment and the possibility of his re-employment.

Acceptable verification of employment and income is:

1. Withholding Statement, Form W-2, U. S. Treasury, Department of Internal Revenue;
2. Pay envelopes or pay statements;
3. Statements from employers; or
4. Statements from the employee if the above sources of verification are lacking.

4347 Income from Relatives

Any support from relatives either in cash or in kind shall be considered a resource.

Regular support payments should be made directly to the recipient. Irregular support payments may be handled as a refund to the Department for assistance advanced, so that the family will have regular maintenance.

4347.1 Determination of Relatives' Ability to Support

The social worker shall determine with each applicant and recipient currently available and potential resources from relatives.

HAWAII DEPARTMENT OF PUBLIC WELFARE STAFF MANUAL

Part IV Public Assistance Programs
Standards of Assistance 4347.1

4347.1 Determination of Relatives' Ability to Support - cont'd

A. Legally Responsible Relatives

Territorial law establishes responsibility for support as follows:

1. A father is responsible for the support of his minor children born in wedlock.

2. The natural father of a child born out of wedlock is responsible for its support throughout its minority if paternity has been legally established.

3. A mother is responsible for the support of all her minor natural children.

4. A husband is responsible for the support of his wife.

5. An adoptive parent is responsible for the support of a minor adopted child.

6. An adult child is responsible, to the extent of his financial ability, for the support of an indigent parent.

7. An emancipated minor child is responsible for the support of his parents to the same extent as an adult child. (The resources of an unemancipated child belong in full to his parents.)

B. Non-legally Responsible Relatives

Relatives who have no legal responsibility may recognize a moral responsibility to care for their relatives (to the extent of their financial ability). Such relatives may be willing and able to contribute to the recipient's support. In all instances, this shall be determined.

C. Stepparents

A stepparent is required by law to support his needy stepchild, if the child is living in his home and he is acting as a parent and

a. The child has been deserted by his legal parent whose whereabouts are unknown, or

HAWAII DEPARTMENT OF PUBLIC WELFARE STAFF MANUAL

4347.1 Determination of Relatives' Ability to Support - cont'd

b. The legal parent is unable to support his child.

Procedures

a. Ability to support shall be determined by the department's 100% Assistance Standards. Deduct federal and territorial taxes and other legal charges against income payments, to obtain net income.

b. Any stepparent who refuses to support his needy stepchild shall be reported by memo to Legal Counsel.

D. Common-law Relationships

If a woman is living in common-law relationship with a self-supporting individual, that person is a resource for the support of the household. The social worker shall interview the common-law spouse to determine the amount over and above his share of the household expenses he can contribute to the woman and her dependents.

If the common-law spouse is the natural father of the needy children, establishment of paternity shall be initiated.

The woman's failure to assist in determining resources available from the common-law husband makes her and her minor children ineligible for assistance.

E. Husbands and Parents

The contribution of a husband to the support of his separated wife and that of parents to the support of minor children living apart from them shall be determined through use of the Department's 100% assistance standards (see Appendix B).

Retention of real and personal property valued at more than $5,000 and income to pay debts may be allowed with county administrator's approval.

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HAWAII DEPARTMENT OF PUBLIC WELFARE STAFF MANUAL

4347.1 Determination of Relatives's Ability to Support - cont'd

F. Adult Children

An adult child is required by law to contribute to his indigent parents' support to the extent of his financial ability unless his parents failed to support him during his minority. If the adult child lives with his parents, his payments for room and board are not considered a contribution.

Procedures

a. Deduct federal and territorial taxes and other legal charges against income payments to obtain net income.

b. If the adult child fails to contribute according to the Schedule, legal action shall be taken to enforce support.

4347.1 Determination of Relatives' Ability to Support - Cont'd

SCHEDULE FOR SUPPORT OF PARENTS

No. of dependents (including self)	1	2	3	4	5	6	7	8	9	10
50% of monthly net income over:	$145	195	245	290	330	370	410	445	490	530

Savings: An adult child who has savings of more than six times the monthly income figure in the Schedule for Support of Parents is expected to contribute 50% of his savings to his parents. The method of payment is to be worked out by the adult child and his parents.

4347.2 Procedures to Secure Voluntary Support

It is the recipient's responsibility to provide information about his relative's financial ability to support.

Form DPW-15 shall be completed by each legally responsible relative. The worker shall interview the relative when:

1. DPW-15 is not returned or is returned incomplete;
2. The relative appears able but is unwilling or not supporting;
3. The relative is not contributing in accordance with the Department's schedule.

If the social worker is unsuccessful in securing voluntary support, he shall arrange an interview for the legally responsible relative with the supervisor or county administrator before initiating court action.

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4347.3 Court Action

The recipient shall be referred to the county attorney or public prosecutor to secure a court order for support against the following:

1. A husband who is able but refuses to support his wife adequately.
2. A parent who is able but unwilling to pay for a needy child's support or is paying less than he should.
3. An adult child who is able but unwilling to contribute toward his parents' support.

If a recipient is unwilling to take such legal action within 1 month following discussion of the need for legal action, the recipient and those legally dependent on him for support shall be ineligible for further assistance.

4347.4 Court Orders

The Department cannot require an individual to make greater contributions than have been ordered by the court.

The appropriate court shall be requested to enforce or amend an existing court order for support against any legally responsible relative who is not complying with the terms of the order or whose income has changed.

4347.5 Natural Fathers - Establishment of Paternity Of a Living Child Born Out of Wedlock

Support from the father is a potential resource to a child born out of wedlock. The social worker shall assist the mother to secure that resource for the child through this process of establishing paternity.

4347.6 Assistance Payments to Unmarried Mothers and Their Dependents

Eligibility for assistance shall be contingent on one of the following actions:

1. The father legally establishes paternity of the child voluntarily; or
2. The mother initiates legal action to establish paternity; or
3. The mother consents to have the Department initiate such action.

4347.6 Assistance Payments to Unmarried Mothers and Their Dependents - Cont'd

Exceptions to this policy shall be made when:

1. It is not possible to establish the identify of the alleged father.
2. The child has been born of an incestuous relationship.
3. The mother has released, or is considering the release of, the child for adoption within 3 months. (If such release is not obtained within 3 months, then the above policy will apply immediately.)
4. The mother and the alleged father are planning to marry.
5. The alleged father is married and living with a family of his own.

Action to establish paternity shall be taken within 6 months after the birth of the child or the date of application, whichever is later. If the mother is unwilling to take legal action or to have the Department do so, she and her legal dependents shall be ineligible for assistance. Whenever the mother reconsiders and takes legal action, she and her legal dependents will be eligible, if otherwise in need, until the child reaches the age of 2 years. However, if the child at the time of application is 18 months or older and the unmarried mother refuses to file for establishment of paternity or to have the Department do so before the child is 2 years old, she and her legal dependents shall be ineligible for assistance for 6 months.

If the mother is deceased, missing or incompetent, the Department shall act as "next friend," attempting to get voluntary establishment of paternity, otherwise filing action in behalf of the child.

4347.7 Legally Responsible Relatives Outside Hawaii

The social worker shall help the recipient secure support from a legally responsible relative who is living at a known address outside the Territory by writing a letter or helping him to write one to the legally responsible relative. If this fails, an evaluation of the relative's situation by the public welfare agency in his state shall be requested prior to initiating compulsory action under the Uniform Reciprocal Enforcement of Support Act.

4347.8 Uniform Reciprocal Enforcement of Support

Except the District of Columbia, all U. S. jurisdictions have laws requiring reciprocal enforcement of support.

Action under the act is initiated by a letter signed by the county administrator addressed to the county attorney of the recipient's county of residence. The letter shall refer to the Uniform Reciprocal Enforcement of Support Law and shall request the services of the county attorney in behalf of the recipient. It shall include:

1. Dates of contacts with legally responsible relatives
2. By whom made
3. Results of contacts

All necessary follow up will be done by the county attorney. Support payments will then be made directly to the individual.

4348 RESOURCES IN KIND

4348.1 Real Property

Real property owned by an applicant or recipient is considered a resource.

Form DPW-63, Property Description, shall be completed and Property Agreement, Form DPW-10 shall be signed by each applicant owning real property before eligibility for financial assistance can be established. Only that portion of leasehold property owned by the applicant shall be covered in the DPW-10.

If a client has a claim to property which has never been established legally, the services of the county attorney may be requested by the county administrator.

4348.11 Joint Ownership

Joint ownership may not permit or may limit the ability of the family to use the property as a readily available resource. The family may receive assistance until such time as the conditions of the title can be changed. If the property is in the name of an applicant and his spouse and his minor children, the entire tax-assessed value shall be the figure used

EVALUATING RESOURCES: Real Property

POLICY	*PROCEDURE*
1. Real property, owned by an applicant and by family members included in his application, is considered a resource except for: a. Home property for his own use if tax-appraised value is $10,000 or less. b. Other property if tax-appraised value is $150 or less. c. Burial plots.	Verify following by checking documents owned by the applicant, or by clearing through State Tax Office: a. Ownership; b. Tax-appraised value; c. Property tax; d. Mortgage status. Verification is also required at eligibility review.
2. Legal Status Property tied up by legal conditions or unclear title is not considered a resource until it has been cleared. The recipient must try to remove the conditions or clear the title as soon as possible.	If legal questions arise, they should be cleared with Legal Counsel or County Attorney.
3. Agreement A recipient who owns real property, must agree to get the Department's permission before conducting any transaction involving real property. This includes selling, sub-dividing, leasing, renting or buying such property. The agreement must be signed within 30 days of application.	Use Form DSS-10, Real Property Agreement.

POLICY	*PROCEDURE*
4. Liens An applicant for, or recipient of, OAA must give the Department a lien on any real property he owns within 30 days of application. Both spouses must sign the agreement even if only one spouse owns the property. Improvements on Homestead land leased from Hawaiian Homes Commission are exempt. a. Amount. The lien on real property owned by OAA recipient shall be for the total amount of assistance granted after effective date of lien, and shall remain effective until paid or waived. b. Waiver. The Department may waive or release the lien in part or in whole if the collection: 1) Works hardship by depriving the recipient or his widow and minor children of a home or maintenance funds; 2) Costs more than amount the Department would realize; 3) Can be made from another source, such as insurance or personal property.	Use Form DSS-66, Lien Agreement. Effective date, first of month lien is signed or date application is signed. For collection, notify Fiscal by attaching Lien Agreement to Form 5 if payment is being stopped or to memo if case is closed. On closed cases, refer persons inquiring about payment to CDA. For waiver, County Division Administrator's approval is required. Notify Fiscal over CDA's signature. CDA's responsibility County Division Administrator must develop procedure to record liens at Land Court or Bureau of Conveyances. Fiscal responsibility a. Compile amount of lien. b. File claim with court. c. Collect money after clearance with social worker. d. Issue certificate of release upon full payment or waiver of full or part payment. e. Notify family or estate.

POLICY	*PROCEDURE*
5. Property Transactions If the applicant has property which is considered a resource, he may either: a. keep it if he or it can produce a regular net income, or b. sell it. The following conditions shall be met before assistance can be continued: a. Submit plan to the Department for permission and approval within 30 days of application. b. Complete action on approved plan within 90 days of submission date. Extension beyond 90 days is permitted with CDA's approval.	Use Form DSS-64, Permission to Conduct Property Transactions. CDA must approve plan within 30 days of date the applicant submitted his plan..
6. Sale If the applicant's plan is to sell, he must accept any offer reasonably near the appraised market value. a. Net income from sale of property, except when authorized to purchase equity in a home, must be applied to meet cost of living requirements.	
7. Income from use of property, such as rental or farming, must be applied to meet requirements after deduction of authorized expenses.	For farm loans and help in developing farm homes, refer recipient to Farmer's Home Administration, U. S. Department of Agriculture.

POLICY	*PROCEDURE*
	For loans to buy farm equipment on Hawaiian Homestead property, Hawaiian Homes Commission.
8. Transfer of Equity from One Property to Another A recipient may sell his home and buy another within the $10,000 limit when: a. his mortgage payments are above the rent maximum and cannot be reduced, or b. his home is tax assessed over $10,000. If he does not have a home, he may sell his other real property to buy one.	Director's approval is required.
9. Conditions for Allowable Home Purchase Following conditions govern purchase of a home: a. Proceeds must be sufficient to pay selling and buying costs. b. Total amount of new mortgage must not be higher than that on property to be sold. c. Total monthly payment for principal, interest, taxes and insurance must be within	

POLICY	*PROCEDURE*
Department's rental allowance for his family size. d. Money from sale must be placed in escrow with a bank or appropriate institution. e. New home must be purchased within one year of date of sale of old home. After one year, money from sale is considered income and must be used to meet needs.	

4348.2 Personal Property

4348.21 Automobiles

An automobile valued at $400 or less by current California Blue Book listing shall not be considered a resource. If the car's value is more than $400, then it shall be sold at the current market price.

A 90-day period from date of application may be allowed to complete the sale of an automobile above the maximum. Emergency assistance may be given during the 90-day period.

4348.22 Household Goods and Personal Effects

Household goods and personal effects such as household applicances, radios, pianos, television, furniture, jewelry, and clothing shall not be considered resources.

4348.23 Food Produced by Recipient for Home Consumption

Food which is raised, produced, or procured by the recipient through his own efforts shall not be considered a resource if such food is used for home consumption.

If the recipient sells or trades the produce in addition to meeting his home needs, the market value of the produce sold or traded shall be considered a resource.

4350.4 Applicant Living in a Needy Family Group - Essential Persons

The needs of OAA, AB, ADC, and AD recipients may include the requirements of a needy person living in the same household if he is considered essential to the welfare of the recipient.

The following persons are considered essential to the welfare of OAA, AB, ADC, and AD recipients:

1. A spouse who is not eligible for assistance from a Federal category in his own right.
2. A parent other than the needy caretaker.
3. Any competent adult child, relative, or other individual who renders specific services which are required by the recipient and which would otherwise have to be provided by someone outside the household.

4350.5 Applicant Living in Self-Sustaining Family Group

a. Needs of an unrelated self-sustaining family shall not be included in determining the applicant's needs.

b. Contributions of anyone, with whom an applicant lives, shall be considered a resource.

CONFERENCE ON HAWAII STATE COMMISSION ON AGING

PREFACE

The commission on aging learned in the summer of 1961 that Mr. Bo Boustedt, one of the world's top 10 architects in the design of housing for the elderly, would be making a mainland speaking tour in the fall, and could possibly include Hawaii.

The housing committee of the commission decided to take advantage of this opportunity to present new ideas in design and construction to all who might be planning housing for the elderly. Mr. Boustedt's main interests, and most of his work, has been in the design of boarding homes for the aged, homes for persons who are no longer able to live alone, but who do not require nursing home care. There are no homes of this type in Hawaii, and the committee felt that hearing from a man of international renown would help in our planning for the future.

An institute was planned to bring together architects, contractors, builders, and planners to also discuss the expanding market for retirement housing. It was felt that a discussion of the philosophy and principles of planning for the elderly would be applicable to any type of housing or planned development. It was felt also that State and city planning officials would be assisted in their overall planning for the future by a discussion of building in relation to the needs of the elderly, including health and rehabilitation factors.

With the assistance of the Home Builders' Association of Hawaii, the commission on aging was able to bring Mr. Boustedt from the west coast to Hawaii as part of his tour. The institute was attended by 70 persons, with representatives from industry, government, the State legislature, and lay citizens of all ages.

Mr. Boustedt also spoke to the Kauai conference on aging, and appeared on radio and television. Mounted pictures (12 inches by 16 inches) of the slides shown at the Institute have recently been received from Mr. Boustedt, and are available on loan at the office of the commission for any use.

The proceedings of the institute are being published in the hope that the information will be widely read, studied, and adapted to the needs of housing for the elderly throughout the State.

HOUSING FOR THE ELDERLY

Planning, design, construction with Bo Boustedt, SAR, partner, Bo Boustedt and H. E. Heineman, Kungalv, Sweden

NOVEMBER 13, 1961

10 a.m.: Opening remarks, E. F. Fitzsimmons, chairman, housing committee, commission on aging.

10:15 a.m.: A panel, L. Rockwell Smith, moderator, member, commission on aging:

"Setting the Stage," L. Rockwell Smith.

"The Best Years of Life Aren't Free," Patrick D. Hazard, director, Institute of American Studies, East-West Center.

"Principles and Philosophy of Planning for the Elderly," Bo Boustedt, SAR.

"The Point of View of the Older Person," Miss Ada Erwin, Hawaii Pacific Homes.

"The Point of View of the Builders," E. F. Fitzsimmons, president, E. F. Fitzsimmons, Ltd.

Audience participation.

12:30 p.m.: Luncheon meeting, E. F. Fitzsimmons, presiding: "Health of the Elderly in Relation to Housing," Dr. R. Frederick Shepard, medical director, Rehabilitation Center of Hawaii.

2 p.m.: "Specific Problems in Design and Construction," Bo Boustedt, SAR; panel members: Frank S. Haines, AIA, Paul D. Jones, AIA. Audience participation.

NOVEMBER 14, 1961

12:30 p.m.: Luncheon meeting, Harry S. Komuro, D.D., chairman, commission on aging: "Architectural Solutions in Housing for the Elderly in Sweden," Bo Boustedt, SAR.

2:15 p.m.: Public housing, private builders, urban renewal and development, Federal Housing Administration, a panel:
E. F. Fitzsimmons, chairman.
A. V. Sullivan, director, Hawaii Housing Authority.
Frank Merriam, Chief of Operations, Federal Housing Administration.
Lee Maice, manager, Honolulu Redevelopment Agency.
Oscar L. Fulford, administrator, Hawaii Pacific Homes.
Harry Lee, specialist, city and county urban renewal.
Audience participation.
Sponsors: Hawaii State Commission on Aging, Home Builders' Association of Hawaii.

INTRODUCTION

E. F. Fitzsimmons, chairman, housing committee, commission on aging

Our purpose in being here today and tomorrow is to encourage you, to enlighten you, and to enlist your help in solving the complex problems in the field of housing for the aged. Their problem of reduced incomes, physical limitations, and special housing requirements poses serious difficulties for the elderly in finding suitable living quarters.

There is certainly a lack of suitable rental facilities for the elderly, especially among the low-income group and single individuals. Ours is a fast-moving, competitive, and rather careless era. We have been giving less and less time to our elderly citizens. This is but one of the byproducts of our current pace of living.

A fact to remember is that 80 percent of our elderly persons have incomes of less than $3,500 a year, with a majority of that amount 95 percent, having around $2,000 a year. The State of Hawaii has approximately 29,000 persons over the age level of 65 and 19,000 live here on the island of Oahu. It is conservatively estimated that over the next 10 years this figure will be increased by 20,000.

Presently, we have 15 nursing homes and 32 care homes operating in the State, with a combined bed capacity of 1,057 beds. Only 40 percent of these beds, however, are classified as "suitable." We have two new ones in design or under construction but these are aimed at the middle or lower income bracket. In our housing for the aging we have a very few small institutions on the island and most of those are supported by welfare or community chest. We have one public housing project—Punchbowl Homes—and there is a long waiting list there. So with these few remarks, I'll close by saying: We chanced an opportunity to bring government, developers, planners, and landowners together today hoping to generate enough interest, to educate you on the problem, and to send you away with a germ of an idea, namely, assist and promote housing for the aged.

I should now like to introduce Mr. Rockwell Smith, a member of the commission on aging, who is the moderator for this morning's panel.

SETTING THE STAGE

L. Rockwell Smith, member, commission on aging

I am going to take a few moments of your time to give you a thumbnail sketch of our progress and our attempts to meet the problems here in Hawaii in the last 7 or 8 years. It all started with the Oahu Health Council, members of which we have present here, and the Honolulu Council of Social Agencies. Here, I'd like to mention the Honorable Dorothy Devereux and Mrs. Ethel Mori, who were key figures in that initiation. A conference was held in April 1954 out of which came the Action Group on Aging which became, in due course, incorporated. Through a period of about 3 years, numerous consultants were brought down from the mainland, including Dr. Heber Harper, ex-chancellor of the University of Denver.

It seemed that the greatest interest centered in housing and because of that the action group set up an independent housing committee, and from this came Hawaii Pacific Homes, perhaps better known to you as Pohai Nani, the 14-story highrise building, shortly, we hope, to go up on the Kaneohe side. At the same time, Fred Clowes headed our legislative committee and cleared away some legislative underbrush that the Hawaii Housing Authority felt was in the way of their starting Punchbowl Homes. Subsequently, Punchbowl

Homes did get underway and, as you know, is now in operation, even oversubscribed at the time when it was opened.

In 1957 we felt it was necessary for the scope of the committee to go to a higher level, if possible, and so, with the help of the Oahu Health Council, the Honolulu Council of Social Agencies, and the Action Group on Aging, in 1958 petitioned the Governor to set up an interim commission. This was done in 1959.

So now we have Punchbowl Homes which takes care of people with an income of $4,200 or below; we have Pohai Nani off the drafting boards and under consideration and review by the FHA; we have the State interim commission reviewing housing and construction in its housing committee. We have now come to November 13, 1961, to take inventory.

Our community committee was very successful in going into the details of health problems and housing problems. However, in connection with the White House Conference we did a great deal of research in the amount of available facts about the community and, you will agree with me if you have read our reports to the White House Conference, have dug out a good many. Add these to those of the 49 States and we have literally had bales of data. We were overwhelmed. We stop now in pursuing a hundred solutions in a hundred critical areas to find out if we can, what are the principles we may use to bring clarity and a little more order out of the situation?

Since people in these housing situations we have discussed do comprise societies within themselves to varying degrees, all the way from none at all to rather a complex community in a place such as Punchbowl Homes, we are going to ask our sociologist to speak to the related principles. Then following him we shall call on our housing authority from Sweden to discuss the principles of planning. We will then come back to you, our audience, for your questions and particularly for an indication as to whether we are going into areas that are important to you. It's awfully easy sometimes to take off in directions of our own interest on a panel and we want to avoid that if we can. So we will try to constrain our comments so that we will have time left for discussion.

I should like to introduce Prof. Patrick Hazard, director of the Institute of American Studies for the East-West Center.

THE BEST YEARS IN LIFE AREN'T FREE: ADOLESCENCE AND AGING IN AMERICAN CULTURE

Patrick D. Hazard, director, Institute of American Studies, East-West Center

My task today is to put your theme, "The Stresses of Aging in a Youth Oriented Culture," into the broad perspective of American history and culture. I was very happy to accept the invitation to participate for a number of reasons. First of all, I happen to be an amateur (in the original sense of the word) of architecture. I love good buildings and I like to talk to architects who make good buildings; and if any of you saw our television program yesterday with Mr. Bo Boustedt, you know that he qualifies on both counts.

Secondly, I have a professional interest in the problems of adolescence in American culture. I should, however, disavow my description as a sociologist. I am not a sociologist. This is a touchy point because I am constantly addressing myself to subjects which sociologists feel they have a vested interest in. I happen to believe that a person, who specializes in the humanities as I do, has as much to say in his own way about their subject as sociologists do, perhaps because I have learned a great deal from some of them.

In general, my quarrel with most sociologists is that they are much too acquiescent in the status quo. They can give you a thousand reasons for people doing just what they are doing, while I, as a humanist, believe more strongly in proposing alternatives. I am an "ought" man—we might as well face that right now. I am not satisfied with the quality of American life. At the same time, however, I am so satisfied with the ideals that America has lying dormant too much of the time these days that I believe strongly there is a place for people like me who are not merely content to offer polysyllabic reasons for why people are doing what they are doing. I would rather offer a few simple words about why people can do much better than they are doing, and why the American ideal is precisely not to be satisfied with the status quo. That's essentially why I am here today.

I want to talk to you in the context of a youth-oriented culture about what I believe is the coming revolution in American life. This is the first society

in the history of man which has brought affluence within reach of everyone. This is the quantitative revolution and it's no mean one. It took a lot of doing; it took a great deal of energy, vision, leadership. I believe in that revolution of abundance. I am not one of these people who think that you have made an adequate criticism of American life if you have made snide remarks about tailfins. I happen to like automobiles. There are too many of them for the number of roads we have, but my answer is not fewer automobiles but more roads.

But the coming revolution in American life is a qualitative revolution. That's what this whole debate over our national purpose (or lack of it) is about. We have achieved a plateau of modest affluence for almost everyone in our society. The job that remains is to raise the quality of American life to just such unbelievable heights as we have already raised the quantity.

Remember those skeptics back in the 18th century (the aristocrats who had a good thing going) who said, "What! Give the ordinary man the vote and make an ordinary person moderately wealthy; why they don't understand these things like we do." Well, the 18th century aristocratic skeptic was wrong. We have achieved abundance for the ordinary man—abundance of the body. It's high time we began pushing and lobbying and agitating for an equally pervasive revolution of quality which addresses itself to the things of the spirit.

That seems to me what President Eisenhower's "Goals for Americans" book is about. That's what the national purpose lectures that Time-Life and the New York Times sponsored are about. This is what we're concerned with here at this meeting. The great exciting new frontier in America is not space, external space; it's interior space. It's the spaces between people's ears that too often in America today are vacant, wide-open spaces.

The New Frontier is the frontier of excellence. But before we can measure up to this new and really exciting frontier, we must disabuse ourselves of the youth cult in America. The reason it's tough to grow old in America is because we have defined happiness in terms of being young and carefree. The best years in life are those free from care and responsibility. In fact, by definition, this makes maturity impossible.

Dick Clark, a teenage idol, wrote a book called "Your Happiest Years." He happens to be a Philadelphia product, and I was doing a television program with the same director that put on "American Bandstand," and a little story may bring this whole youth cult into focus.

One of my Detroit cousins, a senior in high school last year, wrote me a letter saying that she was making a spring tour of national shrines. This is a standard school gambit on the "Big, Big Island" where busloads of adolescents head toward Washington at cherry blossom time. She wanted to see all of her most admired ideals: George Washington at Mt. Vernon, Abraham Lincoln and Thomas Jefferson in Washington—and Dick Clark in Philadelphia. She actually, I think, chose the last one; her teacher chose the first three. I said I would be glad to try to get her on "American Bandstand."

So, the afternoon she arrived, I took her down to the studio and, since I am also a camera enthusiast, I decided to do a photo essay on my cousin and Dick Clark.

As I took pictures of these children and their hero, a very strange thing happened. All of the men who were on the studio floor (who knew me because I did a morning educational program on "University of the Air") would make comments like this: "What are you doing, a photo essay on juvenile delinquency?" or "Is this what the University of Pennsylvania is paying you to do?" or "You must be pretty hard up for entertainment." These people, in short, despised what they were doing, and they couldn't understand why I, a serious man, was participating in their absurdity.

A year before, I had another experience in a television studio which was just the opposite. As part of a contest, CBS television called in a woman from every State. They were asked to spend the week in New York observing television productions and writing home to their local newspapers. I went into New York the day they met with Captain Kangaroo. I must tell you (and I believe that this is symbolic of this whole tension in American living between making money and helping people mature). Captain Kangaroo's people were delightful interpresonally. They kidded each other; they loved what they were doing. When you give people demeaning jobs to do (and to brainwash teenagers is a demeaning job), people take it out on themselves and on others. Captain Kangaroo wants young children to become adults and in the process of helping them grow up, he

gains an immense degree of satisfaction in himself. That explains the difference in the climate between Captain Kangaroo's and Dick Clark's television production. In one case they believe in people, really in people, not just saying that they do, and in the other case they believe in making it, as they say.

This youth cult is responsible, in my judgment, for the arrested development of American culture. For if, by definition, adolescence is to constitute our happiest years, then to grow up is to be under constant pain; it means you have to accept burdens that are impossible. On the contrary, I contend that growing up is difficult, but that it is the only humanly satisfying thing to do. Growing old after one has really grown up can be, on the other hand, the very best years of one's life. To be a perennial adolescent, no matter what age one is chronologically, this is the great tragedy of American culture today.

Look at the Miss America contest. I attended the Miss America contest 2 years ago as a Variety correspondent, and was horrified to find old people in their eighties sitting out in the hot sun from 2 o'clock in the afternoon so that they would have a really good seat, as Ed Sullivan would say, to see this apotheosis of female beauty.

Now, I am not opposed to female charms, but on the other hand, there is nothing I admire as much as a beautiful old person or thing. There are not enough people in America today who have thought deeply enough or long enough over the beauty of character, the beauty of face, that represents a long and useful life rather than a vacant one that is cosmeticized into an illusion of youth.

Look at programs like "77 Sunset Strip," "Surfside 6." The ideal in these programs is to go from one night club to another in a convertible, preferably with a blonde, with the top down. This seems to me is a spurious ideal; it is one that is truly subversive of the quality of American life and it seems to me, ladies and gentlemen, that as you address yourself to the problems of aging, you must be concerned about the context of this problem. We overvalue youth, innocence, lack of wisdom, spontaneity, vitality.

At one stage in our national development this was essential and inevitable, It no longer is. We are a grownup culture. We have grownup responsibilities, and we must begin to devalue youth. We must begin to explain to young people that the only satisfying rewards of the human existence are the acceptance of mature burdens, not flitting around in convertibles as they are being taught to do in programs like "77 Sunset Strip" and "Surfside 6."

While I'm on these American Broadcasting Co. programs, I am reminded of a confrontation with the president of that network after he had put a program on about a year and a half ago called "The Splendid American." It was about Tom Dooley, the medical doctor. In this program (and I brought the script along so I couldn't be accused of being an egghead way out in left field) Dr. Dooley said that he had found a happiness in Laos which wasn't the happiness of blondes, convertibles, and whisky. He could have been talking about "77 Sunset Strip" even though I'm sure he never saw the program, but it was a marvelous thrust anyway. I told the ABC president, "I want to congratulate you for holding up for the young people of America a truly important figure, a person who knows that self-sacrifice, working for the public good under trying circumstances, is a real measure of character in a person. Would you please name one program on your nighttime schedule besides 'The Splendid American' that is calculated to produce more splendid Americans in our country?" The answer was and is, for the most part, his network didn't and doesn't have any.

This is hypocrisy in old traditional terms. This same television network is talking in advertising clubs and trade papers about winning the cold war with American television. Now I ask you, is Dick Clark a substitute for the Peace Corps? Is "77 Sunset Strip" or "Surfside 6" really going to show the underdeveloped nations how to aspire to a mature and complex industrial culture? I think not. How then does architecture for elderly people fit into my equation about youth-oriented America?

Architecture is perhaps the most vital art in America today. We are living, for example, in one of the most important structures that has been built since World War II, the Ala Moana Shopping Center, where artists of the community have been asked to embellish and enhance a completely planned organism to facilitate commerce. No, I am not anticommercial. I happen to like affluence personally. I am very much in favor of affluence that is humane. The Ala Moana Shopping Center is not only efficient as a marketing organization but it's a humane place to be. I like to come here with my children just for kicks, just to walk around, just to look at the place, to sit down and think.

I saw a sculpture today that I had never seen before, a mobile with fish. It was marvelous. This is a handsome place, ladies and gentlemen. This is a microcism, a small world that foretells the coming revolution in American life, the revolution of quality. For clearly, architecture is the most pedagogical of the arts. I can't believe, for example, that small children who have gone to our new well-designed elementary schools are going to be responsible for some of the domestic arcitecture that their parents bought in the last generation partly because the parents had gone to pseudo-gothic or proto-colonial type schools.

This is opinion, but I put it out on the table before you. We are teaching people the good life in the buildings they use. This is why the revival of religious architecture is so important in America today. There have been many very ugly churches built in the last 100 years on the mainland. (I am not very familiar as yet with Honolulu churches, so I don't know if what I say applies as much here.) A lot of these buildings are such that it would be almost impossible to be seriously religious. The saccharine sentimentality of the "almost" art of these buildings does not evoke the depth of religious experience that, say, the Gothic cathedrals could and did. I believe that since we are having this tremendous revival in religious architecture the quality of religious life in America will become much deeper.

It seems to me that if there is one single factor in American life which can accelerate the acceptance of a mature America, that can help us accept a revolution of quality, it is a mature arhitecture. Now, mind you, this is going to hurt, because revolutions do hurt. The quantitative revolution hurt too if you remember the ugly coal towns of the 19th and early 20th centuries. It will hurt some people more than others and they will holler and blow their whistles and say, "Well, what's wrong with the America we have now?" Nothing is wrong with it except it isn't as good as it could and must be. The whole genius of America, by the way, has been its reach for the impossible. The Declaration of Independence is absurd on the face of it. All men are not equal, but in striving for equality of opportunity, we have brought to America one of the greatest arenas for human activity in the history of the world.

So look to your architects. They can not only solve your problems in a limited sense, but over the long haul they can encourage people to be willing, as a Newsweek ad ran a few weeks ago, to "get off (their) big fat patios". This ad in Newsweek has a message for all of us. Our architects can encourage us to get off our big fat patios and insure that the whole of American life reaches the levels of quality that we are perfectly satisfied to have in our own little atrium at home.

We will get off our big fat patios, however, only if we begin to play down the "best years are teen" myth that keeps our culture from growing up. Growing old gracefully will take care of itself almost if we learn to grow up as a culture by bringing our intellects and imaginations fully into play.

Principles and Philosophy of Planning for the Elderly

Bo Boustedt, S.A.R., partner, Bo Boustedt and H. E. Heineman, Kungalv, Sweden

My experiences are based on experiences on housing of the elderly in Sweden and, therefore, I should like to give you some general information about Sweden. It is a small country, about the size of California, with 7.5 million inhabitants. It is highly industrialized. Private enterprise accounts for about 90 percent of the total national product, and 89 percent of the labor force is employed in private enterprise. Thus, the economy of Sweden is a capitalistic one and we are not socialized. The Swedish Social Democratic Party has been in power for almost 30 years and still is. Its program does not include socialization of economic life, but has consistently favored private enterprise. Very early in Swedish history, society and the community gave certain social services to its citizens. Hospitals and some support in housing for the aged were a responsibility of society as early as the Middle Ages. Consequently, the principle that society has an obligation to care for the sick and for the old has a very long tradition in Sweden and is not an invention of the Social Democratic Party, and on this principle all political parties are in agreement.

I will also tell you a little bit about our arrangements in Sweden:

1. Old-age pensions, financed by fees and taxes, and given to all citizens without exception at the age of 67.
2. Retirement pensions for everyone, required by law and financed by fees.

3. Domestic assistance given by the Home Help Organization, which has about 12,000 employees.

4. Government-supported improvements of old, but well-built, houses.

5. Special apartments for old people, built with support from the Government. Such apartments are now located, for the most part, in ordinary apartment houses. The total number is now about 35,000.

6. Increased scientific research work.

7. And finally, boarding homes for the aged.

I feel, and the Swedish people feel, a responsibility to take care of our old people. We feel that the old people should be granted an equal part in the economic development and we feel that the young people must help solve this problem. Our old pensioners have taken part in building up this prosperous society. We have a lot of arrangements for old people, the main goal of which is keeping them out in society. For this purpose it is necessary for the older people to be able to take care of themeslves. Therefore, three things are necessary: economic security, medical security, and a roof over their heads.

Thanks to these economic arrangements and to the Home Help Organization, the majority of the pensioners can take care of themselves. Only about 25 to 30 percent need some additional care. In this connection I should like to say that our old people over 65 equal about 10 percent of our population which is similar to the situation in the United States, and also this number will increase up to 30 or 40 percent by 1975.

I think the idea of keeping old people out in society is most important, and this leads to further discussion on arrangements for old people in institutional situations. It is necessary to avoid, in my opinion, concentration of old people. We try to mix the apartments of old people, middle-aged, and young people. We now try to arrange it so that apartments for older people are mixed with those of other ages. This we were able to do beginning in 1930 and 1940 and more so in the late 1950's.

People living out in society in the ordinary apartments can take care of themselves. When these people need certain care, certain assistance, certain help, more than the Home Help Organization can give, then we can take care of them in these boarding homes, thus avoiding having to send them to nursing homes, hospitals, or institutions. We can then keep these people out in a sort of homey atmosphere, apart from the institutions. These boarding houses, homes for the aged I call them, are sort of the next step from apartments, and this step will not be too big. We try to locate the boarding houses as centrally as possible and to adapt them to the ordinary apartment milieu. They are not institutions; they do not belong to an arrangement like hospitals. They still belong to the ordinary type of living. It is also important to put these homes for the aged in a central part of the community, if possible. We try to encourage the nice type of living between all the tenants in the home and try to encourage contacts with the outside. This location of the homes for the aged is one of the most important parts of this program.

There is no problem in the location of apartment houses for older people. The problem is involved in location of boarding houses. The central location gives the possibility of many visits to the home, by outlook from the home on interesting spots and traffic and outlook over the rest of society where things are happening. We don't believe in concentration of these homes for the aged or in special villages. There is an example of such in Copenhagen called the Old People's Village. This is a concentration of all sorts of arrangements for older people, apartments, homes for the aged, nursing homes, hospitals. It is just a town built up around and with older people. Old people don't like to see other old people around them too much. They prefer to have contact with the younger generation, and this concentration of older people, once more, I think, makes it very difficult to create a natural milieu. That's the reason we try to spread out this arrangement for older people so that it will not show up in any sort of special villages or buildings. That's the reason we try to cut down the size of the homes for the aged into small buildings between 30 to 35 rooms and up to 70 rooms, and to locate them in different parts of the town, so every part of the town or suburb will have its own homes for the aged. It is economic from a cost point of view to cut down the size of these homes for the aged. Homes with more than 70–80 rooms will give increased rooming and construction costs.

Another important thing is that we do not mix medical care or nursing care with homes for the aged. The authorities for medical and social care are completely separate in Sweden. The Hospital Act we have in Sweden since 1959 stipulates that medical care should be handled by medical authorities and not

by social welfare. Also, homes with mixed facilities, with nursing rooms, etc., will give a feeling of an institution, and it is impossible to avoid in this case the institutional character. The hospital arrangements are also now so complicated it is impossible to include this care in homes of limited size. So if we mix sick and healthy people in these boarding houses, we have bad homes for the aged and also very bad hospitals. We will not have solved any problems.

In all our designs for the old person, we try to put him in the center and design everything around him, from the outlying big to the smallest details. Interior design in furnishings as well must be adapted to the old person. It is impossible to study old persons needs and reactions, and it is also possible as an architect to solve this problem to help make the stay in these homes happy and full of activity. One of the main goals in this design is to keep old people out of bed and also out of their rooms, to try to give them this contact with other people in the home, and also contact outside, and in the same way they must be granted the possibility to live as individuals.

I shall end with this since I will show slides this afternoon to give specific ideas how to solve this problem to avoid institutions and adapt designs to older people.

The Point of the Older Person

Miss Ada Erwin, member, Property and Management Committee, Hawaii Pacific Homes

It is very obvious that I was not reared in a youth-oriented era as every day that I live I find more interesting than the day that has just passed.

As a homeowner, I am torn between wanting to stay in that home as long as I can and leaving it for what I know is the right move, a retirement home. As one grows older, looking after the details of housekeeping and property maintenance become a burden physically as well as financially. We do not have, in Hawaii, household help. It has become increasingly hard to find, and a really competent yardman is practically nonexistent. If help can be found, the wages demanded are quite beyond the means of a person on a retirement income.

We all pray that we shall be able to look after ourselves to the end, but as we cannot choose the time and manner of our going, we must make plans so that in case of need, we shall not be a burden to relatives, friends, or neighbors. A retirement home with life care seems to me the best and only solution to this problem. One of our friends who has lived for a number of years in such a home, recommends taking residence as early as possible. It seems less difficult for a younger person to make the adjustment to group living. It is easier to make friends when one is able to take part in group and community activities.

In changing one's mode of life, there will undoubtedly be many adjustments to make—an apartment instead of an entire house with the surrounding garden, different food than one is accustomed to and served in a large dining room, accustoming oneself to a larger group, many of whom are strangers, having to adhere more or less to routine and regulations. But if one makes up one's mind that although different, life may be as pleasant, the adjustment should not be difficult. There are bound to be persons in the group with similar interests and tastes. Perhaps there will be more time for reading and hobbies. In Pohai Nani, Honolulu friends will be only over the Pali. Assurance that one will be taken care of will bring peace of mind that should compensate for all the drawbacks.

The Point of View of the Builder

(E. F. Fitzsimmons, president, E. F. Fitzsimmons, Ltd.)

Many are the problems involved in building which I use generally here today deal not only with housing for the elderly but with all types of housing, particularly on the island of Oahu. We have very intelligent people doing what we call planning work, men who have to use vision and make forecasts which have to do with the forecasts of usage of land, highways, and other uses. I have come to believe (and I am probably the only one in this room who will agree with myself) that planning, particularly when it comes to residential use, and I term "residential use" as all facets of building that have anything to do with human occupancy—that is, where they sleep, work, and have their recreation—has created a mass speculation of ownership of land. Further, I have noticed over the period of years that in our planning, by the time the plan comes out, there already needs new planning done to take up the slack.

To this extent, I should like to digress at this moment and tell you that in England they have a similar problem like ours on Oahu. They have a large population and a limited amount of land usage. Winston Churchill once said that all the wealth of the world, particularly that of England, is tied to land; all wealth is in land.

I will give you another idea of what I am talking about. In 1957 a parcel of land was offered to me in fee simple, 40 acres. At that time the gentlemen wanted $800 an acre for it, and because it was just about 1 foot over high tide, I thought it was just too much money. That land was reoffered to me again in 1960 for the total sum of $200,000. It had risen in so-called value of speculation to that amount of money. Recently a group of gentlemen came into my office and said, "I understand in 1959 or thereabouts, you were interested in this piece of land," and I said, "Definitely I was." "Well, we'd like to offer it to you for sale." I said, "Well, gentlemen, what are your terms?" and they said, "Our terms are $400,000." This land needs 7 feet of fill to make it usable. Now that is going on all over our island, and this brings us back to the first part of my speech which is planning.

I don't understand why planners cannot see further than 2 years or 5 years in growth. It is easily understood if you create 30 acres of apartment area and there is a total demand by the time it comes out for 90 acres, that the person who owns the land is going to get a great amount of money. I can give you an example up in Makiki where land 5 years ago was $1 a square foot. Today you are lucky if you can buy it for $9 a square foot. The people knew that this was coming up sooner or later for additional apartment uses, which gets me back to the problems of the builder in housing for the aged.

The aged, from all that I have been able to read, like to be close to the center of activity. They don't like to be regimented in tall concrete towers. They like to live as we all live presently, comfortably in our own small neighborhoods. They like to visit with small children and they like to be visited by small children. They like to walk by the neighborhood store and to be able to take advantage of open areas within this residential area. They like to be near buses, shops, motion picture houses and the like, but every time we turn to find a piece of land that can be put to that use, either for a garden-type apartment or a small housing subdivision that will take care of housing for the elderly, you hit up against a stone wall of the cost of land. Because the moment you try to put it to the usage you want it for, you find that because of the cost, it is not feasible.

I don't know what the answer is personally and I am hoping that during this conference we may be able to get some concrete ideas. I also hope that possibly as a result of this conference, some of the large landowners we know would come forth with projects to take care of these older persons as well as our younger persons who are in the same financial condition.

Discussion, Panel Members and Audience

Monday, November 13, morning session

Mr. Fitzsimmons. Mr. Boustedt, in your homes for the aged and your care for the aged, is this entirely government supported, or is it private?

Mr. Boustedt. Very little is private. It is not so bad as you think because it is the local community, the local small towns and villages who solve these problems themselves. If it should have been a National Government who had taken care of the problem, I think it would be solved by anonymous. Now it is by the people elected from all groups. They know the people and the care needed, and it is a very personal relationship between them and the clients, as you say. So the homes for the aged and care of old people is on the local level. Because of this arrangement we don't need private help. In the United States it's different. It is necessary to be solved in both lines, along several lines, in fact—churches, unions, private enterprise. Then, also, it is necessary to take care of those people who are not in groups and cannot be helped. Here the local community must help.

Mrs. Devereux. Did I understand you to say that when you get beyond 70 in number that apartments cost too much and that is one of the reasons why you limit the size?

Mr. Boustedt. It is not the apartments. I meant the boarding homes. Where the number of rooms for the homes for aged were larger than 70, we found increased running and construction costs. It's not the apartments. You can make as many as you like. When it's a question of certain care, the boarding homes is an institution even though we try to avoid it. When it is a question

of such institutions, it will be a problem if it is too big. You will not gain so very much.

QUESTION. One other question: Is food service provided for in these apartments for older people?

Mr. BOUSTEDT. The apartments are efficiency units as you say, where people can make food for themselves, sometimes with the help of the home help organization who assist in cooking. There are also possibilities of buying from a central kitchen but not so very much. In Copenhagen they have such central kitchens. You can buy your food and take it to your apartment and eat it. We do not have so much of that arrangement.

QUESTION. Did I understand you to say these boarding homes where they need more care are under the jurisdiction of the medical authorities rather than the welfare department?

Mr. BOUSTEDT. No; it's the social welfare authority. The medical authority has nothing to do with this sort of care of old people. It is divided completely: the social welfare authority, the medical authority, the boarding homes, the apartments, the home help organization, the improvement of old houses; everything is under the social welfare authority.

QUESTION. Then what did you say relating to medical authority vs. social welfare authority?

Mr. BOUSTEDT. I meant they are divided completely. We don't mix any sort of social care and medical care in the same building. They are just not mixed.

Mr. SMITH. Perhaps I can clarify this with a question: When a person in one of these homes is ill, what do they do?

Mr. BOUSTEDT. If they get ill, they follow the usual procedure: go to a hospital, are treated, cured, and return to the homes.

QUESTION. How in Swedish apartments and boarding homes do you rationalize the situation of elderly people being in mixed areas where there is noise of children, traffic, etc., which can be very confusing? In most places older people are separated from the usual community confusion of schools, buses, etc.

Mr. BOUSTEDT. If we mix the apartments among ordinary apartments and homes in the normal community, contact with others is kept in a very natural way. Older people are not disturbed by traffic. The people with rooms facing the highway like the activity of the traffic and don't want to change rooms. Perhaps older people don't hear so very well and like the compensation in activity around them. We have found that homes located next to schools are all right also.

Mr. FULFORD. Is 67 the retirement age in Sweden?

Mr. BOUSTEDT. Yes.

QUESTION. To what extent do you have recreational activities in the homes with just 70 members? In our experience in the Pacific Homes, we have found it necessary, in order to provide the common amenities, to think in terms of 200 from a financial standpoint. To what extent have you provided activities?

Mr. BOUSTEDT. We have hobby shops and hobby work is of the greatest importance. Things they do are not done just for the occupation and then thrown away. They are salable and people like to have them. We have a lot of hobby shops and hobby educators who go around and teach. We have no arrangements for outside sports, such as croquet. Those in the boarding homes are too old and weak. If persons can do activity, they can take care of themselves. As to size, 70 to 80 rooms is a big home already and from the human point of view, we try to cut down the homes to as small units as possible to get away from big institutions and to approach, as far as possible, the family size room. You can live together with 5, 7, or 10 persons, but not more. You cannot live as a unit with 30 to 50 persons. It's not normal. That's why I try to limit the size. I am happy to find that smaller ones are economical. Much of the cost depends on the staff, upon the night attendants. More than that, you must have two people in service. In the United States, of course, you have shorter working hours and higher salaries, and maybe bigger units are more economical.

Mr. FULFORD. The homes you are talking about are different from our retirement homes where we do not need care. Therefore, we can have a larger membership.

Mr. BOUSTEDT. The less care, the more units are possible, of course.

Mr. CLOWES. Thirteen of our States have laws forbidding discrimination in employment because of age. What is the situation in Sweden?

Mr. BOUSTEDT. We try to keep our old people in the employment market as long as possible. We have no situation with people out of work. We are very anxious to keep our people working as long as possible, so we are not interested

in having a low pension age. At 67 you can continue working, but 67 is the year when you get the pension anyway.

QUESTION. There is no compulsory retirement then in Sweden.

Mr. BOUSTEDT. Sixty-seven in a way, it depends upon the employer. In government business, of course, you have to leave.

QUESTION. These homes are for the unemployed largely?

Mr. BOUSTEDT. Yes, because in these homes for the aged, they are so weak they cannot work any more. In the apartments, of course, they can work and we use very much the pensioners. If they don't keep the ordinary work, they can perhaps do something else when they are retired.

QUESTION. What is the relative cost per unit for multistoried apartments or nursing homes?

Mr. BOUSTEDT. The total cost is about $5,000 per person, the running cost $3 to $4 per day per person. The apartments would be around $5,000, also the efficiency unit, as you say.

Mr. FITZSIMMONS. That is for 280 square feet?

Mr. BOUSTEDT. Yours are a little larger than ours.

Mr. FULFORD. Does this include all costs?

Mr. BOUSTEDT. This is the total cost, including common rooms, et cetera.

Mr. FITZSIMMONS. Do you have regulations with doors, corridors, et cetera?

Mr. BOUSTEDT. We have not so many regulations because in our apartments we can solve them rather like ordinary apartments but we adapt them to older people. There are such things, of course, but the difference between apartments for older people and ordinary apartments is very small because we try to solve these things in connection with the ordinary apartments as far as possible so there will not be special arrangements, more than is natural. I know you have a lot of regulations here but we have very little regulations because our social board is anxious to give the architect a rather free hand to experiment and try to develop these things. If there is too much regulation except for the principle, that will stop the development and also the architect who perhaps will not be so enthusiastic.

Mr. HAZARD. Do you have any particular glare and noise problems of control because of the lower fatigue threshold of older people?

Mr. BOUSTEDT. We have a lot of such problems even in the boarding homes where everybody has a single room. We have to do the solution in sound-proof rooms in order to be able to live an individual life. With radio, TV, et cetera, there must be good insulation. We must avoid blinding light; it's a question not of much light but of sufficient light. We work with daylight all the time in all parts of the home, with light from different angles to get much light all the time. I dislike very much to live in rooms with artificial light and artificial air, and there will be artificial milieu. Daylight is a very important thing.

Mr. HAZARD. Wouldn't old people be more susceptible to respiratory diseases? Wouldn't it be worthwhile to have a controlled environment with respect to air?

Mr. BOUSTEDT. We have no airconditioning in our homes. We don't need it. We have a very special problem. We get drafts without any special connection with the outside. The cold outside walls cools the air and the air will pull down and warm air go up in the room making a circulation in the room and giving a feeling of draft. You think something is open but it isn't. They concentrate on hitting the outside wall to make a warm air curtain so the cool air will not go from the outside wall down in the room.

Mrs. DEVEREUX. I was very much interested in Mr. Fitzsimmons' remark that we have been neglecting planning. In relation to cultural opportunities for young people and what it is going to do to them when they mature or what it is doing to prevent them from maturing properly, is there one single thing which we in this community can do to help improve the situation in Hawaii?

Mr. HAZARD. It isn't the function of someone as new as I am to the community to comment. If there is one single thing that we prodigal Americans need to learn, it is that the great break that history gave us, a virgin continent with overflowing intellectuals and economic energies of Europe, imposes a burden on us. We have not lived up to that burden as much as we need to, simply to keep going. We don't know how we can break down this feeling of prodigality. The situation of the litter at Hanauma Bay is a very distressing example. What is there about the prodigal American that makes him unwilling to think about tomorrow? We have in Hawaii one of the most promising sites in the world. yet if you look back on mainland experience, the Weyerhauser people learned the need to timber farm too late; the dustbowl of the 1930's taught us we were prodigal about the land it took centuries to develop which we unceremoniously

dumped in the Missouri River. We are running out of time. We can't go on squandering the heritage that took millenia to build up and expect to be a great country. It simply isn't in the books.

Going back to the Ala Moana Shopping Center, the planned shopping centers that have been built on the mainland and here since World War II are the best single examples of what the America of the future has to be if we don't want to descend into an impossible muddle. It's happened to other great countries before; it can happen to us. Now why is the Ala Moana Shopping Center a pattern of the State? Before my time, in the 1920's, when urban planners told the businessmen that if they don't think about planning for the future, they would strangle themselves, these men for the most part just laughed, saying that these planners were long-haired dreamers and idealists who had never met payrolls. Well, we're strangling and if you have sat in a car as long as I have on Kapiolani Boulevard, just waiting to shift gears, you will see that we are strangling here in Honolulu, too. The painful but actual facts are that we didn't heed our idealists in the 1920's; we didn't heed Lewis Mumford who said it was going to happen and it did, and our time is running out. If we don't learn how to live in a complex industrial culture, we are certainly not going back to agrarian dreams to the small farms which many people are using to keep us from planning thoughtfully about the future. If we don't accept the discipline of collaborative living in a complex urbanized culture, we've had it. It's as simple as that, and I say that the Ala Moana Shopping Center is so much superior to the other streetscapes of Honolulu and a number of cities on the mainland that if we don't learn the lesson that commerce itself is better, more efficient, when it is conducted in a planned orderly environment as it is in the Ala Moana Shopping Center, then we don't deserve the greatness that we are still capable of in this coming revolution of quality. If we don't very soon begin to think of the day after tomorrow at least, then I'm afraid that America is going to turn into a Disneyland of smog, and I can't think of a more depressing alternative to the possibility that we still have, but they are not going to be here very much longer.

Mrs. STANGLE. What will be the relationship of young people and older people with regard to retirement villages for older people? What will be the interaction? Will this have any effect on the younger person as to what will happen to him when he becomes an older person?

Mr. HAZARD. I admit a bad pun with Mr. Boustedt yesterday as we were talking about retirement villages for older people. I called them ghettos or "forghettos" for older people. Since I happen to believe that wisdom is in direct correlation to the number of gray hairs one has, it would seriously impoverish our culture if we try to push the older people off into Cape Coral or whatever. I much prefer Mr. Boustedt's alternative which is to put these places in the circulation patterns of the cities they are designed for, so that the retirement home would be like the Ala Moana Shopping Center, for example.

Mr. FITZSIMMONS. I can't understand why we are trying to make a problem of being a little older, say, than I am. I am sure that the children of Professor Hazard don't mind having older people around and older people don't mind having younger people around. Many of us today are living in neighborhoods where there are both, and we are congenially getting along with one another. I don't see why we should make a problem of what we are going to do with the elderly. Let's do as all the experts claim we should do and commingle people in any form, whether it be arts, sciences, or just plain living.

Mr. BOUSTEDT. I should like to comment on Mr. Fitzsimmons' remarks. It's exactly what I feel myself and exactly what we do in Sweden. It is no problem to be old. The problem appears when you need certain care and then my interest appears and we have the home for the aged to rescue and save people from more institutional and hospital care that they are in need of.

Miss ERWIN. To come back to the question that was asked some time ago about the disturbance of noisy children in the neighborhood where there are older people, I think we have a unique problem in Honolulu where the windows and doors are open the year around. It is quite different from Sweden where they have 9 months of winter and the other 3 months of the year are late fall, where the windows are closed most of the year and you don't get this outside noise. In our particular neighborhood we have lots of children and some old people. I think most of the old people are not disturbed by the children's noises but there are some of them who are disturbed by the noises. We notice the difference when the weather begins to get cooler in the winter and we have the

windows closed perhaps a little bit more than we do in warm weather, and there is quite a bit of difference in the amount of noise, especially at nap time. It seems to me the solution would be to have quiet time in the afternoon when the older people like to have a little rest between 1 and 3 or even 1 and 2, and have it understood in the neighborhood that the children should have quiet playtime instead of some of the noisy play that they have.

Mr. HAZARD. Is there a possible architectural solution even in Honolulu to this sound problem? Is it possible to have an acoustical louvre that would break up the outside sound without keeping out the outside air?

Mr. FITZSIMMONS. A practical solution to that problem is to choose the master bedroom and air-condition it with simple window air conditioning. It should also give you the ventilation that you need plus the quiet, and this can be done very cheaply.

Mr. GILBERTSON. We talk about the cost of land over here and also in connection with the housing. My question is what is the size of apartments here for the elderly as compared to the size in Sweden?

Mr. FITZSIMMONS. Most of your apartment size is governed by Federal regulations. We build either for the elderly or for just those who are going to grow old. The unit size is controlled by minimum specifications under Federal regulations. In an efficiency unit here, with a combination kitchen-bedroom, not including the bathroom, you can get away with 190 square feet. Most of the builders who are building from an architectural point of view end up with the size of about 280 square feet because it is the feeling, particularly in Hawaii, that 190 square feet is just a little too small. You don't have that stretch room that the additional 90 square feet will give you.

Mr. BOUSTEDT. The efficiency size in Sweden is about the same. We also have only one room, kitchen, and bathroom, and sometimes one and a half rooms very much the same as yours. We are the same sized people.

HEALTH OF THE ELDERLY IN RELATION TO HOUSING

R. Frederick Shepard, M.D., Medical Director, Rehabilitation Center of Hawaii

From my standpoint I think that a meeting such as this, or an institute such as this, is really long overdue. I've had some things that I've wanted to discuss with people who come from the backgrounds that you come from, but I've never been able to single out one that might serve our interests better than any other. It is my understanding that you have real estate developers, architects, and city planners here, and you have people interested in the medical and social aspects of the aging population.

I am going to talk about some very mundane things, and I understand that you probably involved yourself in some very lofty conceptual schemes as to whether old people should be grouped together, or whether they should be left where they are, or whether they should live with their families, or whether they should be farmed out somewhere on a high, windy hill. But in joining a group that are in the construction and planning, real estate, and various engineering aspects of housing, I feel that I can belong here. I am an M.D., but a patient referred to me not too long ago as a human-being carpenter. So, as a human-being carpenter, I should be free to discuss some of these architectural things if you will.

Now, I think I share this view with most physicians: That the elderly and the aged present no problems that young people or young adults do not present until they have some kind of physical impairment. A good starting point is an elderly person in New York City where the buildings were built before elevators were available. Here, there are many people living on social security in some of these old, East Side New York hotels and their walkups. One of the things that is keeping these people going and keeping them in good vigor is the fact that they have 5, 6, 7 flights of stairs to climb every day. Now these elderly people are not a problem. I don't think any elderly person finds environmental problems or social problems until he begins to suffer some change in his health.

I wouldn't like anyone to think of me as considering elderly people any different from anyone else. I don't think of handicapped people as any different from anybody else. But if an elderly person gets aging changes in the central nervous system and becomes tottery, and if he has to walk up some of these wonderful outstretched marble steps that are the usual approaches to all our wonderful public buildings, and if there's not a railing that he can get a little

steadying from, why, this person is very prone to fall, develop fractured hips, and never enjoy community living again unless there is a lot of effort gone into finding out what kind of an environment these people are put back into.

We are all, I'm sure, very concerned with the same problem, but, as it too often happens, the left hand does not know what the right hand is doing and that is why it is very difficult for some of the engineers to sit down and say, well, what do we really have to think about? It isn't where it is or whether the people are grouped together so much; it's just what there is in the environment that precludes the individual functioning as an independent social being.

In rehabilitation, people that kept working in this field were intensely interested, not only in the disabling or the handicapping or the physical impairment, but in all the environmental things that are going to be operating to reduce the independence of the individual. When I first came here in 1955, after completing 3 years of residency in this field of physical medicine and rehabilitation, I really did not get an appreciation of what diversified work I was going to be involved in until a paraplegic male, who was fortunate enough to be offered a job in a downtown woodworking shop, came back and said that he was going to have to quit the job. The reason he was going to have to quit was that somebody had put a 24-inch door on the toilet. This 24-inch door would not permit passage of his wheelchair that he was dependent upon. By getting a mason and a carpenter, we all met down at Sorenson the Woodcarver's, chipped out tile, put up a new door frame, found a door somewhere and set it. This made all the difference between this man's enjoying stable employment or going into some sort of sheltered work environment so he could apply his crafts.

The elderly are not different and the physically handicapped are not different as people, but they do differ in terms of how they can function in their environment. We work with handicapped and I would say that probably 80 percent of the patients I work with are over 50. These are the patients who have strokes, patients who develop arthritic conditions that reduce their mobility. Physical medicine and rehabilitation are concerned with diseases that impair a person's mobility. When a person's mobility is impaired, it means perhaps crutches, braces, or more often than not, it means wheelchairs. This is another good reason for being referred to as a doctor carpenter or a human-being carpenter.

It does not really matter whether you're thinking of institutional design, hospital design, private home design, or nursing home design; there isn't a patient that we discharge from the rehabilitation center that we do not have to involve ourselves with as a team, consisting of an occupational therapist, a physical therapist, a social worker, my assistant. This team is very concerned with the changes, the environmental changes, that have to be made in a home so that the patient can stay in the home or even be received in another institution. We do not feel that our job is complete unless we have gone into these places where we are transferring our patients and this can be, of course, his own home. The reason is that we can teach an elderly person with heart condition or a person who has had a stroke to walk with a drop-foot brace and a cane; we can teach arthritics to walk with crutches, but we know that if we don't inspect the home facility (and changes in the home are now routine), the patient may end up as a dependent individual receiving a bed bath and again going back to being bedpanned.

I said these are going to be very mundane remarks; these are the hard facts of life. It's whether a person bathes, whether a person can get to a toilet, whether he can get in and out of the house, that makes the difference. I don't know how many houses in this community we have revamped in terms of putting rampings to the lowest point in the house, usually a back door. We have to put in ramps between 5° and 7° incline over which a wheelchair can be navigated. We have literally put in dozens of ramps for people to be able to get in and out of these homes in their wheelchairs or even on crutches and braces.

I don't know how many walls we have had to penetrate with doors sufficiently wide to accommodate a wheelchair. An adult wheelchair measures about 28 inches from one end of the hub to the other end of the opposite hub. It's amazing how few homes have bathrooms built with space in them for turning a wheelchair. This is not the bulky, old, wicker variety that looks like a chaise longue on wheels; this is a modern wheelchair that has a wheelbase just as short as it can be made; in addition, it has the footrest that can be swung out of the way and even be removed. Yet, in the average bathroom that we see, one cannot even turn an ordinary wheelchair around in it.

We do not have too much trouble making shower facilities and toilet facilities safe for a handicapped person to use. We simply go to Lewers & Cooke and buy these stout towel racks that are really strong (you could chin yourself on them). Putting one of these on the wall is just enough to support a tottery, elderly person or a handicapped person who is trying to put his crutches down or put his cane aside and grab onto something. We are elevating toilet seats; most of them have to be elevated about 3 or 4 inches.

Perhaps it would be too complicated to start changing the design of wheelchairs; the seat of the wheelchair averages 18 inches from the floor. Any elevation that the patient has to go to above that, or any elevation that he has to go below that, is just adding to his problems and increases his opportunity of falling and hurting himself, and so we elevate toilet seats. I don't know whether the plumbing manufacturers are saving material. I don't know how they fixed on the height of an ordinary toilet stool being in the neighborhood of 16 inches—I think they run about 15 or 16 inches high. Everyone knows the older we get, the harder it is to get up from something that you're sitting on very low. The higher a thing is, the better it is. You'll find that older people when they enter a room, won't look for these lounge-lizard type divans where they have to get way down and sit down with their knees up; they will look for chairs that are not less than 18 or 20 inches high. I suppose we should have some furniture manufacturers here to help us get some intelligent design so that when a person ages and gets physically impaired, he does not have to move to a completely different or renovated environment.

We should get patients fixed up in their homes so that they can care for themselves and can go in and out of the house on the ramps. It's shocking how many patients become social isolates because a good show downtown, a symphony concert, and even church, become "unavailable" because of the great slabs of cement with stairs through which we enter most of our public buildings. There will be four steps up and then you will go along the ramp this way; there will be four or five more steps up and then another ramp, and then there will be four or five more so this becomes an insurmountable barrier for anyone getting in and out of any place of amusement. I know it was not through an act of Congress, but it took quite a lot of work to get community-minded people interested in putting a ramp for the public library.

Now, I wonder if public buildings have to be designed with these great concourses in front of them without a way of access to them so that an elderly person, or a person in a wheelchair, or a person on crutches or canes, has to mount all those steps? If I am not mistaken, the only way you can get into the Liliuokalani Building if you are a very severely physically handicapped person, is to go way around the back of the building, go down in the basement, and then I think there is some provision there. This office has been set up for serving the needs of the physically handicapped, but you can't be too handicapped in order to get up over the front stairs to get in and obtain the services that you might require.

This involves church construction, it involves public buildings as all too often there are not elevators in these buildings. It involves getting and maintaining elderly people as effective workers. I know more than one arthritic patient that gave up work because he or she could not get into the building without fear of becoming hurt just going in to work. I know of a physician in this community who had a responsible job with the board of health, who developed a fractured hip and had to retire because her office was on the second floor of the State health department. Her job was going up and down stairs all day long to various offices and she had to give up her job. It wasn't that she did not have the mind and the upper extremity skills to continue to be a very productive worker. I do not know what it is going to take—whether it is much more expensive to develop some minimum standards for the location of bathroom facilities, whether it costs too much to have a 30-inch door in every room in the house.

I am quite sensitized to size of doors. I have been in two or three new houses within the last week and these houses do not have 30-inch doors in them. I do not know whether someone is trying to cut down on expense—it doesn't cost that much more, does it, to have a 30-inch door instead of a 24?

I know children that are being denied public school or community school education in high school. As long as they are in the lower grades in the one-room schoolroom where the teachers do the changing or they have the same teacher every day, they are fine. But I think there is only one high school in this community where a wheelchair student or a student on crutches and

braces could go to school and make the necessary room changes on all parts of the high school campus. I have known a number of students whose education had to be done in an abnormal way or through tutorial work because they had to go to one building with six or eight steps up to it and then they had to come down those and go over to another one and go up six or eight steps again.

These are the problems for the planners, and they are so simple. They have to do with washroom facilities, the areas of entrance, the areas of egress. There is a paraplegic patient of ours that is a very industrious man who has operated a hand-controlled car. He operates this car and is not able to walk around; he has to be in his wheelchair. He pulls his wheelchair in after him and throws it out of the car and gets back into it. He works in a downtown office and he's got the toilet facilities all pegged in the downtown area. There are only two toilets that he can go into and those are in bars at least two or three blocks away from where he works. Those are the only facilities he can use.

These are the considerations for all our patients, I don't care whether he's elderly or she's elderly or what the physical impairment is. When the housing and living accommodations, the working accommodations, and the social outlets of the patient all become restricted, then there is a problem. They are extremely simple to solve in the design of a structure if you just have these simple things. I have had patients at the rehabilitation center who reached maximum benefits and were independently ambulatory, who went to a very commodious, wonderful nursing home with new, very important additions. (It's a palatial, beautiful thing.) They reported that they had to stop taking showers because the shower was, again, the conventional type of shower, just an oversized telephone booth. He was not steady enough on his feet to shower standing up, but if there had been a bench, or a ledge, or a stool, room enough for such a thing in the shower stall, he could have continued to shower himself. Now this is in a hospital.

We have had instance after instance where these ridiculously simple things have made the difference between a person being a normal, social animal, an independent human being, or one that is dragging down and having dependency upon others and sort of living a half life.

So the city planners should just be sure when we build our new music auditorium that there is a ramp for them. If there are any new theaters going in, or any places to be frequented by the public, we will be giving the elderly and handicapped their just desserts by making allowances for them. What you will probably find is that there will be many able-bodied individuals running up and down these conveniences rather than going over the usual entrances. It's this simple to me. I wonder if some of you could raise some questions with reference to the things you were talking about this morning? That, as one of the gentleman said, they were concepts that were difficult to get ahold of, and they were varied and diverse opinions about what was good. These are the things that I know are important and good for the elderly and for anyone with a physical impairment.

Questions and Answers in Open Discussion

Question. Will you describe the facilities, the requirements at the rehabilitation center?

Answer. The requirements that we have at the rehabilitation center must be very simple when the individual is just beginning to make his struggle with a physical impairment. For one thing, we start all of our patients out in wheelchairs as soon as they can get out of bed. Our beds are high-low beds. If you are going to have beds that people can get in and out of, they have to either be low beds to begin with or they have to be beds that can be raised and lowered. There are many hospitals that are handicapping patients because the beds cannot be lowered. When the patient gets into a wheelchair, the first thing he has to do if he is taking care of himself is wash his own face and brush his own teeth. We have all our washbasins set away from the wall so that the underpinning of the wheelchair can go under it. Now some of these very modern devices enclose cabinets around the lavatory; this would be useless for a wheelchair patient because he could not get close enough to it. He would have to be bending almost out of his wheelchair to brush his teeth.

We have sliding doors in our toilet areas. I don't know that that's completely essential, but if you get a 30-inch door—that's a swinging door—it is infinitely more difficult for a handicapped person or even an elderly person. We have had elderly patients with histories of having fallen and broken their hips on attempting to get through a swinging door. Either the wind caught the door or something

unbalanced them. So, in the commonly used doors like the bathroom facilities, I think a sliding door would be ideal. We have those. Then, as far as the water closet itself is concerned, it can be close to the wall on one side, but then there should be 28 or 30 inches clearance on the other side so that individuals can back the wheelchair right up close to the wall as a steadying help.

As for bathing facilities, we have a variety of them. We have the conventional tubs that I think run around 16 inches; that is a modern tub. I think the higher ones are even better; some of the old-fashioned ones are all right as long as they don't get too high; but if they are 20 inches high, then it is ridiculous for a person who is not really secure on his feet (and again, this can be just any mature citizen without any important physical handicap) to be stepping into a bathtub and then stepping out of it with all the water and soap in the bottom of the tub. So, routinely, if the individual that we are discharging from the rehabilitation center has a tub at home, we in our shop manufacture a very simple redwood bench with a back on it. We get the dimension from the tub at home and build it to sit just inside the tub. The individual backs up to the tub with the bench in it and sits down. It is just like going up to a bench and sitting down. He is sitting down on the bench that has been placed in the tub securely. Then it's a very simple matter for the individual to pick one foot up, follow it with the other foot, and he or she takes the shower in a sitting position.

Now you don't sit people before a shower where the water is coming from the wall, because if you turn the water on, the individual, if he is handicapped at all, cannot get out of the way. We made a very simple change of using one of these old-fashioned shampoo nozzled hoses to replace the shower head. Then the individual can soap himself, turn the water on, make sure it's the right temperature, then with the shower curtain drawn, the individual can shower off. We have had to take off some of these modern, hard-glassed, shower enclosure doors. The shower curtain is easier, and the individual can just draw it across inside the edge of the bench and the water doesn't go out all over the floor.

These are the ABC's of getting an individual independent in self-care activities. If the patient has no shower stall at home, we design shower stalls that measure perhaps 42 inches wide, 42 inches deep, with a little built-up seat inside it. The individual can wheel himself up, or go up to it with crutches and braces, or however he has to accomplish his mobility, sit down, pull the shower curtain and shower safely, with grab bars on both sides.

We find it helpful not to put the grab bars at any particular horizontal level, but to angle them so that the individual can grab at a high point when he is standing up and lower himself to a lower point when he is sitting down. We routinely plant them that way on the wall. These are the fundamentals that we use, and we are built to handle the most seriously handicapped. However, just the minimally handicapped find the ideas good, and I am sure that it is good preventative medicine for people to have these things to use regularly whether they are handicapped or not.

We have had to turn garage basements into studio apartments so that the handicapped would not have to move, because every time you put a different level for the individual to go, these are where all the accidents take place.

There's a story of a woman who lived on Long Island in New York. Had polio when she was about 12 or 14 years of age, and she was a shut-in in a wheelchair for about 17 years before somebody discovered that all they had to do was take that 9-inch wall around her home away; it was a curb that she could not navigate with her wheelchair. As soon as that was accomplished, she became one of the most well-liked, most efficient secretaries that the New York University Bellevue Medical Center ever had.

Question. Do you have special chairs made for patients?

Answer. No; it's helpful if chairs have arms that the patients can grab onto as they are steadying themselves to get down into a chair. Usually we solve the problem of a chair being too low by putting a four-by-four block under each leg of the chair. I know at one of the local nursing homes, they have been doing that for some of their patients. They also have another patient whom they do not want to get out of the chair, so they put her in a conventional highchair, then they are sure she is going to stay there.

Question. To Miss Erwin who was on the panel this morning: From your viewpoint of representing the older population, how would they feel about going into a group of houses all equipped with grab bars and special equipment for the elderly—would this bother them? I for one think all doors should be wide enough to accommodate a wheelchair. An accident can happen to one of any age.

Answer. We haven't found that the older people objected, and we found that the younger people were happy that the conveniences were there because they've recounted that "if grandmother's bar hadn't been there, I would have fallen in the tub."

Comment. I might say that our people feel that, rather than resenting the use of the grab bars, we have been pioneers in California, with the department of social welfare setting up requirements in this area for many years. The tenants appreciate the fact that this is not to emphasize the handicapped but rather to prevent them from becoming handicapped.

Comment. I am quite familiar with the 30-inch doorway because I have just finished a remodeling job for one of your patients in which we had to remove or widen a number of doorways and put in a number of ramps for the house. In most cases, only an inch or an inch and a half was necessary.

Question. Would a sliding door be satisfactory? If the door would go all the way back, you would have your full 30 inches.

Answer. Yes, sir.

Question. Would a sliding door be more difficult to push?

Answer. Our patients don't find it so. It depends a great deal upon the weight of the door. We got some Shoji door frames that were only three-quarters of an inch thick or maybe only 1 inch thick, and mounted those over the areaway, and they are very simple for patients; they are so light.

Question. Are there some city planners here who would feel that it would be an unattractive thing to have a handy ramp if the building is at a higher level than the street? Are there any people that would be responsible for plans along that line here? Post office buildings, churches, schools, auditoriums—would this be a hard thing to accomplish rather than having it put in as an afterthought?

Answer. The grading has to be right. It would be pretty hard to push a wheelchair up any more sharp an incline than 7 percent. The wheelchairs tend to capsize backward unless the individual is very adept at handling them.

Comment. I suggest that somebody from the Commission on Aging contact the architects; they ought to arrange for a ramp in the new auditorium. It is in the planning stage now, so it's not too late.

Answer. This will be done.

Dr. SHEPARD. In public housing apartments, there tends to always be this nesting of rooms around the bathroom and we have had patients that we couldn't discharge. They had to stay in an institution until we worked with the authorities to effect changes. We first had to go to the City Housing Authority and then the Housing Authority had to write to Washington to get permission to mutilate a wall. Then we had to get an insurance company to see that if they spent $600 to get a door between a bedroom and a living room (it was a steel door), why, in terms of $700 or $800 a month to keep the patient in a general hospital, this would affect tremendous savings for the patient as soon as he would have passed the 20th day of being back in his own home. He has now been in the apartment for about 5 or 6 months, so that's been paid for over and again. In these public housing places, once the individual cannot navigate on his feet, he has great difficulty entering a small chamber nested between the living room and the bedroom. Then one of the doors off this chamber is the bathroom and the door swings only to 90 degrees because there is a cabinet behind the door, and then the toilet and the lavatory are close together. It's a big problem for us to get a stroke victim who is not a good ambulator to a point of independence in that kind of a bathroom setup. Whereas at the center, where there were 6 or 8 inches more of maneuvering room, the individual required no nurse, no attendant, or anything else.

Question. I have one question about wheelchairs. If the ordinary patient is taught how to use them, are they designed so that they are relatively safe, they won't tip over, etc.?

Answer. Yes, they are a pretty safe device. They usually have the large wheels in the back and the small wheels in the front; that's the most convenient location for the wheels for propelling the wheelchair, but you have to be careful when going up a grade greater than 7 percent.

Question about the lavatory or any other object.

Answer. No, their forward stability is very good because, as I said, they pretty much sit over the axle, maybe a little bit—their center gravity may be a little bit forward of the axle, but the wheelbase of the wheelchair is sufficiently long, so that an individual can actually stand on the treadle. If the patient is sitting in a wheelchair, I can go up and stand on the tread of the wheelchair without tipping it forward, provided one condition is met and that is that these swivel

wheels, these 8-inch casters, are turned forward because that shifts the weight-bearing point about 3 inches forward. And we always instruct our patients using wheelchairs that if they are going to be leaning forward or pick up something off the floor, they should wheel up to the point they want to be and then just back the wheelchair half an inch, just enough force to swing these swivel wheels around in the forward direction and then there is infinite stability in the front. But we have had one or two patients who were learning that—a big man, if he were leaning forward and then these wheels were swiveled back—we've had one or two of those tip forward.

Question. You mentioned that the wheelchairs are 28 inches wide. How much room is needed for the hands?

Answer. They could reach backward and their hands don't have to be on the rim as the rims are passing through the door jamb. The wheelchair is about 27 or 28 inches and if they are junior chairs, they are smaller, but the individual can pull the back spokes further back from the point where the wheeler is just passing through the jamb and he does not have to have his hands on the rail as he goes through the the jamb.

Specific Problems in Design and Construction

Bo Boustedt, S.A.R.

This afternoon I will not speak very much about apartments for older people. I do not think apartments for older people are a special problem, especially as we locate these apartments in the ordinary apartment areas. We don't do special buildings. We try to build them out and mix them with other apartments. In that case these apartments for older people will not be special. The architectural problem is first a question of some special care, then it will be some sort of institution and an architectural problem will appear.

Homes for the aged present a very special problem to avoid the impression of an institution and to create a real home. This problem is based on a new philosophy about the aged which has come about through extensive research. The homes for the aged are built for pensioners who are in need of some physical care in the form of housekeeping and meal preparation and who cannot live by themselves in an apartment or dwelling. They do not require any nursing or hospital care. Every tenant pays rent with his old-age pension and everyone who needs this care is accepted regardless of his financial situation. The homes are built and run by the local communities and receive some help from the government in construction costs. Homes for the elderly aged are needed by about 10 percent of the pensioners over 67.

In 1947 the Riksdag, our national parliament, adopted the principle of building homes for the aged, and directed the local communities to embark on an extensive building program. At the present reading (1962) Sweden has some 1,600 homes for the aged housing 50,000 of our older persons. New homes are dedicated every month. We have accomplished about half of our program.

We are trying to avoid now the concentration of old people in one spot in high-rise buildings. We are trying to mix these apartments out in the ordinary apartment market and to keep the natural structure of the community all the time. There is not any special problem, in my opinion, in apartments. The problem appears when care is needed.

Homes for the aged, the boarding homes, we are trying as much as possible to have in one-story buildings, with the rooms facing on the traffic road. The homes are located in the center of the community near the school, near the community center, allowing contact with the normal life of society outside and to give visual exchange and allow the community to come into the home as well. We try to avoid staff quarters in the home. The tendency today is to have the staff live outside in their own homes; they don't like to live in the place where they work. In small communities it might be necessary for some staff dwellings. Homes are adapted to ordinary houses along the street, to the environment, and do not stand out as something special. We provide for courtyard or atrium, with protection from the wind and from onlookers, to stimulate outside activities. This is as important as keeping the old people out of bed. These courtyards also bring the outside in through the large windows.

I don't believe in highrise buildings. Sometimes it is necessary, as when the environs are highrise and when the land cost is high. I have the feeling that people up high feel cut off or isolated and that one- or two-story boarding homes

are the solution. However, in one area of Sweden north of the polar circle, the highrise is particularly useful in order to rise above the snow and spreading out the houses is not so practical. In the highrise every floor has the same plan and is broken into small units of 6, 7, or 8, with each unit having its own living room and dining room. These units avoid long corridors and give you a normal living group. You are, in your life, used to living together with a certain amount of people, 5 to 6 family size, and I don't know why when you get old, it should be necessary to move together with 20 or 30, 50, 60 persons. I think you should try to stay with the same amount of people around you. That's why we cut down the size of the units and get them as individual as possible.

In the case of one-story boarding homes, they have their own entrances. You know exactly where you live. You don't have to pass the main entrance from the street. You can reach directly into the house where you live.

In the consideration of staff and the running costs, while from the tenant's viewpoint these are small living units, the home is designed so that from the staff viewpoint, it is one large unit, easy to run because of its flexibility. The matter of care and type of care changes every day, every week, in these types of homes. They are not the same as hospitals where the care is the same all the time. It is necessary that the unit be so put together that there will be great flexibility in running it from the staff viewpoint.

Entrance halls

Inside the homes, the necessity for marked deviations from the conventional pattern of institutions become apparent. I design halls much smaller than usual and try to establish a sense of welcoming intimacy. Like all traffic areas, they are furnished and have visual contact with other furnished areas. Administrative offices are placed here, but usually not directly in contact with the front entrance.

Living rooms

I have found a necessity for two types of living rooms. The main living room off the entrance is the more conventional. This room is often designed connecting with one of the dining rooms. They are separated by a movable curtain wall but the two rooms can be combined for use as an assembly room. We also use other combinations of rooms in this manner, such as living room-hobby room, hobby room-dining room, or two hobby rooms with a small living room. The rule of thumb in planning the combinations is to provide space to seat twice the number of residents. Since these halls are used only a few times a year, it is very important to be able to reduce them to more intimate, specialized rooms the remainder of the time.

The second type of living room is the dagrum or small group living room. This room is the size of a normal family room, usually containing a small fireplace, and the furniture is designed specifically for the needs of the elderly.

In the beginning we made large living rooms. It became difficult, noisy, people were not comfortable eating with all these people and oftentimes could not eat, so we made small dining rooms of 12 each. More staff is not necessary in this instance. The older person could help his neighbor if necessary.

Living rooms are next to the dining rooms to give the old people some place to sit when they come in to meals a half hour or an hour early. When possible, dining and living rooms are often combined to make the dining room livable and usable and not one dead room just full of legs and tables.

The living room is often an integral part of the solution of one of the major problems of the humanization of institutions—the corridor problem. The long dark antiseptic corridor, lined with rows of doors and facing a dead end, is one of the hallmarks of the average public institutions of any kind. To get away from this, we have developed several solutions best illustrated by photographs.

(1) Corridors should be as short as possible—staggered plans help this.

(2) Varying the width of the corridor breaks the monotony and can provide inexpensive supplemental living space.

(3) Broken corridors, furnished, well-lit and entering furnished rooms in the viewline give a homelike atmosphere.

(4) Visual and physical contact with outside areas remove any sterility.

(5) Recessing doors in niches varies corridors' width and conceals the number of doors. It also gives better living area to the residents' rooms.

(6) The choice of material will underline the institutional character.

Pensioners' rooms

Because the residents often use their individual rooms as private sitting rooms, they must have a sense of privacy and as much usable floor space as is economically feasible. They must be comfortable and familiar and not have too much bedroom character.

(1) A separate "entrance hall" for each room is formed by placement of the lavatory and a specially designed and prebuilt closet unit. This leaves the remainder of the room free for flexible furniture arrangement.

(2) The floor plan permits lengthwise placement on the inside wall of a bed designed to eliminate the bedroom appearance while functioning like a hospital bed. Any other furniture may belong to the resident or the home.

(3) Each room has a large window and the rooms are oriented to receive maximum sunlight. In rare instances where this is impossible, bay windows toward the light may be used.

(4) For married couples a kind of duplex is designed with 2 rooms off a small entrance hall in the corridor with a joint lavatory. These can be made into a living room and a bedroom or can be used as two individual rooms, giving privacy in case of illness. This allows for home nursing care instead of going to an antiseptic infirmary where I don't think you will get well any quicker.

In order to break the living pattern as little as possible, provision is made for normal activities. Three rooms filling this need are hobby rooms, coffee kitchens, and libraries.

(1) Since homelife is kitchen centered, a home-size coffee kitchen where every pensioner has a locker for his or her supplies fills a big need. Here the residents can chat over a cup of coffee as they did in their own homes.

(2) Men and women alike are used to working and producing usable products. This can continue in the hobby workroom.

(3) Their produce can then be sold in the little shop and the payment provide additional spending money as well as giving a sense of pride to the creator.

(4) We also have much sculpture in our homes in our daily living and in our yards to give something to look out on.

To guarantee a well-run institution, the administrative facilities must be well-planned and pleasant.

In conclusion, I would like to reiterate that we do not have the only solution. Different segments of our population need different types of housing just as they did when they were younger. Every day we will analyze another element of the problem, solve it, and wonder why it did not occur to us before. But we will analyze and solve only as long as we remember that the first principle of the architect of homes for the aged must be the preservation of human dignity and privacy.

DISCUSSION, PANEL MEMBERS AND AUDIENCE

Panel members: Frank S. Haines, A.I.A., Paul D. Jones, A.I.A.

Mr. HAINES. Within the framework of the public housing law we attempted to make Punchbowl Homes suitable for elderly occupancy. As you know, the Public Housing Administration dictates pretty closely what we can do in a project which will be financed by them. The Hawaii Housing Authority helped us put as much as we could into Punchbowl Homes and still qualify for Federal assistance. Specifically, we were able to put in elevator-type apartments, interior layouts suitable for wheelchair occupancy, doors wider than they would usually be, fixtures in bathrooms located for wheelchair use and additional grab bars in the bathrooms. Also, we were able to provide them quite a bit more in the realm of meeting facilities and areas than public housing projects can usually afford. We convinced them they should have a central meeting area, a kitchen area where they can serve meals and have group meetings, and another large area adjacent where they could have hobbies just as some of Mr. Boustedt's slides illustrated. Obviously, it is not as nice, it is more institutionalized than anything we just saw here. That, unfortunately, is necessary because of rather rigid restrictions put on public housing by the National Government. I understand now that some of these regulations have been modified. A project in San Antonio has many more amenities than we were able to devise here. Fortunately, the trend to recognition of the problems we must design in providing for the elderly will come to the fore and we will be able to do more for them.

I would like to comment on Mr. Boustedt's suggestion that the elderly should be mixed in with other types of tenancy. In Punchbowl Homes the lower three floors are designed for family occupancy, the upper four for the elderly. This has worked out reasonably well. The elderly like to be involved and see the activities of the families. After all, they have been involved in family life before they moved into it. However, I don't think living next door to a group of children will be suitable, so I think this type of thing works out pretty well. In the play areas and the rest of the building, they encounter the families with children but when they go up to their own floor, they are pretty well away from them. It's quieter and the type of life they wish to live is easier for them there.

Mr. JONES. The basic precept for homes for retirement is different from the slides we have just seen of the boarding homes designed by Mr. Boustedt. In Pohai Nani we wanted to provide an atmosphere entirely free of worry for the tenants, and yet one in which they could have a great deal of stimulus from each other's company and from involvement in the community around them. What I wondered about in trying to relate some of Mr. Boustedt's slides to some of the problems we faced in our situation probably could largely be explained by the high cost and actually the high rise of land in our area in Kaneohe. We had a very steep site. This was another factor that forced us into a highrise solution and another reason to add to Mr. Boustedt's list of some reasons that make highrise necessary. I also wondered about the vertical transportation problem in the two- and three-story solutions that he showed here. This has become one of our major problems in Pohai Nani, the fact that it must be an elevator-type building. We also find that the central dining facility is a philosophy which differs from that of Mr. Boustedt. We use the central dining facility as a means of bringing people together and getting an interchange of interest and stimulus. If we did not have this, we feel that people would tend to grow away from each other rather than become involved in the affairs of the entire community.

I also wondered about the tendency in the work you just illustrated to orient the outlook of the building to the street. I can understand the reason for this interest in the passing scene by the elderly people and that this is why you have done so. I wondered if this is more true in your homes for the elderly than it is in your other residential situations in Sweden.

Mr. BOUSTEDT. Yes; I think in the boarding homes this outlook on traffic and heavy roads, and the central location is very important, because these people are so very limited in their movements. They are forced to stay in their homes most of the time. In apartments for older people, it is not a problem because they can go out and find places, if they like, outside the homes. It is just because of the limitations of these people who have to stay inside that I try to give them all sorts of different views outside and of activity inside the home.

As to the other question about vertical transportation, when we have two stories we must have an elevator. If we have as much as one stair, we must have an elevator. We cannot have a single step in the home without an elevator.

On the other question, too, I think this was very interesting, mingling the younger families with the old. Is this building an apartment or boarding home?

Mr. HAINES. This is an apartment building. The elderly occupy specially designed one-bedroom apartments, and families have two-bedroom apartments.

Mr. BOUSTEDT. Then it is quite analogous to what we do. You have mixed young people in a building for old; we do the same, too. With apartments it is absolutely the right thing. With the boarding homes it is not good.

Mr. HAINES. Back to your one- and two-story units. Due to our high cost of land, it is much more practical to build a seven-story building than one of just two or three because you have to have the elevator anyway.

Mr. BOUSTEDT. I use this argument with my communities: To keep my buildings to one story, which eliminates the elevator and is less costly, except, of course, when high cost of land is involved. In other cases I try to limit it to two stories because I think three stories is rather high. But if the environs have three or more stories, then it is all right. It's a question of adaptation to environs. The apartments, however, you can make as high as you want. The people can get down and get out. For these boarding homes for the aged, however, where they are limited, they will be cut off if they are higher than three floors. They need the contact with what is happening outside. They need to see not the big beautiful view but the little space with the bushes.

and the flowers and what is happening in nature, etc. They are very limited in distance, too. They need to see things happening very close. This is why I try to avoid high rise.

Mr. HAINES. I'm also very much interested in your statement about the curiosity the elderly have in the passing scene. At Punchbowl Homes we have recently enclosed a lobby and provided a seating area there because so many people were just hanging around to see what was going on, people going up and down the elevator, etc.

You did not agree with apartments oriented to the aged. Why do you feel that this is not a good thing?

Mr. BOUSTEDT. I said we try to avoid special apartment houses for old people. We try to mix them up. The problems appear when it is a question of care; then the aged need special housing.

Question. Don't you feel that in an apartment building which was for occupancy by the normal family that it would have to have special provisions in order to accommodate elderly people within the same building, such as we have done at Punchbowl? Doesn't this throw an additional problem upon the building of the apartment to allocate what rooms are for the elderly and which are for others?

Mr. BOUSTEDT. Yes; of course, there must be an adaptation to that, too, but it is when you create the whole milieu for a person that it is very sensitive. Still in an apartment they have their own things; they live their own life, and this should be just like any other apartment but, of course, with certain arrangements to help and to make it possible for the older person limited in movements to get along. That's right.

Mr. SMITH. When they are no longer ambulatory, do they move to the boarding houses?

Mr. BOUSTEDT. This is a very interesting thing because it means movement. I hate all sorts of movement: house to house, or inside the house to infirmary wing, and such things. It is something we try to avoid. Here it will be a movement from their nice apartment. They usually can stay longer in their apartment with some help, but eventually they are kicked out and must go to a nursing home. This jump will be very, very big in many ways in milieu, in standards. I try to save these people from this institutionalizing or hospitalizing; I try to save them from this and give them still the possibility of living in a homey, human milieu. This we can do with these boarding homes. This jump from apartments to homes for the aged, these boarding homes, will not be so very big. Of course, they will not have their own kitchens but they will have a possibility for individual life.

In the same way we also save money for society. It is less expensive for society, of course, if everybody takes care of themselves outside in their own apartments. When home help is necessary, it costs a little, but for hospital and nursing homes, it costs very much. The care in boarding homes will cost less. So at the same time we save money and give these people a more human milieu. These homes for the aged need a good staff, of course, such as a matron with good training and a staff in a ratio of 1 to 5 or 1 to 3. The number of staff often depend on the quality of architectural design, so it is possible for the architect to save in the running costs. This is a lot of people we are helping. Some 25 or 30 percent of the elderly need additional care and 10 percent can use these boarding homes. I have seen many county homes and nursing homes in the United States and many of these people could live very easily in these boarding homes without any complications if there were such possibilities.

Also another question in this field, it is often impossible to ask a young family to take care of old people. It is impossible to put this care on the shoulders of a young wife. The reason this still occurs is because the young people have a guilty feeling. The older people like to do for themselves; the younger people should like to do the same, but they feel guilty about putting their old people in nursing homes. No young people in Sweden feel such a guilt. It is possible in these boarding homes to have close contacts with the younger generation by visits, by phone, etc., and they are not forced to live under the same roof with each other.

Question. Are these homes fairly well self-supporting, or is there a very large subsidy from the National Government? In other words, could they be duplicated here in Honolulu and be financially possible for an investor to go into?

Mr. BOUSTEDT. These homes are financed and built with the local taxation money, the little community, with some support from the National Government, but very

little, only enough to encourage the community. We have practically no private homes in Sweden. I understand in the United States it is necessary to solve this in different ways, with churches and unions and private enterprise. All the time you are housing for groups and in groups and it is necessary also to take care of others outside the groups. Therefore, I think it is necessary for the local community to take part in the solution. There are certainly possibilities to run these homes as private enterprise. The operation of church homes must be on a certain economic base, I understand.

Comment. That is very true, but we have the disparity of taking care of certain categories of elderly people who could not afford the costs that would be necessary to make a return to the private investor and make it worth his while to go into this. In covering the whole range of cross section of the population, I think we have our big problem. Between what you have shown here that they are doing in Sweden and what we are trying to do in an entirely different type of economic society. As the socialistic benevolences would tend to increase to take this responsibility over, it would have to be something that is accepted on a more uniform basis than it now is under our economic system. I think we may be coming to that in due time, but at the present, I think this is the difference between what you are doing and what we are trying to do.

Mr. BOUSTEDT. This is what I mean, that the question must be solved by all different means by churches, unions, etc., so that it is possible to reach everybody, even those who cannot afford the rent.

Mr. JONES. Back to apartments for aging, since I'm working so closely on Pohai Nani, it still is not exactly clear to me why this cannot be justified in your mind. In this type of thing we have apartments for people who are in full vigor of life. It is recognized that sooner or later they will reach an age where they cannot take care of themselves to the fullest extent and some provision must be made for them. Homes such as Pohai Nani have provided for infirmary care as part of their total care. We don't feel that this makes an institution out of Pohai Nani. Why could not this be taken into account as the gradual step from one change to another rather than moving to another home?

Mr. BOUSTEDT. This is a very difficult problem. The main problem in this sort of housing is the mixing of medical care with ordinary housing. There are different opinions in Sweden as well as in the United States. I'm not a social worker and not so capable of discussing the problem. In Sweden they have chosen this way of solving the problem based on scientific research with which many scientific workers in the United States agree, such as Dr. Burgess of Chicago. As an architect, I have to listen and collect information and I have to realize it in buildings. It is hard for me to discuss it in a more qualified way, but I have found that this connection with medical care will give an air of the institution and also give a rather bad hospital. Because the hospital equipment is very expensive and difficult to solve if you have to limit your homes in size to 70–80 beds.

Our pensioners when they are sick have the same right as any others. When they get sick, they go to a hospital and then come home again. Their homes are still the ordinary apartments. I think that from the beginning, and I don't know if it's right—as a guest, I shouldn't say anything about things that happen here in the United States—but I have a feeling that the reasons why you have hospital care connected with homes for the aged in the United States are twofold: first, hospital care is expensive and not so built out as in Sweden; second, if you have a home and take an old person there, he will be taken care of there till he dies. You will have many more old people, you will have many more needing medical care. You will, therefore, need more medical care and hospitals.

Mr. JONES. Pohai Nani is providing for the declining health of the residents of a retirement home on a size where it can be handled within the project itself without making a medical institution out of it. Until such time as actual hospital care is needed, then under the same care arrangements, people are sent to a qualified hospital. We're not trying to build a hospital to take care of these people.

I think that basically you have answered the question. If I understand you correctly, all citizens of Sweden are entitled to certain hospital care as part of a socialized medical program. Is that correct?

Mr. BOUSTEDT. It is about the same system as in England.

Mr. JONES. That I think again is the basic difference. The concept with which we are working here under private enterprise would make it a little more difficult to do what you are trying to do in Sweden.

Mrs. DEVEREUX. Dr. Michael Dasco lauds the plan of Pohai Nani. He would hope that ultimately in the United States every housing project which is erected for the elderly regardless of whether it is public or private, would have built-in medical service, not hospital service, but medical service such as in Pohai Nani for several reasons: We do not have the medical plan as in Sweden. The question in my mind—in many of our minds—is what are Punchbowl residents going to do from here on out if they reach the stage where they need some care? Where are they going? Who is going to provide it? How are we going to take care of them? In Pohai Nani we know how they are going to be taken care of. Our hospitals are expensive and there is a human factor. If a person young or old becomes acutely ill (not surgically) for a week, a month, or 3 months, if he can be taken care of in his own environment, he has an incentive to get back on his feet again. If he must be moved to another place, he loses contact with the people he sees every day. Dr. Dasco said that in America we have a system that does not provide for this. Therefore, it is up to us to provide it. In Sweden, England, and some other countries, they have all the hospitalization they need and all the other things where a person goes from step to step and automatically gets care at a certain age without worry, without insecurity. We in America are insecure; we do not have this security. Therefore, we must plan to provide as much security as possible without too much change. I think this comes to Mr. Jones' question, basically, the difference between what we're doing here and what they are doing in Sweden. What they are doing in Sweden is right for them, but Dr. Dasco who knows Hawaii's problem said, "I beg you for the future of Hawaii's elderly population, to plan for infirmary service or intermediate care in the place where they originally go rather than plan apartments only and nothing more to take care of their needs. This will necessitate the jump to a nursing home or a hospital."

Question. From an economic standpoint: No. 1, what is your cost of land per square foot in Sweden? No. 2, what is your building cost per square foot? No. 3, do your people live in these homes free? Our land is somewhere in the neighborhood of $10 per square foot; building costs around $15 a square foot. We will have many people not reached by the wonderful new home coming up. These are in the $65–$85-a-month bracket. Many are lucky to have that.

Mr. BOUSTEDT. I'm sorry I cannot give any figures based on square feet. Our land cost is very high also, but perhaps our town planning is arranged differently. I should like to say, however, the homes cost about $5,000 per person; the running cost is between $3 to $5 per person per day. Your costs and ours I have found are not so greatly different. How can you afford to do all your schools in one story and so spread out?

Mr. JARL. I would like to give you my views from the management side. I agree with everything Mrs. Devereux said. There is nothing that a person in a retirement home hates worse than to go to a hospital and leave their friends in these homes. The first thing they want to do is to get back into the infirmary so they can be close to the people they have lived with for quite some time. These are the things that people in talking about hospitals do not consider.

Also, I have found in selling these homes that the top floors are the ones that always sell first.

One other comment: In regard to small dining rooms, I feel they should be large ones because people like to meet other people three times a day and discuss the problems, whereas a small dining room in this area would not work. What we are trying to get are the things people would like to have.

Comment. With relation to Mr. Jarl's comments, in Punchbowl Homes if one of the tenants does get sick and is removed to a hospital, not only is he removed from his friends, but the chances of getting back in again when he is well in 3 or 4 months are very slim. By that time someone else has moved in and you're on the waiting list. So it is even more critical in this respect.

Mr. SMITH. I raised the question of the dining room in a Presbyterian home in Denver when I was there recently. It seated 120 people and I asked if they had a seating schedule. They said they left it up to the people and they themselves change their tables. They are interested in socializing.

Miss CATTON. I want to thank Mrs. Devereux for saying exactly what she did. I think it is absolutely wrong for elderly people to have to go to another institution when they become ill. One of the strongest recommendations of Pohai Nani is that it means absolute life care, your home until you die, except, of course, when hospitalization is necessary.

ARCHITECT. I'd like to say that we are discussing here a particular variety of orange with a comparable variety of apple. I don't wish to do anything that

would reflect on the idea of a boarding home. It obviously is an entirely different concept from a retirement home. The one thing that might come out of this conference that would be well worth considering is how we can best establish something comparable with the boarding home in our own community for those people who cannot afford to go to something like Pohai Nani which is admittedly something of a luxury. I was very impressed with the caliber, not only of the architecture, but of the way in which these people were brought together in a boarding home. It is a new concept to me and I appreciated it.

Mr. SMITH. Mr. Boustedt brought out one point several times. He spoke of the cost being low for the care of a person who was ill. He also made a comment about food preparation. It made me think that possibly relatives and friends came in and assisted with nursing or food preparation, or was this a regular staff who assisted?

Mr. BOUSTEDT. In food preparation I think I meant the coffee kitchens spread out around the homes where they can make their own little meals and invite their relatives. I did not understand your question of care.

Mr. SMITH. You indicated that costs were kept down by nursing care in their single rooms so that they didn't have to go to an infirmary. Who takes care of them?

Mr. BOUSTEDT. The matron is a nurse, of course, and the doctors come in. I meant that I think it is better to stay in your own room if possible rather than being moved to an infirmary. When the question of more qualified medical care and hospital care arises, then it is necessary to move.

Question. Do the elderly persons pay anything at all?

Mr. BOUSTEDT. They pay with their old-age pension. Everybody pays the same without regard to income or property, because we don't feel it is democratic that for the same service one should pay more than another. With additional pensions now in 1961, similar to your social security, I think it will be possible for them to pay the real running cost.

Mr. CLOWES. It struck me that Mr. Boustedt was talking about a considerably older group than we get into our homes. Probably in Sweden they have the attitude that is heresy here that to deprive people of their work, their income, and their status, is an immoral act. As I have said this morning, 13 States have made it illegal to discriminate in employment because of age. I have a couple of friends in Punchbowl Homes. I was surprised that the Federal Government allowed this to be built on a hill. Even in my youth I disliked to climb. It is a long way from any shopping centers. The bus transportation is poor and you can't go walking around there. There is a big gap between the people whose income is low enough to get into Punchbowl Homes and the people who can afford to get into Pohai Nani. I am here as a representative of the organization of 400 public school retired teachers. Of that 400, 100 are in California. They couldn't afford to live here. I don't know of any of my friends who is a candidate for Pohai Nani. One of my university friends said he wouldn't move to the other side. They will probably go to a Methodist home in Palo Alto.

Mr. FULFORD. In terms of cost we maintain our people for $6.66 per day. This includes all medical costs and is not too different from Mr. Boustedt. Our great difference lies in the fact that this is private money that finances this and yours is financed by the community or State.

Mrs. FAYE. Representing the Commission on Aging, I would like to agree with Mr. Clowes. The main gap in the housing with which the Commission is extremely concerned at this point is the gap between Punchbowl Homes and Pohai Nani. We are also very much concerned as to what will happen to the residents of Punchbowl Homes when they become ill. We are concerned as well for those who are living in their own homes now and who soon may need a little more care but are not yet ready for a nursing home. Here you have your boarding home situation. Mrs. McConnell of the Rehabilitation Center is keenly aware of this need from the standpoint of those who are today being rehabilitated by the independent living project. There are no homes to which these people can go. They are unable to get into Punchbowl Homes and if they could, some of the accommodations cannot take care of the handicapped. There simply is a tremendous need for more facilities in the community. We do not care who builds them as long as they build accommodations that the community is going to need even more in the next 10 or 20 years than we need today. We hope that from the conference will come some solutions as to how we can get these facilities in our State.

Mr. SMITH. May I reenforce that point? There is not only a gap between Punchbowl Homes and Pohai Nani (Punchbowl takes care of people with an in-

come of $3,400 a year and down and actuarily the best guess we can get on Pohai Nani is $5,500 a year and up), but actually there is a gap below $3,400. Punchbowl Homes is oversubscribed and there is a long waiting list today.

Mrs. FAYE. Mr. Haines, will you be doing the new project in Kalihi? The reason I ask is this: I am interested in having someone from our housing committee sit with the planning group in the hopes that all the facilities will be designed to accommodate handicapped people, of any age, incidentally.

Mr. HAINES. Yes, we are designing this public housing project. It is temporarily stalled because of site problems. We are already in contact with Dr. Shepard on this problem of the handicapped. I don't believe that any of these units are specifically designed for elderly occupancy. In the discussions we have had with the HHA, at least portions will be designed for wheelchair occupancy.

Question. Is it possible in the islands to have an intermediate type zoning that would permit a nursing home type or boarding home that would not require an act of Congress to get through? Is there anything being done by the architects along that line?

ARCHITECT. To my knowledge you have to have an apartment zone in order to put in a nursing home. There is no intent to change this that I know about.

Question. I noticed that Mr. Boustedt's homes are in small communities like Waipahu, etc. This would be the solution to taking care of the aged in the rural area. In a city like Honolulu you have a different problem both in land costs and everything else. I wondered if our zoning requirements would stymie that, too?

ARCHITECT. If a retirement home were to be put in the same classification as a church or a school which can be built in a residential area, that would open the door for a lot of developments of this type. To my knowledge, this isn't on the books now.

Comment. I think it would be a good idea if we all tried it.

Mr. HAINES. I am not a city planner but there are dangers both ways. Building must be controlled to the extent that, as Mr. Boustedt's pictures showed, it fits into the area. Here if we opened up residential areas to private builders of retirement homes, we might have an unfortunate result in the blighting of certain residential areas. It has to be handled very carefully. Possibly it could be done on a basis of the density that would be involved. Some zoning nowadays is directed in this vein. You are sometimes allowed to put a project of low density, even apartments, into a residential area; if you go into greater density, multistories, etc., then it would not be allowed.

Mr. FITZSIMMONS. In answer to Mr. Haines, I believe that most builders and developers take great pride in what they are about to accomplish and would certainly work toward improvement of areas.

We are presently working within the city and county framework on such things as zoning, building requirements, and subdivision requirements. This item of land usage is becoming quite heavy. I don't know why a member of the architects association is not sitting on this committee. We are attempting to do away with zoning in its entirety on the basis of the classification that now exists. We are trying to get it down to the uses of density requirements and open areas. I think, if we can change the thinking of the planning commission that now exists to accept our ideas in concepts which we feel are very progressive, that we will be able to get nursing homes and boarding homes within residential areas. They will still fit the pattern of land usage and environment.

ARCHITECT. This is the trend in many places on the mainland. That's why I mentioned that if it is controlled as far as density is concerned, it would probably fit in very well. But if it is under the present regulations, the present type of zoning in which just use zone is allowed, it might produce some very unfortunate results.

Question. I would like to have an explanation of the word "density."

ARCHITECT. Zoning is now based on the use of land. In a commercial zone you can build stores or apartments. In an apartment zone you can build as much as you wish to on the land, that is, any number of stories. Zoning based on density would control the number of dwelling units you could put on a piece of property rather than type of use. For instance, in certain areas, they would allow 10 units per acre, in others 200 per acre. For example, Waikiki is a densely populated area; Makiki is less. Density refers to the number of persons in families per certain areas of land.

I was impressed with the town planning of Sweden and the way they solve the problems. Knowing now that these boarding homes are under the auspices

of the local governments, I was wondering if from the architect's standpoint, you run into a problem of restricted regulations in the design of the buildings.

Mr. BOUSTEDT. Our government has made up certain principles for these homes. I am very happy to say that the national government has a very wide view and they give the architect rather a free hand. They have the opinion that if they begin to make a lot of regulations, they will kill the development in this field. They are always grateful for new ideas to save construction and running costs. If they should start to regulate too much, there will be no stopping and there will be little enthusiasm from the architects.

Mr. SMITH. To conclude the afternoon session, I should like to comment that the warmth, the avoiding of the institution atmosphere, was outstanding in your homes. Offset wings, offset corridors, have assisted in cutting costs and in making small units for easy and homelike living for the elderly who need to live in boarding home situations. The problem which is with us now in Honolulu is, what will happen to the tenants of Punchbowl Homes when they need more care. We hope that this session will help us find some solution.

ARCHITECTURAL SOLUTIONS IN HOUSING FOR THE ELDERLY IN SWEDEN

Bo Boustedt, S.A.R.

Sweden is a nation with a strong democratic tradition which stresses the essential premise of the rights to human dignity of every individual in our society. Because of our respect for the value of each individual, we feel a corresponding duty to try to provide an atmosphere in which each person is guaranteed a sense of uniqueness.

Today I should like to add some more about our pension system to what I said yesterday.

The national pensions system is a most important part of social security. In 1959 the total cost amounted to about $480 million. The benefits consist of the old age pensions, paid to all people at the age of 67, which I have already mentioned, and of disablement pensions and widows' pensions; on top of these benefits there are special family allowances for children under 16. The pensioners get a basic sum regardless of their economic situation, and this sum assures them a minimum means of support. A married couple who are both pensioners, receive a 60 percent higher pension than a single person. Eight hundred and eighty-six dollars or in purchasing power about $1,772 for a couple and $530 or in purchasing power about $1,120 for a single person. To all pensions are added means-tested municipal supplementary benefits. Because of a certain index regulation pensions are constant in value. As the standard of living has risen for the economically active part of the population, the pensions have been increased, and thus the pensioners have had their due of the improved standard of living.

The Government, the communities and the policyholders finance the pensions. In 1960 a new pension act came into force. Over and above the flat rate national pension, a supplementary pension related to previous income will be paid to all employees and self-employed persons. The sum of the national and the supplementary pensions will equal about two-thirds of the average yearly income earned during the 15 best years of gainful employment. The new insurance system includes old age, disability and survivors' pensions. Employee premiums will be paid by the employers, while the self-employed will pay their own premiums.

Thanks primarily to the two pension systems I mentioned, the great majority of the aged are able to take care of themselves. Only about 25 percent to 30 percent need some additional care.

Dr. Ali Berggren, Swedish sociologist, has pointed out that modern society should recognize that the aging process produces a period in later years in which the person is physically limited to a point of partial infirmity without being either ill or senile. In this period, we are still individuals in the human sense though our hands and bodies cannot move as readily or our minds move our tongues as quickly as before.

These older citizens, while requiring some physical care in the form of housekeeping and meal preparation, are neither bedridden, requiring hospital-type care, or mentaly deficient, requiring custodial care. But what they do need is a homelike atmosphere where they can retain a sense of human dignity and a maximum of usefulness while their physical needs are cared for in as efficient and economical a manner as possible. Many older people can live in apartments,

detached, or semidetached housing. Some are, of necessity, in hospitals and nursing homes. Homes for the healthy aged are needed by approximately 10 percent of the population over 67. In the average small city of 50,000 population, this would amount to some 500 oldsters.

The program of homes for the aged is based on a new thinking and a new philosophy about aging. Dr. Berggren says the main points of this new thinking are: first, a clear understanding of the mental difference between the normal process of aging and the pathological changes during old age; and second, old persons should not be looked upon or treated as a special group of society, but as far as possible be granted the same opportunities and services as other citizens. We look upon aging as a normal phase of human life and we fight against such uncritical, unrealistic, passive, and dangerous attitudes toward old persons that imply that everyone of them must be sick and senile.

While I work with apartments and other forms of housing, it is primarily in the field of homes for this segment of the aged that I have specialized since 1947. The milieu problem is the most important and most stimulating part of designing these homes for the aged. The right milieu is built up by so many different things.

The first problem is adaptation to site. We build primarily small homes for 30 to 70 occupants. This allows the residents to continue to live in the locale in which they have spent their earlier years. In addition, we have found these the most economically sound size. Less than 30 is too expensive per resident. Over 70, the staff must be increased out of proportion. Also outside this range, the construction, as well as the running costs, have a tendency to increase. We adapt the exterior design details to fit the characteristics of the architecture of the region as much as possible while still striving for new forms. This makes the home more familiar to the residents and esthetically more satisfying to the community.

(At this point Mr. Boustedt showed slides similar to those shown Monday noon, with explanatory comments.)

In conclusion, I would like to underline how necessary it is that all types of care for the aged that I mentioned in my opening remarks function fully at the same time. Lack of hospital beds will result in sick people in homes for the aged. Lack of apartments for old people will overload the homes for the aged, which, of course, is a more expensive form of care than apartment or home help.

Public Housing—Private Builders—Urban Renewal and Development—Federal Housing Administration

A panel: E. F. Fitzsimmons, chairman

If I may take a chairman's prerogative and make a few statements—first, I don't agree with Harry Lee, but that's from a builder's point of view. I'd like to point out a very unhealthy situation that exists here in the State of Hawaii. There are presently, according to the latest statistics that have been given to us by the Hawaiian Telephone Co., 62,000 single dwelling units in the process of planning one way or another. Of these 62,000 units, 97 percent are on leasehold.

Now as to my disagreement with Harry: When you deal in leasehold land, you don't have the free movement in construction, design, or the uses of material that you would ordinarily have in fee-simple land. The trustees of these estates dictate your method. They even dictate to the architect the method of design. That's why I say it's unhealthy. I don't think they have a primary interest in low-cost housing. I have talked to a number of them, only to be turned away. I believe that there should be some method by which you could reach the minds of the people who are controlling what is eventually going to happen to the housing situation in the State of Hawaii. You can't do it alone. I have probably stuck my neck out more times than anybody has. That is my answer and I am quite sure, Harry, if builders and developers in the State of Hawaii were given the freedom to build this mass type of housing, that we would be more than willing to accept 2 percent in our investment, and we only make about 3 percent now, believe it or not.

I should like to show you, if I may, on the blackboard, exactly what Mr. Merriam was talking about in using the new method of financing in comparison between the 221–D3-type loan and a method using the 231, which is housing for the elderly.

These figures are particularly for multistory, that is, anything over one story. Under the 221–D3 low-income housing, the interest rate at the present time is

3⅛ and there is no mortgage insurance premium. I know this can be done because we have done it, built units for $8,000 per unit. Your principal and interest payments on a 40-year loan, which this is eligible for, are $29.20 per month. Estimated taxes per unit are $4 a month. Your fire insurance is calculated at $3 per month. Your maintenance and management fee, which I will call M. & M. is $10 a month. This is your total outlay, and adds up to $46 a month. That's creating rental housing for the people who can afford it. That is in the low 20 percent of your income bracket in the State of Hawaii. Anybody earning over $2,400 a year can afford this type of housing.

Now to show you again how this same formula can work under rental housing for the elderly, taking the same factor of cost of $8,000 but because it has a 5¼-percent rate and does include mortgage insurance premium, the monthly payment on principal and interest, including one-twelfth percent of your mortgage insurance premium, is $43.24 on a 40-year loan. Its taxes will remain the same—$4—as will your insurance, your maintenance and management fee. The total of this is $60.24; 20 percent again of your low-income bracket can afford to live in this type of housing. These units will not be architectural monuments, but they are very livable units.

Another surprising fact is that in developing a nursing home, in the first 4 years, if you happen to lose money in an operation of this kind and your depreciation is higher than what you have lost, you can't do anything about it. But if your loss exceeds your depreciation, you can go back to the FHA and have your loss included in your mortgage. In other words, they will refinance your mortgage to include the losses you have made. I don't know whether that exisits under low-income housing or not. I know it does exist under nursing homes. And in the post-4 years of operation, if you lose money and the depreciation on the buildings you have does not exceed your loss—in other words, if you have a $12,000 loss and your depreciation is only $9,000, you can finance the other $3,000. You are still not losing any money.

A. V. Sullivan, director, Hawaii Housing Authority

I cannot say at this time that our program is a very ambitious one, although we are talking about building more housing for the elderly as soon as we can get some plans underway. You are all familiar with Punchbowl Homes. One of the problems in developing Punchbowl Homes was the lack of knowledge as to whether there would be enough families to move in there. A survey in 1956 indicated we could not fill more than 30 units specially designed for the elderly. Lee Maice, who was executive director at that time, didn't believe it. He pushed hard and overcame a lot of objections by the Federal Housing Administration people and was successful in getting approval of a program of 96 units for the elderly. For reasons of economy, these would have to be combined with some units not especially designed for the elderly. We have in the large building 144 units, 96 of which on the upper 4 floors are for the elderly. Both in the San Antonio large homes, with 186 units similar in design to Punchbowl, and here in Honolulu, I have found that elderly families are as happy as they can possibly be. This happiness has been brought about by furnishing them with these good homes at rentals they can afford to pay.

The authority at the present time does not have a very large approved program, and by that I mean a program which the Federal Government has recognized the need for, that is, not already on the boards or built. We are in the final stages of planning for a project of 614 units in Kalihi. This project will be largely in two high-rise buildings but will not have housing for the elderly. However, we have undertaken preliminary exploratory discussions with several of the commissioners and with Mr. Maice looking toward the development of a project of approximately 330 units in one of the redevelopment areas, possibly the Kukui redevelopment area.

Because of land costs, the buildings would necessarily have to be high rise. In Punchbowl, the high rise is particularly suited to the elderly. They like that kind of development. We also find that they like to go as high as they can get. They all ask to get on the top floor. We are talking at this time of a division of 120 units in one building for the elderly and the balance of 110 units in adjacent buildings. This would provide what we have found the elderly want: to be insulated from youngsters and others but not be completely isolated. Here we think that with some separation of the building housing the elderly from the other building, perhaps by way of a street, we can accomplish what we have found they want.

In Punchbowl Homes we think we have done an excellent job in design in providing for the comfort of these people. Perhaps we have gotten some ideas today from the pictures we have seen of housing in Sweden. Perhaps many of you have ideas. I know Mrs. Devereux has ideas on how we can do a better job of design when we get to the next one. The authorities are all interested in going ahead in developing the extra housing approved by FHA with as large a proportion of these units for the elderly as we can.

Frank Merriam, Chief of Operations, Federal Housing Administration

The FHA has numerous programs for helping the elderly. One of the most successful that has been in use on the mainland is the single-family housing. Under this program any individual 62 years of age or older can purchase an existing or brandnew home. Previous to the preparation of that particular program, it was a little difficult for a person who had reached that age to get financing on the normal market. However, now the Federal National Mortgage Association has the funds and the elderly are permitted to borrow at a very low or no discount rate. The terms on these loans are up to a maximum of 30 years on existing structure, 35 years on new construction. This means much lower payments than a person could possibly get otherwise. I have actually seen some of the subdivisions that have been developed in various areas of the United States and some of them are unbelievable. Of course, they do not have the high land cost we have here. Many of them are in terms of $8,000, $9,000, $10,000; two-bedroom homes particularly designed for senior citizens with nonskid flooring, wide doors, grab bars, etc. Most of the developments I have seen have taken place in warmer sections like Arizona and Florida.

It is also possible in this particular section for the senior citizens to borrow the downpayment. Ordinarily, FHA does not allow this. However, in this instance, they can borrow the downpayment from a friend or a relative or in certain circumstances from a corporation. Also, if their retirement income is borderline as to servicing the mortgage, they can have a daughter or son or other close relative cosign it.

Another one of our areas in which we are having considerable success is our multifamily units, single story, or high-rise two-story, section 231 of the FHA, both profit and nonprofit. We are happy in having our first application for a nonprofit building here in Honolulu. Mr. Fulford will talk on that later. We can loan up to 100 percent on nonprofit. If profit, we drop down to 90 percent of replacement cost. In the event of existing structure, we base our loans on value rather than replacement cost.

In Seattle I was fortunate in going through one of the first high-rise developments of this type. It was a very modern looking apartment and does not look at all like a home for the elderly. There was also a nice one-story arrangement in Eugene, Oreg., which is a combination of a large structure with a rehabilitation of other existing facilities.

Another program we added a year ago was nursing homes. We know that sometimes we have our illnesses which we cannot take care of in a regular home but do not require hospital care. So the nursing home program is beginning to move. Just before I came here I saw one that was just being started in Las Vegas. We are allowed to insure loans up to 90 percent of the value of the nursing home for 20 years, and that is a much longer term than you can ordinarily get for that type of structure. We work very closely with the State department of hospitals to see that there is a need for it in that location and also to comply with their regulations. I understand that our office in Honolulu has been approached by a nursing home and we are very happy because we feel that apparently there is a need for it.

Another type of loan that is available is a direct loan from the Housing and Home Finance Agency which is our overall agency. They have given that particular program to the Community Facilities Administration. Recently they have been allowed to insure loans up to 100 percent of the cost of the project and at a submarket interest rate of 3⅜ percent. The amount of applications have been sweeping in on that program. Its aim is to reach above the public housing and below where the FHA comes into the picture in order to fill that gap. The current session of Congress gave us another program, 221–D3. Although not slanted particularly to the elderly, it is housing for low- and middle-income families, and that is another submarket interest rating program. On that, the FHA waives its mortgage insurance premium. Income limitations and

mortgage amounts have not been set for the islands. It should be a real good program for Honolulu as soon as we get the information on rates from Washington, D.C. It will enable us to get rentals.

The senior citizens will have some kind of a program in the new condominium housing. Hawaii is the only State that has passed enabling legislation for that particular type. I presume that in this type there will be a special plan for a person 62 years or over should they be interested in actually purchasing their apartments under the condominium plan. We have been approached already to find out what our feeling is on that type of structure in the islands. We are very receptive to it. We expect there will be some apartments along that line built in the not too distant future.

Lee Maice, manager, Honolulu Redevelopment Agency

The urban renewal agency as an agency does not build anything. We only make it possible for private enterprise to do so. Our objective generally in urban renewal is to clear slums and to make it possible for redevelopment of the area to provide good homes for our citizens and also to develop the center of our cities. In our projects we may provide for public facilities such as public housing. I mention that particularly because in the planning of the Kukui and Queen Emma projects, there was no such provision in the plan, and in order for the agency to make land available to public entities, that must be included in the plan when it is adopted by the city council. We are incorporating that now into the revision of the Kukui redevelopment area. The plan that we are restudying does include housing for both elderly, private and public, and also will provide other housing for families of moderate and low-moderate income. Planners have been instructed to give full and due consideration particularly to the moderate and low-moderate income people in that general area.

The agency is having a market study made and it is a very comprehensive market study of the housing needs for Oahu and will be completed about January 1962. We anticipate having the Kukui renewal plan, as it is revised or amended, at least for consideration before the city planning department, the Urban Renewal Administration, and the city council early next year. In this plan we are trying to achieve many things; one is a balanced neighborhood, to provide, within the design of the project, spaces and areas for elderly low income and middle income, and also to provide facilities within those areas for parks and other open spaces that they can enjoy. We are now agreed on this: to stay away from mixed use but at the same time provide facilities within easy walking distance for the necessities of life for the family. We have parted company with some planners in regard to what is mixed use, integrated use, and proper urban design.

To be frank with you, I sometimes get confused with the terms that all of the planners use, and in addition it is difficult for all of them to agree on one thing. We have, I think, something written into the urban renewal plan that is of benefit to housing for the elderly. I believe there is no possibility that we can ever have enough housing for the elderly, much less too much. One of the things that some of our realtors are considering very seriously is the influx of elderly people coming here from other parts of the world and from the mainland to retire. We have a tool within the urban renewal process to provide lower land cost. We can't write down the cost of land as such; however, one of the amendments to the Housing Act permits the price of land to be set in terms of the market for housing families of moderate income rather than in terms of the highest or best use for the land. Purchasers committed to develop, under section 221(d) nonprofit coroprations, cooperatives, public bodies or agencies may take advantage of this provision in the law to benefit the community. The density and the use can be determined, and the appraisal for disposition will be made on that basis. It might be that land for the particular use would be from $1 to $3 a square foot cheaper than it would be for the highest and best use.

Another thing in the urban renewal area that would be helpful in the long run would be the open spaces and setbacks required. In addition, the construction will be under agency control for a period of 35 years. In other words, you won't be able to develop within the limitation of the plan at the present time, and then in 2, 3, 4, 5 years subdivide and sell for different purposes. For example, in the Kukui project if there is space, and a private corporation comes in to build a home for the aged, that developer will be assured that his neighbors will

not encroach upon him with incompatible uses. He will be in a good neighborhood and it will remain that way.

The agency members are enthusiastic and feel that not only housing for the elderly, but housing for families of moderate and low-moderate income is a must in the Kukui area and all areas in the neighborhood of Kukui, Palama, and Kalihi. Our chairman asked that I convey to you the assurance that we are doing everything in our power to include housing for the elderly in all our planning.

Oscar L. Fulford, administrator, Hawaii Pacific Homes

I think in view of our somewhat complicated organization, I should like to tell you that our parent corporation as mentioned is Pacific Homes of California. Locally this organization began in 1951, and Mrs. Devereux, Miss Catton, and Rocky Smith have been in this from the beginning. It has developed in various stages until at the present time we are just about to go before the month is out.

I think you would be interested in knowing something of the financing which is the primary purpose of this particular panel. There are two financing programs necessary in operating homes like this, and let me say that I shall speak in general terms, whether it be a Congregational home, a Methodist, a Presbyterian, or what not. And if it is necessary to use our own experience to make specific examples, I hope you will pardon me. Frankly, I hope it is necessary, from time to time, to bring out details about our own particular Pohai Nani, which incidentally is Hawaiian for "surrounded by beauty."

The first program that needs to be financed is the capital expenditures, and with a nonprofit group, this can be done in various ways. The happy way is to find a philanthropic-minded individual who would like to donate $3 or $4 million to take a comparable tax reduction, and your problems are all solved. There aren't too many of those kinds of programs available. Some churches, though, and some conferences do assist. I know of one that started out by giving the first $325,000 to buy the land. However, in recent years these homes are financed largely through their own initiative and through private funds. This financing, or these funds, are then recovered through the sale of accommodations.

We use the term "sale" and it isn't technically correct. The resident does not actually buy the accommodations. He never owns or holds title to it but neither does he ever pay taxes or have any maintenance. What he pays for is a lifetime lease or lifetime occupancy of the accommodations and then there is a reversionary clause which says that when that member is through with the accommodation, it reverts to the corporation. He has received that for which he paid, which is lifetime occupancy, whether that lifetime be 60 days or 16 years. Then that accommodation is resold and the income goes to pay off the loan.

There was a time when it was possible for the first generation of people or residents in these homes to completely pay for the home. That is no longer possible because of increased building costs, the type of equipment necessary to put into these homes now and, of course, competition is getting keener, even in nonprofit organizations. By way of example, three of our five homes that we are already operating are completely clear and free of indebtedness on the operating property. Two are not. Here in Hawaii our building costs are higher and so we are financing a larger percentage of our building costs over a longer period of time in order to keep our accommodation fees comparable with accommodation fees on the mainland. I have some very up-to-date examples of that comparable position that we are in, having just returned from the mainland. I was in a Congregational home last week and our accommodation fees are almost dollar for dollar with theirs. Our corporation is building a home in the San Diego area, and actually our accommodation fees begin a little bit lower than theirs. Theirs happen to go a little higher, I admit, say, by only $500 higher than the highest accommodation fee in that home; so we're keeping this thing comparable.

Then there is some difficulty in a nonprofit organization financing one of these from two aspects. In the first place, you are building what is essentially a one-purpose building. The only thing it can be converted to—and this would take a little doing and be a bit expensive—would be a hotel. However, we now put in so many activity units, hobby shops, libraries, and gamerooms that they

rather frown on that from that angle. In our own particular case at Pohai Nani, we would have two entire floors devoted to our activity program. Of course, one which will take up a lot of room is the dining room, but it certainly houses an activity. The other part of the program that makes it a bit difficult is that you are a nonprofit and, in most cases, community-sponsored or church-sponsored organization, and the lending agency would not be in a position from a public relations standpoint to foreclose if you got behind in the mortgage. That is a very serious problem with them in that they cannot foreclose, so that can be dragging on. However, thanks to FHA, once we convince them we are all right, that difficulty is largely overcome through their mortgage insurance plan.

The other financing program that needs to be taken under consideration is their operational fund necessary for the life care, and this is where the great variation occurs in the operation of these programs. This fund covers the day-to-day maintenance of the person. The operational fund, or the life care fee as it is known in all these homes, covers meals, maintenance of the apartment, upkeep of the property generally, taxes and those things that go along with it, and medical care. There is the biggest variation—in the degree of medical care given, in terms of cost for this.

This life care fee can be paid in our particular home in either of two ways: either by the month, or it can be paid in a lump sum based on life expectancy times cost per annum of maintaining a person. However, in new homes, Huggins & Co., of Philadelphia, who are actuarial specialists to the Government and to various large organizations, recommend that unless you have a program of at least a thousand members, you do not go into a prepaid life care program. It isn't stable and safe, either from the standpoint of the resident or from the standpoint of the corporation. In our particular case, having 5, we now have 1,200 in our homes. We have another home in San Diego which will have about 350–400 and at Pohai Nani we will have 250–300, so we are free to go ahead on a prepaid life care program if we choose. But a single home alone cannot do that.

This matter of paying by the month presents some problem to people, too, who are in the business. That is the increased cost of care over a period of time, and we are, to my knowledge, the only home which does not have an escalator clause in the contract. We guarantee that once a contract is signed, this life care fee will not be raised so far as that individual is concerned. I am certain we are changing more than we changed 52 years ago when we started our first home, but as far as the individual is concerned, when that contract is signed, that's it. It only affects the person from that point on.

That I may tell you how serious this is in financing a program like this, I was in a home last week on the mainland that had been in operation less than 6 months. This was not a Methodist home but that's beside the point. I can show you some Methodist homes that are in the same trouble. This home had been operating less than 6 months. They started at $175 per month under a life care fee. They are now up to $200 and in discussing it with the chairman of their board, he says they are slowly going under and are going to have to raise, he thinks, to $250 per month. Now that's why the life care fee is so important, and in financing this, you need to set this at a point you feel you can operate, otherwise you can get into difficulty. We are able to make this guarantee because we are part of this large organization and we have over $11 million in reserve for life care fees specifically earmarked. It isn't derogatory against a home if they cannot do it, and they will be in the same position we are in after a few years of operation.

The medical care is probably the biggest reason for variation in that some give only infirmary care, and you must realize that we in the United States approach this matter from a different angle from the pictures we saw. This is in terms of a retirement home and all the modern ones where people are ambulatory. They basically do not need medical care. All these have an infirmary or dispensary to take care of their small needs, but then in our particular case where they do need medical care, they get it without limitations, including surgery. In the homes that we saw when they get to that point, they are taken out of their accommodations and moved into a different home or into the boarding home or apartment into the sanitarium, and here in the United States in the modern homes, we approach it from a different angle.

Harry Lee, specialist, urban renewal

Mr. Maice just spoke to you about redevelopment projects. My talk this afternoon will be more on urban renewal, redevelopment being one phase of urban renewal. As far as our office is concerned, we have a job of integrating the planning features, the comprehensive general planning of the city, planning the housing picture of the whole city, citizen participation such as you people are doing today, participating in solving problems for the aged and financing these various projects and activities that are concerned with urban renewal. We call this the work program. It has seven elements, and I mentioned three already.

One of the big problems that we face is the construction of housing for the low and middle income families and also for the aged people. I must admit we have failed in our promotion, in our development, and I say that we have failed because it's really the city's fault. The planners so far have been thinking more in terms of the monster—the automobile. They have thought about buildings but nothing in terms of the people, in terms of the people's need, one category which is very, very important at present.

We are not planning for the people's needs. We have to change our whole attitude toward planning from now on and that means we have to plan for people. We must plan the way people in Sweden have been doing, think about the people and their needs. We have talked to a lot of private developers, and the law of supply and demand has been that the demand has been so good they are not interested in building housing in the $15,000 bracket where you can make only about $1,000 profit. They are not interested in building housing for rent at very low rental per month. The profit is not there and I don't blame them because after all there are still other people and lots more other subdivisions where they can go into and make more money.

I should like to urge that if private developers fail in developing housing for the aged or for the lower middle income people, that we go and look to the nonprofit institutions and let them come up with their ideas as to how they can help. The FHA has programs, and the Federal Government and the State government, and even Mr. Maice's agency has programs to assist private developers come up with some kind of housing for the aged and for the elderly. So I, too, should like to see more and more of the nonprofit institutions come up and when I say nonprofit institutions, I am talking about, say, the HEA, the retired teachers' association, or the ILWU—labor organizations—the McInerny Foundation which deals with nonprofit activities, or any of the trusts that have capital and would like to serve the people. I think they should come into the picture and help. I think it is going to be "gravy" for them for that matter because FHA practically finances the whole thing in terms of insurance and I don't think there need be any worry concerning losses.

Another area that we would like to encourage people to look into is the rehabilitation or the reconversion of old mansions for the older people. We have an old home—instead of tearing it down, let's fix it up. There is a program on FHA that can help you plan that kind of a project and, therefore, I think we should go more and more into rehabilitaion or reconversion of old homes.

We are in the midst of trying to promote a study called a community renewal program. We hope that this long-term study or program will come out with some idea as to what the future of Honolulu is going to be and how we are going to tackle this problem of slum clearance, conversion or conservation or reconditioning and rehabilitation. As we make this study and as you read these articles in the paper concerning this study, if there is anything that you would like to see oriented for people, we would like to have you approach the city for help, for their consideration as far as your wishes are concerned. We feel that unless the plan is geared to your need, your desires, I think the whole urban renewal program is going to fall down. We think the program should be for you people and not for somebody who wants to build a monument or somebody who wants to build just cities for this monster, the automobile.

So we would encourage you then to go along on our urban renewal program. If you think we can help you, we would like to have you call upon us and our office is geared to citizen participation. We will work for you either through city planning, through the mayor's office, through Mr. Kunimoto's office, or any office you want to see or contact in the city.

DISCUSSION, PANEL MEMBERS AND AUDIENCE

Tuesday, November 14, Afternoon Session

Mr. FITZSIMMONS. What happens to these elderly persons when they have to go to the hospital and are away from their apartment for a month or more, what happens to their apartment—do they get it back?

Mr. SULLIVAN. The apartment will be held if the rent is paid. There is no provision in the U.S. Housing Act to keep the unit for a family or for an individual without rent being paid.

Question. What would be the profit on those figures you have given us?

Mr. FITZSIMMONS. First, let's take the 221D3. You can be nonprofit; therefore, you only get your maintenance, your overhead, and management fees out of it. Second, if you are a limited dividend type of corporation which allows you 6 percent up to 8 percent on your maximum investment, your investment is only what equity you have in the project. The third would be a profit motive. If you had a profit motive and if you happened to be a developer, you would get your construction fee which is normally allowable anywhere from 8 percent to 10 percent. You would in addition to that, have an allowable profit fee of 8 percent to 10 percent. Also, if you had a built-in vacancy factor, you would be picking up another 7 percent. So you could have as high as 15 percent if you were profit motive. On a limited dividend corporation, you could still make up, I think, on your vacancy factor. Frank can answer that better than I can.

Mr. MERRIAM. We have not encountered that at all. I don't imagine you could stop it.

Mr. FITZSIMMONS. The only type of loan where there is no profit involved is the nonprofit institution. If you are a limited dividend or profitmaking firm, you can make some profit out of it. It all ties back to profit on equity. If you have 10 percent in it, you can make money on that 10 percent.

Mr. SULLIVAN. The figures you put on the board do not take into consideration any cost of land, do they?

Mr. FITZSIMMONS. They could take in the cost of land on multistory.

Mr. SULLIVAN. On $8,000 a unit?

Mr. FITZSIMMONS. Yes. I am not saying you are going to go out and buy a $15,000 square foot property and do this. You can do it on anywhere from $5 to $7 a square foot. These are efficiency units. It could be one pattern. In some cases, if you are efficient enough, you can even get two patterns out of it. I can tell you now developers are doing this right here in Honolulu though they have not been on FHA.

Mrs. DEVEREUX. How do these units compare with the Punchbowl housing units?

Mr. FITZSIMMONS. They would be very comparable.

Mrs. DEVEREUX. Fireproof and everything?

Mr. FITZSIMMONS. Yes, fireproof.

Question. Mr. Sullivan, what was the cost per unit?

Mr. SULLIVAN. Including the cost of the land, it ran around $13,000 per unit, including parking space.

Mrs. DEVEREUX. You're including in this the recreation area, the public area, all the rest of the land cost of a highrise building?

Mr. SULLIVAN. Yes, but it would have to be over 10 stories to get down to this cost factor.

Mrs. DEVEREUX. I have a question for Mr. Lee. You suggested we purchase old mansions and rehabilitate them for housing projects for the elderly. If I remember correctly, somebody here in Honolulu did just that, and the surrounding residents raised the roof off the town and the press and the city and county. People who were making an honest attempt to get good care for these elderly people found themselves in a bind. Until such thinking is changed and arrangements are made whereby residents will accept a unit within their neighborhood remodeled for housing, you can't even take the first step.

Mr. LEE. There are a lot of arrangements presently planned for hotel and apartment units. There are lots of older homes which can be converted to four units that can be very well adapted to financing through FHA.

Mrs. DEVEREUX. Now you are talking about residences for them. You are not talking about any kind of care. What we need in this community really are boarding homes or whatever you want to call them, that we saw here, that are really good.

Mr. LEE. We need that type.

Mrs. DEVEREUX. Our new regulations say that those buildings should be fireproof.

Mr. LEE. I think with regard to the new fire zoning, you have to build in the outskirts where it is not fire zoned, other buildings, that is.

Mrs. DEVEREUX. With the rigid standards required for new construction, I am questioning why the Government does not encourage and lend money for rehabilitation of old facilities.

Mr. MERRIAM. You do have a problem here, and when I mentioned rehabilitation, I was perhaps misleading you a little bit. The particular wing I mentioned in Eugene, Oreg., was only a couple of years old. When you go into actual rehabilitation, there is a problem. We did have one on the mainland where there was a hotel and they proposed to convert that to housing for the elderly, but we were not able to accept it because they could not meet our fire standards. This does not mean that, in certain instances, rehabilitation is not possible. One of the big things would be to meet the fire requirements, and they are pretty strict on that.

Mr. LEE. I would like to see tried here a nonprofit organization picking up a big building and see what could come out of it. The housing authority picked up all these army shacks that were once long barracks and converted them to living quarters.

Mr. SMITH. There was a home in Manoa that proceeded along that line. It was a boarding house for a while. It was cut up into relatively small rooms; the lot was big. The question arises, how would you rehabilitate to get sufficient housing capable to take care of the fixed overhead? Obviously it was valuable and yet there was a low square footage of space. It seems like a pretty rugged problem.

Mr. LEE. Did you know that under the present law anyone of you in your own home can rent out to less than five boarders provided they eat with you in one kitchen? The house can be converted to a boardinghouse for four or five individuals where they will eat with the family. This can be done very easily.

Comment. This is for the Government agencies: We have the slum clearance in San Francisco. They built three-story buildings and put in elevators. It was primarily for Negro families in the community although it was intermixed. It is now known as being a deathtrap in that you can no longer enter an elevator without being knifed or raped. So everybody uses the staircases. It is the one way of staying alive in San Francisco in this Government slum clearance project. It is common knowledge that those who live within the project itself are attempting to move out of it.

Question. How do you justify a 40-year loan on houses that will not be with us 40 years? The type of housing that is built will not last 40 years and, therefore, we are just creating and compounding a slum and also a burden on the taxpayer.

Mr. MAICE. We have sold 8⅓ acres to Queen Emma Gardens. The buildings will be 25 stories high and going to be privately owned the same as your co-ops are in Waikiki. If there is a danger, it is under private ownership, not Government ownership because we will have nothing to do with it except to maintain control for a period of 35 years, and FHA isn't going to finance that project or insure it for 20 or 40 years, or any length of time, unless the development meets all of the requirements of FHA. In this particular development (Queen Emma Gardens) the plans are being prepared by Minoru Yamasaki and his associates in Detroit. I talked to him 2 weeks ago and they are sending the plans over. After review by the agency, they will be returned to the developer who will in turn submit them to FHA who will go over them. Based on the comments that have come back to us already from FHA, I can assure you that they are going over them with a fine-tooth comb.

In regard to the problem of elevators, the Government operation and private operation, I must grant, do differ. In the private operation plan for this particular project there will be a sufficient number of people on the project to police this very thing. Whether Government can or cannot do that, I am not prepared to say. I know we are not having trouble at Punchbowl Homes, but I do know they are having trouble in New York and San Francisco.

Mr. FITZSIMMONS. And to further answer your question as to whether a structure will last for 40 years, you are probably not aware of Government action in Honolulu. The State department of health has just enacted a new housing code and the city and county is presently enacting a new housing code whereby you will be policed to keep your yard and your home in good shape to prevent blight.

It has always been a part of the physical requirement but has been neglected. In order to make a workable program in urban renewal, that is one of the conditions that has been laid down by the U.S. Government. We will not allow these areas to go down in value, and while I am at it, I want to ask both urban renewal and FHA: As long as the city and county has a workable program, is it not possible to create low-income and nursing homes and homes for retirement and other plans to take advantage of the urban renewal program, even though it is outside of the physical limitation of the urban renewal area? I will give you a hypothetical case: I want to build 221 highrise and you do not have the area within urban renewal to take care of me. I can still get a sponsored program even though I take it outside of the area?

Mr. MAICE. That is correct.

Mr. MERRIAM. Yes, 220 is within the urban renewal area; 221 can be any place.

Mr. FITZSIMMONS. Or even 220.

Mr. MAICE. Well, normally 220 is in that project area.

Mr. FITZSIMMONS. Is it still true that if I come in and want to build a 221 rental housing project and you do not have room for me, I can ask you to condemn a piece of property and have it done for me?

Mr. MAICE. We can do that. In fact, we were talking about it with a group this morning. This can be done in two ways: one is an auxiliary housing project outside of this particular project area to provide for a residential area to house those being displaced. We also have the same possibility under a State law which was known as 101, the section of the law in which the Kokea housing project was built. The fact is that we were talking about an area of land in Moiliili which is removed from the development project by some 4 or 5 miles. That process is possible and we're endeavoring with all our means to try and develop more of that housing because we need it. We have still about a thousand families in that area to relocate and the majority will fall in two categories: low income or low moderate.

Mr. MERRIAM. If I may make one more point—you asked regarding the homes, how long they're going to last. I am speaking of single family, not of your class type A construction. If you know FHA, we operate under something called 203D. That is our regular bread-and-butter-type of housing and that is where we get all our income and our income from our mortgage insurance business keeps us in business. On some of our longer term loans, which are special type, in which Congress sees fit to help out certain segments of our economy which might not be buying or renting, they set up a special insurance fund. It does not come out of our regular reserve which is created for our regular single-family operations. They set up a special fund, actually alloting funds to do it, realizing that there is a greater risk involved. In these longer term loans, or 100 percent loans, if there is loss, it would be taken out of this special fund; and again, in our single-family housing or even in our 207, we have certain criteria which we apply to attempt to arrive at economic soundness. In these special programs we don't do that because we realize, as Congress did when they set it up, that there is greater risk involved.

Comment. On the 40-year loans, we never expect that the person who buys it will pay it off. He is never going to be there. I think that 8 years is all the time the buyers live in it. So it is sold again when it comes up for redevelopment; by that time it has had 3 or 4 owners and then will be paid off during the condemnation proceedings.

Mrs. FAYE. I want to raise a question that has been in the minds of the housing committee regarding State lands, and it is also in relation to a resolution passed by the last legislature asking that the use of State lands for retirement communities be looked into. I was wondering, whether your figures had any relation to the possible availability of State lands. I am thinking particularly of the neighbor islands. There is a demand there now.

Mr. FITZSIMMONS. My figures naturally don't relate to single-family dwellings when you have a lot and build a house. You would have to add at least another $5,000 to these figures here. As to the outside islands, they might be very close to the land and dwellings for these figures.

Mr. SULLIVAN. With regard to the resolution that Mrs. Faye spoke about requesting the HHA and the department of land and natural resources to study the feasibility of developing communities for the elderly on State-owned lands, we have discussed it with the department of land and natural resources and a group of people from the community, including Dr. Shoemaker, representatives of the department of research and planning, representatives of banking and

financial institutions. There was a general agreement that the first thing that would have to be done would be to determine before considering the feasibility of developing whole communities, the attitudes, needs, and desires of the elderly. The housing authorities have taken over that responsibility and we are making plans to have the necessary survey conducted because it deals with the elderly and because they are a relatively small part of the population and pretty widely distributed geographically. However, we will probably be able to determine whether such things are needed and at that time when we get the results of the attitudes survey, then we will discuss with the department of land and natural resources what lands could be made available for such communities. We are going ahead and getting the survey. I think the results will be of interest to a lot of people concerned with planning for the elderly.

Mrs. FAYE. Will that have some relation to the survey being done by Lee Maice? He did the market survey. Will that hit the same type of people?

Mr. SULLIVAN. No, I don't think it will. The survey we are planning would be directed specifically to the elderly and only the elderly. The people surveyed would be probably 60 or a larger percentage of the elderly, so that we would get a high degree of reliability of the survey results. We are thinking of it on a statewide basis. We are now in the process of trying to get a questionnaire or, as the marketing experts call it, a schedule. The difference is, as I understand it, if it is a questionnaire, the respondent fills it out; it is a schedule when the enumerator fills it out. We are in the process of getting this developed, and while we were at luncheon today, Frank Lombardi told me that I can have the assistance of Bob Schmidt of his staff in developing that. I have also had the promise of assistance from the regional economist of the Public Housing Administration. I have talked with the Commissioner of the Public Housing Administration in Washington. We are going to get a lot of help on it. I think we are going to develop something that will be reliable and will tell all of us in planning housing for the elderly what the housing needs are, where we can put it, etc.

Mr. FITZSIMMONS. You are making reference, Mr. Sullivan, to their desires once they find the homes. I think we will want to know whether they want to live in such communities.

Mr. SULLIVAN. I think that's essential, and then I think if we find that if elderly people as a group want to live in such communities for the elderly alone, the next thing you would have to consider is the different types of housing to be put in there. I think public housing would be only a part of it, but I think in such communities private enterprise would play the larger part and would build for many economic groups that public housing does not attempt to serve.

Comment. We have been hearing all through this conference that the elderly do not want to live by themselves in isolated groups. They want to live where they can be with other people, young, middle-aged, and old, and so would these villages for the elderly be the wrong thing.

Mr. FITZSIMMONS. To tell you the truth, I don't believe the statisticians believe in their own figures sometimes. Since 1954 the first book I read on this was published by the University of Indiana on research into what people liked in housing for the elderly. What you say is very true. It was pinpointed then and every year since then, and the statisticians don't believe it. They always make another survey. I have some statistics here in relation to several wants or desires:

Need to be near a clinic office: 66 percent desired it, 31 percent did not, and 3 percent said it was not important; visiting nurse service: 35 percent said it was essential, 40 percent desirable, 25 percent did not care; swimming pool (which is very important): 60 percent wanted it, 26 percent said it was desirable, and 14 percent said they did not care; bus service: 81 percent wanted it, 15 percent desirable, 4 percent did not care; good library service: 70 percent needed it, 27 percent desirable, 3 percent was not; shopping center (they wanted to be near shops): 85 percent wanted it, 14 percent desirable, 1 percent was not. There's a whole list of statistics which have been drawn up since 1954. Nobody pays any attention to them.

Mr. SULLIVAN. May I say another word to that? We have a job given us by the legislature and I think we have to do it. I'm inclined to think, as you are, that the findings will be that elderly people do not want to live in elderly persons' communities. We have found as I said that they want to be a little bit insulated from the noises of the youngsters and teenagers but they don't want to be isolated. I think that the questions we can include in these surveys will develop a lot of information that will be useful in planning, even though it may develop

that people don't want such communities. I'm against such communities myself. I think all of us should be integrated.

Mr. FITZSIMMONS. I know one thing: you are going to find out that those apartments in Punchbowl are not enough and the six units that you are planning should be at least 50 percent for the elderly and not zero.

Mrs. DEVEREUX. I'm certainly not very much in favor of the resolution. Those of us who have no idea of going to an area like this, or of even looking for a low cost housing project, sit around a table and decide what we are going to do for others. I think you could get a whole lot more information if you sent out a call for a mass meeting to all people over 65 years of age who may be thinking of moving from their present place within the next 10 years and find out from them what they want. When you send out a paper with a lot of questions on it—how would I know when I get a questionnaire like that what kind of place I would like to live in, or whether I want nursing service—never had nursing service, never had to move, don't know where I would go, don't know what I want. But if I could get together with 50 or 60 other people who might be in my boat, I would start talking it over with them, then get an idea of what I think I might like to do. I don't think this survey will give you the answer that you want; it will be costly, as you said, and we will just go around in another circle and have another resolution of some sort introduced at the next session of the legislature—so where are we?

Mr. SULLIVAN. We don't intend to do the survey until we tell the legislature what we propose to get. We are going to give them a set of tables and tell them the information we anticipate will develop, and the anticipated cost; then if they want us to proceed, we will.

Mr. KROH. I don't have much information about these communities but I do know that retired people who have bought their homes are tickled pink to be living in a retired community where only retired people can buy in that subdivision. This is in Youngstown, Ariz.

Mr. JARL. I think if you will take the advice of myself and Mr. Fulford, being managers of retirement homes and being associated with people of that age, you will get the answer quicker. Because if you ask them what they would like and what they don't like, you will soon find out what you should have. I contend, and I know Mr. Fulford does, that in these retirement homes you are building, you should put in things that they like, and all you have to do is go in or be a manager of one of these homes and you will soon find out what they like and what they don't like. I would like to ask one other question: Is there any property tax exemption for people interested in putting up retirement homes in the State, as in California where there is no property tax on retirement homes?

Mr. MAICE. There is no such tax exemption except in one category and that is if a group forms a redevelopment corporation, there is tax exemption under that particular corporation. That could be for displaced elderly but not elderly as such. That's the only tax exemption I know of other than the home.

Mrs. DEVEREUX. There would be an additional tax exemption in a nonprofit organization which falls under another category in legislation passed at the last session of the legislature delineating any situation like this where there is clearly no profit involved, eleemosynary in scope.

Mr. FITZSIMMONS. You mean such as a church that may want to undertake a program?

Question. That brings up a question for Mr. Fulford—not that I want to put him on the spot, but he mentioned that in the years of operation, they have built up a $4 million surplus. How do they get by with that?

Mr. FULFORD. This particular reserve that we have for life care has not been built up through profits. Actually the past 2 years our corporation has lost money and we have certified accountants' statements to that effect. This reserve that we have built up has been built up by our people who have paid their life care in advance.

Mr. FITZSIMMONS. So one side of the books is reserve and the other side is the liability.

Mr. FULFORD. That's right, but it is built up and it's from the investment of that money that we are able to guarantee that we will not raise the rates because we are able to build up and to cover these loans as they occur.

Mr. LONGMIRE. In the last year there was quite a number of projects in the discussionary stage which appeared as if they might proceed this year. What's happened to them? There was a lot of talk about them last year and they did not get off the ground. My conclusion is that it was the cost of developing them at a profit. A lot of us here are private citizens. It is our civic duty to

try and work out these problems. Several things have been said here this afternoon which this group, all representing people from the community, is going to take out into the community.

One thing that Mr. Lee mentioned to which you objected and to which I objected quite strenuously is that the reason they are considering turning over the development of this low cost housing to nonprofit organizations is that other developments work for profit. Everybody is entitled to his opinion. We would be very happy to make $1,000 profit on every house that we do. I know we have been trying in the last few years to get into an area of $14,000 to $15,000 homes. You can't do it without a profit—there's the cost of land, the cost of developing the land. So let's be certain that when we go out of this room, we do not leave with a lot of misinformation and misconceptions. I would like to see a project like this go ahead, Mr. Fitzsimmons, and I would like to talk to you about it some time.

Mr. FITZSIMMONS. It is feasible.

Mr. LEE. No apologies needed because our experience so far with private developers has been that they come in with over $100 per month rental, and these units may come in $15,000; some come in as low as $13,500 but eventually they get up to $15,000, $16,000, $17,000, depending on how people seem to grab at it. That has been the experience that we had so far. If anybody can come in with that kind of figure and say we will build it at that kind of price, we will work with him, but nobody has yet. We encourage private developers to come in and if they don't come in, and this has been going on now for the past 4 years, we can't do anything. Our next step would be to encourage nonprofit organizations to come in so they can come down to those rates that we want. And that's what FHA wants, too, because otherwise they can see the rise of these 221 projects at over $100 a month rental or over $15,000 per unit.

Mr. FULFORD. May I say something from the standpoint of nonprofit organizations, or eleemosynary organizations operation? It is our experience as we have looked over these for the past years, in order to be successful, our type of homes need to be operated by an eleemosynary corporation, a church, or a lodge, something of that type. To the best of our knowledge, none of the homes of our type have been operated by a profitmaking organization that had been successful. This may be due, perhaps, to their attitude, and maybe that's not a polite way to say it, but on the other hand, theirs is an attitude that they are in there strictly to make money. This is due also to the fact that if you are going to make money, you are going to have to get your costs beyond what the market or traffic will bear. And we have a couple of classic examples in California. I was there a couple of weeks ago and saw one now being operated as a hotel. Frankly, there is no money to be made in the operation of a retirement care home such as ours, and that's why private builders, private money stay away from.

Mr. LEE. I think the only way to make it successful is to have a certain amount of public interest in this whole program with a limited amount of profit. It's all one way or the other. Eventually if nonprofit organizations do not come into the picture, then government will have to step in and that is where your survey will come in. We have to get Federal money to back us up and Federal agencies are going to insist on a survey before we can even present it to them for the money.

PROCEEDINGS OF THE INSTITUTE ON THE OLDER WORKER

Edited by Harold S. Roberts and Joyce A. Matsumoto, February 1961, University of Hawaii, Honolulu, Hawaii

PREFACE

In May 1960 some 500 persons met at the Governor's State conference on aging to discuss and assess the problems of the aged and aging and the resources existing to meet their needs. A number of recommendations were made at the conclusion of this conference, including one urging the community, through various organizations, to provide programs and conferences designed to prepare persons for retirement. The Institute on the Older Worker, cosponsored by the State interim commission on aging, the School of Social Work and the Industrial Relations Center of the University of Hawaii, was an outgrowth of this call for assistance. Attending this meeting were more than 100 educators, community leaders, industry and labor representatives, and oldsters in active retirement.

The purpose of the Institute on the Older Worker was to provide a discussion of the questions involved in retirement such as the nature and magnitude of the problem in Hawaii, flexible versus compulsory retirement, the physical and social aspects of aging, and industry's and labor's views toward the older worker. The conference was directed by Mrs. Alexander Faye and Dr. Harold S. Roberts.

The proceedings are being published to provide the members of the institute with a partially edited copy of the presentations by the speakers. Summaries of the discussion of the work groups were prepared by the work group chairmen.

We want to thank all of the speakers for their able and stimulating discussions and their excellent cooperation without which this present volume would not be possible. To the Honorable Hiram L. Fong, U.S. Senator, we wish to extend our appreciation for his presentation on the national interest in the older worker. Special acknowledgment is extended to Mrs. Eva L. Goo and Mrs. Betty Lee for the extra care in the clerical and typing work. The cover was designed by Mrs. Mary M. Tachibana.

Introduction

(By Stanley D. Porteus, Ph. D., professor emeritus of psychology, University of Hawaii)

The problem of the older worker is certainly a most complex one—how broad a problem I did not realize until I read the excellent data book prepared for our information.

On page 16 I noted that Dr. Linden, a psychiatrist by persuasion, believes that a basic question—I would call it a fundamental one—is "Who wears the pants in the American family?" He says that in the last 200 years, male leadership in American family life has become reduced and impotent, with women becoming the dominant decisionmaking persons. The psychiatrist calls for a reversal of the situation, and I heartily agree with him. What self-respecting man would not agree? The answer to the question as to who wears the pants is obviously: "Everybody."

But let me see—200 years ago the date was 1760, so it looks, after all, as if the women won the American Revolution. Even the DAR has made no such claims. And if this is the sad truth, what can we do about reversing roles? The most persuasive education, even directed by psychiatrists, will not put the trousers back where they traditionally and rightfully belong.

There is no doubt that the world is changing rapidly, not only its fundamental attire, but in other ways, as witness the purpose of this institute. It is supposed to give counsel and advice to older people. Surely this is a reversal of roles. It has always been the privilege of the aged to hand out advice to younger people. Now we elder citizens are asking consideration from our juniors. The problem can be summed up in a nutshell. There are too many nuts. As Earl Russell is supposed to have remarked: "The great trouble in providing for the feebleminded is that there are so many of us." The same applies to the aged.

The problem is not continued employment, financial security, hobbies, spare-time usefulness, contentment, but simply one fact—old age. I do not know what we can do about it except talk it over, and that is what we are here for today. Even if the discussion resolves itself into consideration of what the labor unions call featherbedding, which happens when there are more workers than work, it certainly will be helpful to know how it can be brought about most economically.

This brings me to the reasons, justifiable or not, why I was asked to preside over this institute. In the first place, I am old. My parents persisted in stating that I was born in April 1883, and those still capable of it can do their own arithmetic. But as far as my own knowledge goes, I was born about 5 years later. I know I was alive in 1888 but I have no recollection of any earlier activities. My father, as a Methodist minister, was poor but respectable; but, as he was 63 years old in 1888, his memory might have been failing.

The second reason is that the board of regents believed my birth certificate and 12 years ago graciously retired me. Since that time, I have done a very satisfactory job of featherbedding for myself. Some of my colleagues may think that in 1948 I gave up featherbedding and began to work. In any case, I have produced more since that time than in any comparable period previously.

It is a pity that men, who Dr. Linden would have us believe should be described as the foundering fathers, could not declare in the preamble to the Constitution,

that all men are born equally tough. Fortunately, elderliness crept up on me gradually. So I have found people willing to read what I write, and even as you, listen to what I have to say, without serious objection. Only now do I find featherbedding beginning to fail me. I expect to pay for my own lunch.

Since I have a captive audience, may I speak for 1 minute as a psychologist. At the university we believe that we have discovered a method of measuring people's tendency to fall into set patterns of response: in other words, to become set in their ways. We hope to obtain additional funds to find out, among other things, the age at which we become rigid or inflexible in our judgments and actions. How to put off this proneness to compulsive thinking, this fondness for being sure that we are right about everything, would be a most useful study in geriatrics. At present we don't even know whether being sure is characteristic of old age or youth. Perhaps it is youth that is so positive, and long experience that prompts us to see two sides to a question.

But now, with no further indulgence of volubility, we shall proceed to hear from my young colleague Dr. Willard Wilson, provost of the University of Hawaii. The fact that he is well educated and that he was born in 1904 are attested by Who's Who in America. What is not mentioned is his most mellifluous voice, so that whether singing or speaking it is a pleasure to listen to him. Though from personal experience Willard cannot know much about aging, what he has to say may be regarded as grace before meat. Willard, you have 10 minutes to give us your distant views of old age.

Opening Remarks

By Willard Wilson, Ph. D., Provost and Senior Professor of English, University of Hawaii

Mr. Chairman, fellow gerontologists, ladies and gentlemen, I know there are many wiser and perhaps some older people here with much better ideas on the subject to be discussed in this one day seminar than are mine. Before I attempt to say anything further, however, I wish on behalf of the university, particularly the school of social work and the industrial relations center, to express our great pleasure in having some part in sponsoring and pulling together this conference which is preliminary, of course, to a national session in Washington. The University of Hawaii, as a State university, feels very strongly its obligation to assume leadership in facilitating the discussion of problems affecting Hawaii's citizens, whether they be old or young. We have, as you know, played a very strong part recently in youth conferences. It is now only fitting that we also round out the picture. A university cannot do all things for all men and women but certainly within our own legitimate interests of research, education, and certain forms of service we should do our best to facilitate the shedding of light, and even occasionally the generating of heat.

It would be presumptuous of me, obviously, to attempt to make a definition of what constitutes an "older worker" or even an "older person". "Older", I have observed, invariably means anyone who is older than the speaker. This is quite proper, for obviously a person is only as old as he feels. Age in many ways, even though it has a certain subduing influence, does not have for all men all of the fearsome connotations that it once did have and also that it still has in countries remote from our own where the economic level is appreciably lower. I take it that much of the consideration involved in the specific topic before you in this conference will have to do with economic matters. This is only natural, for the ability to enjoy the best years of one's life which are the mature years (or at least should be), is desperately inhibited frequently if the concern of a man and a woman to his last days must be that of securing food and shelter. I know these problems loom very large, and it would be perhaps presumptuous to remind us all of the conditions prevailing in other countries where many of us have traveled; but nevertheless I am quite sure that as you, in the words of Browning, "grow old along with me" for "the best is yet to be", a bit of cheerfulness and reflection on the past may make our plight more tolerable.

I have been warned never to tell stories on my family, but I was somewhat amused not long ago when my 15-year-old daughter said to me, "Daddy, being a teenager is just simply awful. I wish I were 20." This to her, obviously, represents middle age. To bring the subject even closer home, when my wife and I were returning from Europe 4 years ago we sat at a table with a charming group of youngsters: a Swedish girl, a young French girl who was going to be a teacher in New York, a Spanish college sophomore, an Austrian ski instructor,

and a young man who had been given a European trip as a graduation present on his completion of Yale. My wife and I did not regard ourselves as exactly Methuselahs; we were entering into the spirit of the occasion and having a really delightful time without feeling any great bridge between us and our tablemates, when one night after a particularly spirited multilingual and multisubject dinner session that we all had enjoyed tremendously, we were rather set back on our Wilson heels by a grateful and appreciative remark from the recent Yale graduate. He turned to my wife, who was looking particularly youthful and charming to me certainly, and said with the greatest of sincerity: "Mrs. Wilson, you don't know how lucky we all feel to have you both at this table with us. It is very rarely that one finds an elderly couple who can enjoy things with us the way you two do." I don't know whether women are more susceptible to this thing than men, but I do know that as my darling young bride looked at me I could see in her eyes a species of genuine shock. Perhaps this is enough of an illustration of the point with regard to the relativity of age.

The plain fact is, my friends, that we all do grow older and we all want to make these years increasingly productive. I take it that no one here is of the opinion that productivity should cease arbitrarily at a given dateline, whatever that line may be.

From the point of view of the university in particular, we are increasingly aware of the real necessity for providing learning experiences through many classes both credit and noncredit for people no longer under the necessity for punching the timeclock. It is significant, however, that in the title chosen today there is voiced a real feeling about the matter that the older citizen should not be encouraged merely to spend his days vegetating, but that we should make available to him facilities that allow him to continue and frequently diversify his productive life. Your subject is "The Older Worker" and I daresay many of you will heartily subscribe with me to the emphasis on the last word of the three.

In a recent booklet on "Long Term Growth Investments" which was called to my attention last week, and growing out of the possible development of various expanding interests reflected in growth stocks which may be expected to continue in the "singing sixties", linked to a hope of an expanding economy, increased leisure, and extended longevity due to medical advances, the following areas were specifically mentioned as worthy of attention: Book publishing; writing; hobbies; sports; travels; gardening; dance studios; carpentry; entertainment devices; boating; hi-fi; cameras; drinks. (The last item I didn't quite understand but anyhow there it was.) Also mentioned were all the fields having to do with correspondence courses and extension courses. Should our economy not collapse, there is reason to believe that we may all have increased time, even before retirement, for some of these pleasures and developing interests, and some of the money to indulge in some of them.

The person who is well-informed, who has developed habits of reading and conversation even before retirement, will be in an excellent position to take advantage of the changes in a rapidly changing world. Elmo Roper, the public opinion surveyor, was recently quoted in a local editorial as saying: "The plain fact is that if Russia sank into the sea tomorrow, most of our—and most of the world's—problems would remain." These problems can only be resolved by knowledgeable, reflective, people "who are able to use all that is in them, their hearts, their senses, and their minds, as fully developed, mature human beings."

One of the most encouraging things to me is a somewhat baffling American phenomenon which we still persist in calling "the drug store" is the increasing number of high-level paper book reprints that obviously are selling in substantial quantities. But perhaps I've made enough of a pitch for continuing reading and learning as something that will provide many of the answers for the older worker.

"It is better to wear out than to rust out" said Richard Cumberland, that 17th century Bishop of Peterborough who lived to be 87 even in that unhealthy age. This might well be the slogan of the Nation's 14–16 million men and women of 65 and over, about 80 percent of whom we are told are no longer in the labor force. (Although the Nation's population as a whole has doubled since 1900, the number of Americans over 65 has quadrupled.) It might even serve all the members of the labor force over 45, a total of 28 million according to some small-scale surveys.

On the other side statistically, Secretary of Labor James Mitchell calculates that by 1970, the American economy will require a labor force of 87 million. Of the additional 13.5 million workers this entails, 40 percent will be over 45.

Without them, there would actually be a labor shortage, the more keenly felt because the greater proportion of the 13.5 million increase will be in the less experienced, under 25 category. Secretary Mitchell has taken his own slogan, "Ability is Ageless" in a concerted program begun about 5 years ago to lower employer resistance to hiring or retaining older workers.

Lest the man in his thirties think his problems of age and employment are at least a decade or two in the future, one employer survey in Houston indicated that 24 percent of those surveyed would not hire a man at 35. In the same city, 70 percent of the employers surveyed would not hire a man at 45. The same article showed that of the employers surveyed in liberal East, 75 percent of the firms queried would not hire a man at 55. (Fortunately, the sampling, reported in American Mercury, was small enough so that optimists might want to disregard it altogether.)

Roul Tunley, writing in the Saturday Evening Post, speaks of work, paid or otherwise, as a "secret weapon" with which to revitalize old age. He quoted Roland Baxt, director of the Federation Employment and Guidance Service in New York, to the effect that "Life for most people is work." Tunley recounts several dramatic examples of retired people beginning new careers or building on their old ones and making a real contribution to their communities or the Nation or, not least, themselves.

"A group of retired engineers in Schenectady sets up a firm to design work on a contract basis and in a dozen years earned $1 million in fees. Their group now numbers 150.

"A Detroit man retired from his shoe manufacturing business, went to California at the insistence of his sons to take it easy, became interested in physical rehabilitation and eventually designed a shock-absorbing boot for paratroopers. From this, he produced the ripple-soled shoes, which made him more money than his first shoe career had."

Tunley also quotes Dr. Edward L. Bortz, former AMA president and geriatrics specialist: "These are the harvest years when one can reap the benefit of wisdom and maturity and start a second career which may or may not be a continuation of the first. Ideally, the first career, having been personal and acquisitive, should give way to a second career which is devoted to the larger interest of serving the people around one."

But I know that all of you are familiar with stories of this sort, have immediate problems that you wish to consider, and have the people to assist you in doing so.

I merely want to assure you that the university itself will be very much interested in any way in which we can ameliorate the problems of the aged and aging worker; and we stand ready at all times to implement things that lie within our sphere.

You have our very best wishes for a productive and stimulating conference.

Aloha.

Dr. PORTEUS. Because our next two speakers are sharing a subject but dividing their time, I will make a dual introduction. Mr. Rockwell Smith is chairman of the State delegation to the White House Conference on Aging. Very fittingly, he has found his later career in insurance, but was formerly engaged in agricultural and industrial relationships. He is treasurer of the group sponsoring the cooperative home for elderly people, Pohai Nani, which has been translated as "Surrounded by Beauty," but as the Hawaiians had no abstract idea of beauty, it might be the more literally rendered as "The Sky's the Limit," not, of course, in the commercial sense but in point of view of vision.

The decisive half of this team is Mrs. Alexander Faye, vice president of the Honolulu Council of Social Agencies, and executive secretary, commission on aging. Between them they will outline for you the nature and magnitude of the problem in Hawaii. In face of crisis, the rule is ladies first, so I will call on Mrs. Faye.

NATURE AND MAGNITUDE OF THE PROBLEM IN HAWAII

Mrs. Alexander Faye, executive secretary, commission on aging, and Rockwell Smith, chairman, State delegation, White House Conference on Aging

Mrs. ALEXANDER FAYE. The White House Conference on Aging in January will bring together the thinking of the 50 States in all areas of concern to older people. All States are preparing for the Conference in a variety of ways, including meetings such as this, in order that their delegates may be well informed

as to the situation in their own State, and fully aware of the thinking, the hopes, and the wishes of the people in the State.

What we talk about here today or at the White House Conference on Aging, does not concern only those who are over 65; it concerns people of all ages—youngsters and teenagers who need an understanding of older people; young marrieds with older parents; and middle-age persons who are beginning to realize that retirement is not too far away, although they hate to admit it.

The challenge of the next decade for those of us interested in this problem is to change public opinion in regard to aging, from a negative to a positive concept of the later years as useful and rewarding ones, both to the individual and to the society in which he lives.

Mr. ROCKWELL SMITH. Speaking for the Governor's interim commission, we are delighted to have such a fine attendance exceeding by half again our greatest expectations. The representation, not only of White House Conference delegates, but of county officials and their associates is particularly encouraging. Further, and of tremendous importance to the progress and accomplishments of the commission, is the splendid effort of the university led by Dr. Wermel and Dr. Roberts in putting on this highly informative institute.

Our search for answers to the problems of aging started with the joint 1951 collaboration of the Oahu Health Council and the Honolulu Council of Social Agencies culminating in the conference in April 1954, which was attended by 300 people. Following a directive of that conference, the Action Group on Aging was incorporated and proceeded to develop the area of housing which was the greatest concern. From this effort came the projected Pohai Nani retirement home scheduled for 1961 construction in Kaneohe. To bring resource people into closer relationship with the problems of the aging, the Action Group joined forces with the Oahu Health Council and the Honolulu Council of Social Agencies in a petition to the Governor for an interim commission on aging which was granted. With the Federal grant of 1959, the commission put on a comprehensive conference last May in which over 500 people participated. This meeting today is the fifth of six to prepare our White House Conference delegates for active representation of Hawaii in Washington next month.

The scope and magnitude of our subject include income maintenance, housing, medical care, preparation for retirement, and the uses of retirement. Within these broad divisions are many related and vital supporting functions. Since we expect the present 29,000 over age 65 to increase to 49,000 by 1970, Hawaii has a few years that the mainland States lack to prepare for our needs. Let us look at income maintenance for a moment. Basic to the problems is the increased life span afforded by great progress in medical care added to which are expected breakthroughs in the scourges of heart diseases and cancer. Young people go to school longer, retirement age largely remains at an arbitrary 65, and more people are swelling the ranks of those over 65. The income producers in the middle are supporting more and more of the younger and older populations and in addition facing a constant rise in prices. How, then, can incomes be maintained for the retirement years?

Since we are talking about the fact that the bulk of American homes are moving from three to four generation families, we realize that housing also is an acute problem. Preference ranges from remaining with one's family during the retirement years to living in a home for retired people. Tremendous strides have been made in both these areas. We estimate that those with an annual income of $3,400 or below can look to low-cost Government-subsidized housing such as Punchbowl Homes and that those with $5,600 or up may find the answer at Pohai Nani or similar retirement homes. We have a tremendous challenge in the $3,400 to $5,600 income range for which the Federal Housing Administration and other Government agencies are developing special loan plans. For those who prefer living with their families, we have the need for larger houses, with provision for the needs of several generations closely associated. We must exhaust every possible approach and solution to a complete answer to housing while we have time.

As we search for ways of maintaining income and developing housing, we must search for the means of maintaining a healthy and active aging population. This brings us to medical care. Since the incidence of illness and length of hospital stay roughly double after age 65 and incomes roughly decrease by one-half, we have acute problems to solve. Homes for the aging which include medical care are felt to be expensive and conversely homes that are economical in cost are found to have minimum or no medical care. Further, we need an

estimated 2,000 nursing home beds of which we have 1,000. Of these only a few over 700 meet State standards. Doctors, hospitals, insurance companies, unions, and Government are all concerned and looking for ways to cut the cost of medical care and yet maintain the quality of that care.

In summary, then, we must find a way to keep incomes adequate in the face of rising prices to maintain a dignified and adequate living for our aging people. Further, we must meet the problem of housing whether as homes for retired people or as to sufficient space for those who prefer living with their families. Let us include with housing those facilities in which the aging may carry on meaningful activities, projects, community work, and recreation. These facilities might take the form of added space in our homes for aging people and separate day centers for those who continue to live with their families. Health must be kept at a high level in order that life will be active, meaningful, and useful. This means that some way needs to be found to reduce medical costs to a point where income can take care of them. These three major areas will be investigated today and on this foundation we will hope on a later date to build the essential preparations for retirement, and the opportunities of retirement once we have arrived there.

In conclusion for the commission on aging, I would like to bespeak our gratitude to the University of Hawaii for this splendid institute. To the Honorable Hiram L. Fong, U.S. Senator, our very sincere thanks for his addressing us at the coming luncheon on "The National Interest in the Older Worker." May we offer our appreciation to University Provost Dr. Willard Wilson, whose opening remarks have set a happy approach to a profound subject, and to Dr. Stanley Porteus who as a senior citizen is chairing the morning's session with keen insight and marvelous humor. We extend our heartfelt appreciation to Dr. Michael T. Wermel, dean of the college of business administration, who first suggested the idea of this institute and who will make a major contribution this morning on the subject of "Flexible Versus Compulsory Retirement," and later in the day will summarize the institute; to Dr. Harold S. Roberts, director of the industrial relations center, who will lead a panel on "Industry and Labor Look at Preparation for Retirement" and who has directed the organizing of this institute; to Mrs. Katherine Handley, director of the university school of social work, who will chair a panel on "Understanding the Aging Process"; to Mrs. Alexander Faye, executive secretary of the commission on aging, and her staff, who have assisted Dr. Roberts with structuring the institute. Through the efforts of all these dedicated people and many others, surely our delegates to the White House Conference on Aging will be prepared indeed to truly represent Hawaii.

Dr. PORTEUS. Our next speaker is Dr. Michael T. Wermel, professor of economics and dean of the college of business administration, University of Hawaii. Economics has been called the dismal science. Aging is a wearisome if not a dismal process and the economical problems involved in providing for the elderly is certainly serious. Dr. Wermel has had exceptionally fine actuarial experience, and this kind of guidance is essential for any sound national or State planning. His counsel will be most welcome and I am sure that if there are any rays of light and hope in the situation, he will present and direct them. His own background is well lit by entries in various Who's Who's. His subject will be "Flexible Versus Compulsory Retirement."

FLEXIBLE VERSUS COMPULSORY RETIREMENT

(By Dr. Michael T. Wermel, dean, College of Business Administration, University of Hawaii)

The widespread expansion of retirement plans and the number of people covered by such plans created a controversial issue out of the problem of when should workers be required to retire. In the absence of a formal retirement program this issue rarely arises since employers are not likely to institute fixed retirement ages without providing retirement benefits.

The retirement plan itself, in the calculation of the costs and the setting of benefit rates, requires some assumptions with respect to a normal retirement age and therefore introduces also such concepts as "early retirement" and "delayed retirement."

It should be noted that the problem of whether there should be a fixed retirement age is quite a different problem from the problem of what this retirement age should be. Age 65 has been so widely used both in public and private re-

tirement programs as the "fixed" retirement age that "fixed" retirement and age 65 have become synonymous to many.

This, of course, is not necessarily so. A fixed retirement age may be set above or below 65 and a criticism of the age 65 target is not necessarily a covering criticism of the fixed retirement age idea, or vice versa.

Those who are in favor of retiring all employees at some fixed predetermined age support their position by a number of convincing arguments. They say that it provides an orderly method of retirement and thus constitutes a vastly superior practice from the point of view of personnel administration, than a policy requiring individual determination in each case. Moreover, they suggest, a fixed retirement policy is nondiscriminatory. All employees are treated alike and all know just what to expect and when—and therefore make the best possible preparation for it. Another important argument advanced in support for a fixed retirement age is that it creates more opportunities for advancement for younger people, makes possible to plan and train in advance for replacement and leads to a better overall personnel program. Sometimes additional arguments are advanced in terms of lowered accident rates and lowered disability benefit costs, but these arguments do not appear as convincing, because of uncertainties with respect to the relation between the age factor and the incidence of accidents.

On the whole it would appear that the arguments in favor of a fixed retirement age may be summarized along these lines. For management: Better personnel administration, easier to retire unsatisfactory employees, better advance planning. For the worker: No discrimination, ability to plan for the future with greater certainty.

The arguments for a flexible retirement policy are, however, also strong and broadly advocated. Fundamentally, those arguments are based on the indisputable proposition that while "all men are created equal," they differ greatly in their physical stamina and their abilities and capacities for work, and these differences become more pronounced with age. By the time the sixties are reached, the differences in individual abilities are very wide indeed. A flexible retirement age, it is argued, permits an employer to recognize these differences. It permits individual treatment for individual workers. As a result good workers can be retained as long as they remain capable and only those no longer capable of performing the work need to be retired. It is argued that flexible retirement will permit more employees to enjoy higher earnings for a longer time with a beneficial effect upon the economy as a whole and also that such a policy would result in lower pension costs. In summary, for management, flexible retirement would mean lower pension costs, a supply of experienced labor which at certain times may be difficult to get. For the worker it would extend the period of his economic activity to coincide close with the period of his physical ability, and would lessen the hardship for those who might otherwise retire on inadequate benefits, and perhaps make adjustment to retirement less difficult.

An examination of these arguments by proponents of a "fixed" and "flexible" retirement age policies raises a number of questions. Would the arguments be the same:

1. If all workers would look forward to a comfortable retirement income?
2. If all workers were better prepared to face the problems of retirement and make a satisfactory adjustment as a result of good preretirement preparation?
3. If unemployment were persistently at levels so high that many younger people could not find work at all?
4. If longevity increased to the point where life expectancy after retirement doubled?
5. If productivity of labor increased at a very high rate and this enormous increase in productivity was accompanied by greatly increased life expectancy?

These questions are merely raised so as to suggest that the issues we face today and the attitudes we develop toward these issues are greatly conditioned by prevailing trends and existing institutional arrangements. Since trends and arrangements constantly change, it may be the better part of wisdom to view these issues without developing excessive partisanship.

Dr. PORTEUS. Before a completely voluntary retirement for coffee, I am supposed to make some announcements. During this interval the room will be partitioned off into three, to which you have been assigned. Those in group I are in

the room on the entrance side, group II in the middle room, group III on the Diamond Head side, while group IV will be in the conference room across the hall.

The chairman of group I is Mr. Scott Brainard, very well known for his 35 years in life insurance and president of Brainard & Black; group II has as chairman, Mrs. M. Gay Conklin, pension coordinator for Castle & Cooke and experienced in personnel work; Mr. Charles G. Spalding is assistant secretary and benefit plans administrator, C. Brewer & Co., and chairman of group III.

Group IV will be presided over by Mr. Rockwell Smith, chairman of the State delegation.

At 11:40 we will hear the reports of the work group chairmen.

NOTES ON WORK SESSION, GROUP I

Work group chairman: Mr. Scott Brainard

Mr. Brainard opened the meeting by presenting the subject "Flexible versus Compulsory Retirement."

The first part of the discussion dealt with preparation for retirement and with whom the responsibility for such preparation rests. The three areas of responsibility were defined as individual, employer, and community.

It was agreed that preparation for retirement should include provisions for:

Financial support
Health—medical care
Interests—cultural, educational, civic
Reduction in overhead
Attitude toward retirement
Social—friendships
Proper utilization of time

There were several opinions regarding the time when preparation for retirement should begin, i.e., as children in the home, in school, at age of maturity, etc. No conclusion was reached. It was pointed out that there should be balance in the planning for retirement. A young person whose thoughts were only on retirement could bypass the opportunities and achievement of stages prior to retirement. On the other hand, the longer the span of time between planning for and reaching retirement, the less traumatic the actual experience.

There followed a discussion of what some companies and employers are doing to prepare individuals for retirement. Some larger companies are giving gradually longer vacation periods in the years just prior to retirement so that when the age is reached the change from work to "vacation" is not as abrupt. An interest was shown in learning more about plans which are combining flexible or compulsory retirement. It was pointed out that compulsory retirement affecting all individuals at a certain age prevents discrimination.

A vote was taken which resulted in 14 favoring compulsory and 9 favoring flexible retirement. A number of persons attending did not vote.

MIMI DONNELL,
Mrs. Fitz Donnell,
Recorder.

NOTES ON WORK SESSION, GROUP II

Work group chairman: Mrs. M. Gay Conklin

Group II did not develop true discussion on any one of the major points you might expect to be raised on the question of flexible versus compulsory retirement. The usual points revolve around:

1. Whether the employer has a right to tell employees well in advance they are to cease work and retire. Are pensions deferred compensation which an employee may elect to receive when he desires, or are they a reward for service?

2. Assuming compulsory retirement is acceptable, what age should be used as the normal age when the full retirement benefit is available to the employee?

(*a*) Increasing longevity.

(*b*) How much has medical science increased the vitality of older workers.

(*c*) Work opportunities for older workers.

(*d*) Cost versus reasonable retirement benefits.

3. If flexible retirement (which is the lack of compulsion to retire at the normal age when the full retirement benefit is available) is desirable, how should you set up the plan?

(*a*) Employee choice, medical examinations, year to year reviews, etc.

(*b*) Any maximum age limit.

4. Discussion of the pressures operating in any community, industry, or company which influence the determination of the normal retirement age and whether retirement is compulsory or flexible.

Comments from the group pointed out experience with some of the major pressures under item 4, such as adequacy of retirement income, inflation, personal planning for retirement, making room for younger employees, etc.

Under item 1, the right to require compulsory retirement was not questioned in discussion by any member of the group. It was apparent, however, many felt the need to increase employee rights. Suggestions under items 2 and 3 implied vesting and employee option changes in a compulsory plan to make the plan less arbitrary before the normal retirement age.

Under items 2 and 3, where major changes in current practice may be desirable as pointed out by Dr. Wermel, the group was hindered in utilizing their experience by lack of definition of terms. Most of the discussion and proposals revolved around retirement at ages younger than currently accepted as normal. This may have been due to confusing flexible retirement with early retirement provisions which reduce retirement benefits. Several suggestions appeared to propose the Armed Forces type of retirement based on years of service. As Dr. Wermel pointed out in his final remarks, reductions in the normal retirement age, except as required for special occupations, would seem to be contrary to any solution of the problems presented by the increase in human lifespan.

Notes on Work Session, Group III

Work group chairman: Mr. Charles C. Spalding

The group first discussed the possibility of another method of selecting employees for retirement besides age. Mentioned were the criteria of years of service, amount of pension benefits, tests, work record, and the type of work being performed. It was agreed that all the above methods had obvious defects and age was considered to be the only satisfactory basis to select for retirement.

It was the consensus of opinion that compulsory retirement should be at a fixed age and voluntary retirement prior to that should be based on years of service or at a certain age below the age of compulsory retirement, or both. Any employee kept on the payroll after the fixed retirement age should be hired on a contract basis to do a special job or on a part-time basis because of special skills.

Objections to compulsory retirement pointed out by the group included (*a*) lack of sufficient retirement income, (*b*) lack of outside interests, and (*c*) lack of planning for retirement. It was felt that with education in retirement planning most of these objections could be met; hence, education for retirement should commence long before an employee's retirement with the responsibility for such education being borne by the government, company, social agencies, and the individual.

Notes on Work Session, Group IV

Work group chairman: Mr. Rockwell Smith

1. Most of the conferees were spontaneously working out their plans for retirement in various and ingenious ways. They all agreed that a big problem was posed by those workers whose work experience did not allow of continued and satisfactory activity in their particular field after retirement. These people would include laborers, semiskilled, routine operatives, and farmers.

2. The group felt the next most important problem was money. How do you do what you want to do without money? Fears were expressed that automation forces premature retirement or prevents a retired worker from continuing work under a flexible retirement system. It was stated on good authority that the group's fears were founded on fact. Fourteen conferees were for arbitrary retirement and nine for flexible retirement.

3. The conferees wanted to know the effect of employer contributions on pensions as contrasted to noncontributory plans. The effect of age on pensions and their amount was also raised. Several group members were able to state that as a general rule contributory plans return more pension benefits to the retiree at a given age than noncontributory plans.

4. Retirement as a vacation versus retirement as a satisfactory pursuit was considered by the group to be largely determined by attitudes developed over a lifetime. Long-range education was felt to be necessary to change these attitudes.

5. The volunteer service bureau was reported to have many retirees happily at work doing interesting and useful work. Many tasks remain available for those interested.

Dr. PORTEUS. Anyone who attempts an introduction of Hiram Fong, especially to an audience in Hawaii, has a difficult task to perform. Immediately you say that he is the senior Senator from Hawaii to the U.S. Congress, you have taken the icing off the cake, delivered the punchline, after which all else is anticlimax.

It really does not seem to matter much that he is a Phi Beta Kappa, a graduate of Harvard Law School, and the possessor of honorary doctor of law degrees from three colleges or universities, is a member of a highly successful firm of lawyers, and director or owner of prosperous commercial concerns.

There may be others who can claim similarly successful records. But no one in the world now or at any time can dispute the claim with him that he is or was the first U.S. Senator from Hawaii. So Hiram does not have to wait for the Hall of Fame. He's in.

Then, too, Senator Fong has already put a damper on introductory enthusiasm when he told a group that he knows what a waffle feels like when it has been smothered with sirup. Such an apt and witty remark makes the unhappy introducer look for a squeeze of lemon to leaven the saccharine lump. But I must confess that I can find not a drop of acid to inject. Senator Fong's career has been too rapid for a mere pedestrian to note any hesitation or change of pace, except that I believe that he was once defeated as a candidate for the local legislature, a fact that voters here would rather forget. He has since flown too far and too high for any backtracking. May he fly still higher and farther, but to where, the Lord only knows.

His biography states that he is the seventh of 11 children, and these two numbers may suggest to dice players an element of luck. But no one can throw such a succession of 7's and 11's without more than a suspicion that Hiram's dice are loaded.

They are loaded, loaded with ability, persistence, ambition, self-confidence, and the will to succeed. So there is nothing more to say than that we await with eagerness your thinking on one of the most troublesome problems of our time, how to make longer lives more worthwhile. His topic is "The National Interest in the Older Worker."

THE NATIONAL INTEREST IN THE OLDER WORKER

By U.S. Senator Hiram L. Fong

I am happy to be here with you today to participate with you in this important conference. Conferences such as this portend much promise for substantial social progress for millions of our fellow Americans.

I wish to commend each of you for your hard labors and for your diligence in doing your part to define the dimensions of the problems of our aging population and to find workable solutions to deal with them. I know that you will contribute much useful information and many worthwhile recommendations to the White House Conference on the Aging in January, only a few weeks from today.

Since the topic assigned to me for this institute is "The National Interest in the Older Worker," I shall not dwell upon the many other complex and related aspects of the aged, but will confine my remarks to the employment problems and outlook for the older worker.

In Hawaii the number of so-called old workers is proportionately less than in many States because our population is younger than the national average. More than half of Hawaii's citizens are under age 24. However, for those who already have attained middle age, their problems in employment, housing, retirement, health, a decent standard of living are just as acute and pressing as those who reside in the rest of America. Today in Hawaii, 29,000 persons are 65 years and over, according to estimates.

For them, we in Hawaii feel a sense of great urgency to stretch out a helping hand, just as we acknowledge the need now to prepare for the ever mounting numbers of our people who in the future will come into the higher age brackets.

In the next 10 years, it is expected there will be 49,000 persons in Hawaii in the 65 and over age group. Clearly, what we face is not a temporary trend; we face the hard fact of life that more Americans are living longer, with better health, and inbued with higher standards of acceptable living conditions. For the future, this means increasing numbers of older Americans ready, willing, and able to work and demanding more than mere subsistence-level existence.

Among some primitive tribes, the customary way to deal with the aged was to banish them into exile from the community, leaving them to the perils of the jungle and to certain death in the wilderness.

We civilized people are more humanitarian, and yet, regrettably, attitudes and prejudices which are decidedly heartless still persist toward people in the 40 to 65 year age bracket. This is true in America as an other countries despite our humanitarian tradition and history. Beginning with our Constitution, our national policy has always held the individual in high regard and our constant endeavor as a Nation has been to attain a better life for all Americans.

As we approach our 200th anniversary of the signing of the Declaration of Independence, however, there are still some people who earnestly seek jobs but cannot find them and there are still people struck down by disease who lack the means for decent care. There are children without access to suitable education; people denied equal rights because of race, religion, and national origin; old people without the basic requirements for a life of dignity and self-sufficiency.

These are blights on our national conscience. They are blights we must remove as we proceed to demonstrate the superiority of our free way of life over any other system of organized society.

Without exception all of our people should share in our national goals in America which are:

(1) Opportunity for productive jobs at living wages for every man and woman who seeks work and who is ready, willing, and able.
(2) Individual security, undiluted by inflation and excessive taxation.
(3) Truly equal rights for all Americans.
(4) Educational opportunities for everyone.
(5) The most modern medical, hospital, and health facilities.
(6) A world at peace.

In these goals, every American, regardless of occupation, regardless of race, regardless of religious faith, regardless of national origin, regardless of age has a personal and indisputable stake.

Attaining these goals demands that America marshal our bountiful national resources, of which manpower is one of our greatest. Of our manpower, it demands the utmost effort. Continuing their tradition of working hard, producing much, and accomplishing great things, our energetic, vigorous and intelligent population should, in the next decade or two, carry America well along the road to these objectives.

But this means as a nation we must shed old prejudices against workers on account of race, on account of color of skin, on account of age. Our guiding criterion should be ability, ability to do the job, whatever it may be. It is patently illogical and shortsighted, as well as cruel, to impose general age barriers against qualified persons. It may indeed be dangerous to deny the skills and talents and experience of any of our people, including the aged, considering the deadly competition we face from the Communist countries who seek to demonstrate superiority over our system and over our way of life.

If maturity were a handicap, then our Constitution would set an upper age limit, along with its present lower age limit, as a qualification for service in the U.S. Congress and for holding the office of President. Had our Constitution declared no man over 50, for example, could serve as U.S. President, only six of our past Presidents could have been inaugurated.

I am thankful no such age barrier deprived our country of George Washington, Abraham Lincoln, Thomas Jefferson, William Howard Taft, or our many other distinguished Chiefs of State whose age went beyond the half-century mark.

If we can entrust the stewardship of America to men over age 35, surely we need not bar lesser posts to men otherwise qualified but who have lived out more than three and one-half decades.

Let the Constitution be our cue to productive use of our Nation's manpower and womanpower, imposing no ceiling on opportunity for our growing number of "old" workers.

Astounding though it may seem, to talk about the national interest in the "old" worker, as I have been asked to do, one must talk not only about the over-65

worker, but about millions of persons ranging in age all the way from 45 to 65 and in many cases even as young as 35.

It seems preposterous that, in a population whose expected life span is 69.4 years, men and women over 45 are often deemed too "old" to be hired.

Even in our Nation's Capital, where the Federal Government has provided a laudable example by removing maximum-age limits for civil service employment, the age prejudice persists among employers. Here is the classified section of the November 27, 1960, Sunday Star of Washington, D.C., where sprinkled throughout the "help wanted" columns for men and women are age barriers: "under 40," "25 to 35," "23 to 33."

It is incredible that a woman otherwise qualified but over 35 years old should not be eligible for hiring as a stenographer or that a qualified man over 35 should not even be considered for sales jobs, yet that is precisely what these ads say.

It is paradoxical that, when employed, a worker in the 45 to 65 age category is a respected and valued member of the office force, the production line, the executive staff, or the sales team. But, when looking for employment, the mature worker all too often is looked upon as "too old to hire."

By 1975, according to estimates, the number of persons 45 and older in the work force will total 33.5 million persons of which some 4.1 million will be 65 years or older.

Unless we can keep the 45- to 65-year-old workers employed and unless we give job opportunities to over-65 persons desiring work, more than one-third of our work force will face a life of economic uselessness. These millions cannot be left to the jungle law of survival of the fittest. They will demand a decent standard of living, and, if economic life becomes too hard for them, they may form a most potent group to force some kind of public program to supply their livelihood.

There are some factors now at work which augur well for the mature workers and which will help break down some of the discriminatory barriers against them.

By 1975, the labor force is expected to increase to 91.4 million, a net addition of about 18 million workers.

The increase and the age composition of our labor force indicate we will have to fill a rising number of highly technical jobs from the 45 to 65 age group which is currently being bypassed by some employers.

Another hopeful factor for older workers is the expected continuation of the trend toward more and more white collar jobs. Such a situation puts ever greater premiums on mental agility and alertness which have been sharpened by use and experience. Men and women 45 to 65 will be better able to compete with the under-45 groups for white-collar jobs where a maturity and judgment are regarded as more valuable than physical strength and stamina.

A third element in the job picture of the future is that more and more of the available jobs will require more and more education and training. This is true of both blue- and white-collar fields.

For the older worker this signals a need to keep up to date in his own field or to learn related skills that will qualify him for jobs in our rapidly changing world. Technology in both business and industry will doubtless continue its revolutionary progress, outmoding old ways of doing jobs. Agility, adaptability, and willingness to accept innovation will enhance the "hireability" of workers young or old in the eyes of prospective employers.

But, whether we talk about today or tomorrow, we cannot ignore the fact that, of the over-45 population, our elder citizens have special problems. Today there are about 16 million persons 65 years or older, of which about 3 million are employed either full-time or part-time. By 1975, if the Nation continues its current patterns of work-life and retirement, there will be 22 million persons 65 or older, of which 4½ million will be in the work force.

The almost universal practice of compulsory retirement, usually at age 65, irrespective of the worker's ability and desire to remain as an effevtive producer, continues to throw a roadblock toward hiring of men and women about that age.

Compulsory retirement based on age alone fails to consider the mental and physical capacities of the individual worker, which vary greatly among workers of the same age. While a convenient device for ridding the personnel rosters of persons no longer able to meet the pace of the job and who would not otherwise leave employment, arbitrary retirement unquestionably deprives employers of the services of superior men and women.

Here is an area where Government agencies can set an example for private employers by introducing flexibility into their retirement practices to the best interest of both the employee and the Government.

For those persons over 65 who are ready, willing, and able to work, our national policy should be to help them to stay on their pobs or to find new jobs for them.

In addition to improving employment and retirement prospects for the older worker, it goes without saying that means must be found to improve the resources of our senior citizens so that they may have adequate housing, medical care, food, and clothing and live in dignity and self-respect. Social security benefits, private pensions and annuities, the new Federal-State medical care program for persons over 65 unable to meet costs of illness—all these are steps in the right direction, but we must admit they do not meet the problems fully. We must do better.

Even the most casual observer soon comprehends there are no magic elixirs, no genie of the lamp, no fairy godmother, no simple formulas to resolve the infinitely complex and interrelated aspects of our aging Americans.

These are tough problems demanding of private business and of every level of government ingenuity, imagination, fresh direction, constant attention, and a variety of approaches appropriate to the need—all within the context of our respect for the dignity and the freedom of each individual American.

It is fortunate that our federated system of government permits experimentation and innovation by local communities and individual States. In this way, pilot plants, trial runs, test experiences are possible whereby on a small scale we can learn by actual doing what works and what doesn't.

For instance, regarding the so-called old worker, nine States and Puerto Rico have passed laws prohibiting discrimination in employment because of age, just as they prohibit discrimination because of race, creed, color, or national origin.

These statutes bar employers from practicing age discrimination in such employment processes as hiring, discharging, or promoting employees, and in working conditions. Most of these laws prohibit also discrimination by labor unions with respect to union membership rights, and several prohibit age discrimination by employment agencies in connection with referrals to jobs.

Although there is little evidence to date that these laws have effectively prevented age discrimination, the combined experience of these States brought before the White House Conference on the Aging, may well provide guidelines for Federal legislation that will be effective in prohibiting age discrimination.

If our economy is to continue its high rate of production for a growing population, our older workers must be given equal access in the competitive job market.

If we are to maintain a skilled work force for the defense of our country, our older workers must be allowed to keep their skills up to date, and not grow rusty from inactivity.

If America is to remain in the forefront of world powers, in technology and industry, we must enlist the talent and experience of our ablest workers, regardless of age.

If our Nation is to enjoy full and complete economic health, our older workers must be full-fledged members of our labor force, permitted to contribute their lifelong best to employer, to family, and to community.

If our cherished way of life is to win the fight-to-the-finish with the Communist police-state system, we must enlist the best efforts of every capable American.

True, the challenges we face are complex and tough, but America has faced challenges before and met them successfully.

In our own lifetime, the genius of our people has harnessed the tremendous force of the atom to work for mankind. That genius has launched manmade objects into orbit around the moon and around the sun. That genius has sent man faster and farther through the atmosphere and under water than we dreamed possible only a few years ago. The miraculous has become commonplace.

What our scientists have done, therefore, is to apply time plus brains plus resources plus effort to overcome problems once regarded as insoluble.

What our people accomplished in the scientific, technological, and medical fields, we can match in the field of human rights—for the young, for the middle aged and for the old. With application of time, brains, resources, effort and great respect and tolerance for all our people, we will undoubtedly solve the urgent problems confronting our senior citizens.

As delegates to this conference you are serving in the best tradition of America in your efforts to attain a better life for our older workers and a status of dignity and opportunity which is their rightful heritage.

Understanding the Aging Process

By Prof. Katharine Handley, chairman-director, School of Social Work, University of Hawaii

I am sure we are all well aware, after this morning's session, that the process of aging is a relative matter and depends to a great extent upon the individual. Nevertheless, there are certain factors, physical, emotional, and social, that need to be understood in connection with the process of growing older. We have three experts on our panel today to help us with that understanding. Each speaker is to have 15 minutes, and this will leave 15 minutes at the end of their talks for questions and answers from the floor.

The first speaker is Dr. John Chalmers. Dr. Chalmers is a graduate of St. Louis College in Honolulu and the University of Dayton in Ohio, and he received his medical degree from Northwestern University. At the present time, he is a surgeon with the medical group in Honolulu. He has been a lecturer over a period of years with the School of Social Work at the University of Hawaii. He will speak on the physical aspects of aging.

The second speaker is Miss Evelyn Cochran who is an associate professor with the School of Social Work, University of Hawaii. Before coming to Hawaii, Miss Cochran taught at the Tulane University of Social Work and the College of William and Mary School of Social Work. She also worked as a medical social worker at the Charity Hospital in New Orleans, La., with the U.S. Public Health Service in Baltimore, Md., and with the national foundation. She has been the faculty member in charge of the medical social work sequence at the University of Hawaii School of Social Work since 1957. She will speak on the social aspects of aging.

The third speaker is Dr. William Cody of the Hawaii State Hospital at Kaneohe. Dr. Cody is a graduate of Boston College and received his medical degree from Tufts University. His residency in psychiatry was pursued at the St. Elizabeths Hospital, Yale University, and the Hawaii State Hospital. He is a diplomate of both the National Board of Medical Examiners and the American Board of Psychiatry and Neurology. He also has been a lecturer at the School of Social Work, University of Hawaii, for 2 years. He will speak on the psychological and emotional aspects of aging.

Physical Changes in Old Age

(By John F. Chalmers, M.D., surgeon, the medical group)

Rather than define "old age" and give it numerical classification, I believe we should refer to the process of "aging." Even this is difficult to categorize, particularly since it has been said that "we start to get old the moment we are born"—and for all practical purposes this is true, for our very first heartbeat starts wear and tear on a mechanism which must keep going to keep the rest of us going.

So, if aging begins when we are born, where and when does it begin to be apparent? With the first gray hair, with the first "crick" in our back, or with the solemn notice from the front office: "As you are well aware, our retirement policy states that your services will be terminated on the last day of your 64th year"?

For some reason, probably best known to the compilers of actuarial statistics for insurance companies, old age has been taken arbitrarily as being that nebulous time somewhere around 60 or 65, and thereafter. This is the time when we are supposed to "fall apart."

We are all familiar with the people like Charlie who was still running the elevator at Northwestern University Medical School when he was 77 years old. I asked Charlie one day what kept him going so strong at 77, and with a big smile and twinkle in his eyes, he said "Being around young people, and a pint of booze every day for the past 50 years." Others would say "Because I've never smoked a cigarette or touched a drop of liquor in my life." Everyone seems to have his own recipe—and for him, it works.

Nonetheless, changes are taking place, and in discussing these changes, we must place them roughly into two categories—those attributable to degeneration and those attributable to disease.

The degenerative changes are those associated with so-called "hardening of the arteries," or more specifically arteriosclerosis and atherosclerosis. This process—the laying down of plaques of cholesterol, in time to be intermingled

with, or replaced by, calcium—either narrows, or diminishes the resiliency of, the arteries which carry the nourishing blood supply to the various organs of the body. Every organ has a fairly rich blood supply and since this occlusive process is generally rather slow the various organs have a chance to compensate, either by setting up what we term collateral circulation, or by diminished activity manifested by a slowing down of the metabolic activity of an individual, or the development of conditions such as the so-called senile diabetes where the pancreas no longer is capable of producing enough insulin to metabolize sugar properly.

Coronary artery disease, cardiac decompensation manifested by swelling of the feet and ankles, or the accumulation of fluid in the lungs, some forms of high blood pressure, and senility are but a few manifestations of the end result of this occlusive process. In the case of the so-called coronary or heart attack, a blood vessel to the heart muscle becomes obstructed and the muscle supplied by that area dies for lack of nutrition. The size of the vessel obviously determines the magnitude of the muscle degeneration and generally the outcome. With hardening of the arteries and the loss of their expansile and contractile qualities, the heart is forced to work harder in order to force the blood through the circulatory system; with the end result that, as a muscular organ, this muscle increases in size and may distort the heart enough to make it impossible for the valves within to approximate and work as they should. This is a form of the so-called leaky heart and is acquired rather than congenital. Inability of the vessels to expand and contract with the rhythmical beating of the heart may sometimes cause an elevation of the blood pressure by simple dynamics. Senile dementia and forgetfulness are the end result of occlusive processes affecting some of the blood vessels in the brain. These are but a few of the degenerative changes which are manifested by the occlusion of blood vessels. We could go on indefinitely enumerating the other changes which take place throughout the body as a result of this.

These changes, then, are reflected in every part of the body. Tissue demands are less, skin loses its resilience, muscles lose some of their tone. In other words, the metabolic demands are lessened and the production is lessened. This is a vivid, but often unrecognized representation of the axiom, "Demand creates supply." It is a vicious cycle because the demand is no longer there because of the inadequacy of the supply.

In brief, then, the production of the endocrine substances which keep an individual going slows with the aging process of the individual. The BMR (basal metabolic rate) or PBI (protein-bound iodine) of an 80-year-old, or the blood sugar of a 90-year-old may be reported as "normal" because the general metabolism of the individual has accommodated to the level of demand.

Age brings no specific immunity to diseases like pneumonia, tuberculosis, poliomyelitis, cellulitis, infectious hepatitis, etc., other than those acquired through previous illness such as mumps, measles, chickenpox, whooping cough, etc.

It is perhaps very true that the ability to fight off infectious diseases diminishes with increasing age but this, I am sure, is largely associated with decreased metabolism rather than the particular causative organism, virus or bacteria, is more virulent than that which strikes a 30-year-old.

Finally, with disease commonly associated with old age, is raised the specter of cancer. There are so many variables here that it is actually impossible to say that cancer is a disease of old age. As the lifespan of individuals increases, as our diagnostic aids improve, I am sure that we will statistically find that cancer is on the increase. And this, I am sure, is because of these two factors—that diagnostic aids are improving and because people are living longer. We know that cancer is more common in the older age group, but the young and middle-aged are not invulnerable.

In conclusion, and though I may be treading on the scope of someone else on this panel, I make the plea for understanding of the oldster—whether they be 50, 60, or 90. Nobody likes to be left out, to feel that he is not needed. Somewhere along the line in our social scheme, we must encourage the idea that at 60 you're not on the shelf. We must educate people to prepare for retirement, not only financially, but physically and emotionally. This must be reciprocal. We must foster in the youngsters the idea that age does not mean decrepitude, but experience and wisdom, and in the oldsters that there are still horizons to conquer and vistas yet unseen.

The Social Process of Aging

By Prof. Evelyn Cochran, School of Social Work, University of Hawaii

It is significant that when we think of aging, we virtually always think of "the-problems-of-aging," almost as if it were one hyphenated word (like "damn-Yankee" used to be, in my native Mississippi).

For example, the excellent feature article in last Sunday's (Dec. 4, 1960) Star-Bulletin bore the headline, in red, "The Aged: Problems, Problems, Problems, Problems, Problems, Problems"—exclamation point.

The phrase, "social processes of aging," then, may very well be considered synonymous with "social problems of the aging." A more mellifluous term than "problems," however, was used by Dr. Ethel Shanas, director of the National Opinion Research Center, Chicago, in her recent studies of the aging. She speaks of the attainment of old age by a large proportion of the human population as "a modern invention; an aftermath of the industrial revolution, which—like all new inventions—involves accommodation (or adjustment) on the part of society and its members."

But name it what you will, aging is inevitably a time of loss—physically, mentally, and socially, and it is to the problems created by these losses that the aging person must try to accommodate himself, and for which compensations in the form of new opportunities must be found, if he is to make the transition to his latter years successfully.

A list of the social losses that accompany aging would include:

(1) Loss of employment (which, indirectly, is the subject of today's discussions).

(2) Loss of family and friends, resulting, not infrequently, in social isolation.

(3) Loss of income and financial security.

(4) Loss of opportunity for recreational and group activities.

(5) Loss of self-esteem.

Community attitudes, in a society which places highest value upon vigor and the contribution of youth, serve to intensify the effect of the losses enumerated.

In exploring the meaning of these losses to the aging individual, let us look at, first, loss of employment.

As was brought out earlier in today's discussion, employment means more to the individual than simply a way of earning a living.

Work exerts an influence on the person that pervades his whole life. Making a living and making a life are absolutely inseparable for most mortals. An individual does not make a life in a vacuum. A great part of all his waking hours is spent at his job, and many of his greatest personal satisfactions should come to him, and do if his vocation is suitable, from this source.

In addition to providing the individual with a source of livelihood and financial security—employment serves as a means of social participation. It is a wedge into a social group. The base for many a lifelong friendship has been laid in the company's bowling team, or in the stimulating shop talk around an exciting or difficult assignment.

His job determines to a considerable degree the individual's status in the larger society in which he lives. "What do you do?" is one of the first questions of new friends and acquaintances, and his prestige in the community may be enhanced as his answer identifies him with a specific profession or work group.

Some degree of prestige is inherent in every job, for work is a very important part of our American culture. The "11th commandment," which Dr. Wermel so deplored this morning—"Thou shalt earn thy bread by the sweat of thy brow"—is still in force. There is a historical reason for this which dates from colonial days. The need to conquer a hostile country and, during the American Revolution, to become self-sufficient, forced everyone to contribute toward the common good. Little sympathy was given, but instead open hostility and punishment were directed toward anyone who did not assume his share of the responsibility.

A job gives the individual a feeling of usefulness. His self-respect is increased by his feeling of being needed, and of contributing to the family's and the community's economy.

The more meanings that work holds for the individual over and above that of providing a source of income, the longer he will want to continue past the usual retirement age. These extra-economic meanings of work become increasingly important to him as his level of skill arises.

Loss of the therapeutic value of work through forced retirement, then, may bring to the older person loss of prestige, self-esteem, and social participation as well as reduced income and economic stress.

The loss of family and friends is an inescapable concomitant of aging.

Children grow up and move away. They are occupied with bringing up their own families and working at their own jobs. Feelings of loneliness and of being no longer needed or wanted constitute a common problem for the aging which defeats even the strongest personality at times. The reversed roles, in which the parent is dependent upon the child who formerly depended upon him, puts additional strain upon the older person's self-esteem as well as upon the familiar relationship itself.

Most modern housing does not permit the living together of three-generation families, even if this were desired by both the adult and the aging generations. A physical separation, with homes in different buildings, does not necessarily mean abandonment of the aging parent by his grownup children, obviously. But lack of communication with them, coupled with living alone, may serve to aggravate the feelings of frustration and bewilderment which follow deprivation of one's niche of usefulness to family and society.

Lifelong friends die, each successive loss leaving gaps in his network of human relationships that are beyond healing. George Bernard Shaw effectively expressed this loss in writing of the death of a dear friend: "All of us, as the years slip by, face increasingly the problem of living with the abiding subtractions of death."

A study of isolation in later life which was completed in Chicago recently, using a sample of old-age assistance recipients, made an interesting distinction between the two types of isolated persons discovered. These were described as the "isolates" and "desolates." The "isolates" had always been that way. They had never had any close personal relationships and were maintaining in later life a pattern which they had followed in youth and middle age.

The other type were isolated older persons who were accustomed to close relationships in youth and middle age but who had only a few surviving near relatives or friends. These, unlike the lifetime isolates, felt their isolation greatly. These were the "desolates."

Loss of income and loss of opportunity for recreation and participation in group activities will not be considered separately, as attention was given to both problems in conjunction with that of loss of employment.

We hear a great deal about images these days—not in the sense of a mirrored reflection of what we actually are, but the image, or mental picture that we have of ourselves and that older people have of us as we play out our various roles in society, as mother, as daughter, as teacher or social worker; as father, as son, as physician. And we know that the image other people have of us is perhaps the strongest determinant of what our own image of ourselves will be. Community attitudes which tend to expect the other person to fill a role which is essentially passive and unproductive will eventually distort his conception of himself and of his abilities to that selfsame image.

This pervasive community attitude represents a cultural lag. Despite the knowledge that we possess in this area, the American culture has thus far failed to provide a meaningful role for the person who has lived beyond the traditional period of usefulness. A possible exception is that part of the culture of our own State which still bears the imprint of its oriental ancestry. And, speaking parenthetically, for it is not my function on today's program to suggest solutions to the problems which I have presented, we in Hawaii will lose a rare opportunity should we fail to capitalize on the values inherent in this multicultural community with reference to the status of the aging.

I should like to conclude these comments with a positive image of the aging person, excerpted from a research project on adjustment to old age conducted 2 years ago at the University of Chicago by Prof. Robert J. Havighurst and Ernest W. Burgess. Their study was designed to measure the personal and social adjustment in old age of persons in a variety of occupational, religious, and cultural groups. The older persons found to have the highest adjustment scores were married and living with their spouses, rated their health as fair or better, had had no marked decline in health in the preceding 10 years, participated in both secular and religious activities, had plans for the future, believed in an afterlife, and, regardless of calendar age, considered themselves "middle aged."

To the extent that the aging individual maintains his health and financial security and finds new opportunities for usefulness and new sources of compan-

ionship, he appears to make the transition to the later years rather easily. There is evidence, however, that a large proportion of aging and older people are not finding their needs met. Results are seen in premature physical and mental deterioration, and in such personality changes as constriction of interests, withdrawal, irritability, submission, and paranoid tendencies.

The challenge of an aging population, the task before society, is twofold. First, there is the problem of creating an environment in which the normally aging person can remain a self-sufficient member of the community, finding new opportunity for utilizing his accumulated experience and wisdom, and for satisfying his other basic needs. A second challenge is that of providing facilities and services for those in whom the aging processes, disease and malnutrition, poverty, social isolation, and personality deterioration have made encroachments.

Psychological Problems in Aging

(By Dr. William J. T. Cody, medical director, Hawaii State Hospital)

Mental health in elderly persons is often a much discussed but much misunderstood subject. If we get our ideas straight about mental health, we are then in a better position to consider this point. "Mental health" can be defined as an optimal psychological state wherein there is a smooth and harmonious balance between the various components of the personality on one hand and with the environment on the other, as manifested in the maximum use of psychic energy in constructive work, heterosexual adjustment, and altruistic living. Flexibility is also an important hallmark which allows a normal individual to utilize a wide range of possible reactions, based on external reality and not on a rigidly constructed pathological internal defense system. Mature people have a healthy interest in what is going on about them. They meet each new problem with a desire to solve it as well as learn from it.

From this, it will be seen that the mental health of older persons can be threatened by internal pressures as well as external reality. Erik Erikson speaks of the central issue in old age as one of ego or personality integrity versus despair. By "despair," he means the feeling that time is short, too short for the attempt to start another life and try to alternate methods of achievement and success.

Hence, the older individual not only has to cope with obvious reality problems such as lowered income, (frequently) impaired health, and possible family rejection, but also the major internal problems of maintaining emotional stability and preserving ego integration.

Flexibility in the older person is limited because personality characteristics have become firmly fixed. Disturbances in judgment may occur owing to rigid, inflexible personal standards, limiting the possibility of a choice based upon all the factors in the situation. Vision may be less acute and manual dexterity may be impaired. Consequently there is considerable difficulty in coping with new tasks and yet the environment is often filled with just such new challenges to the aging individual.

Very frequently there are defects in remembering recently acquired data, new names, addresses, procedures, etc. Such an incapacity may be quite serious as, for example, an older person who wanders away from home and becomes lost and cannot remember where he lives. However, old memories remain firm, and it should be noted that this dwelling on the past is not simply the result of an inability to retain new material but in many cases is due solely to the fact that such recollections produce pleasant feelings of previous high esteem by self and others.

All these difficulties and frustrations are very exasperating to the individual so handicapped and may well be the main cause of the constant irritation often seen in older people. It might be said with some degree of justification, that many of the problems of the aging individual have to do with the attitude of his society toward him rather than on the individual's own physical or emotional problems. Finally it should be emphasized that we must not commit the serious error of believing that all of the problems of an old person are simply due to the fact that he is old. Many of the problems of the aging individual have to do with the aging process, it is true, nevertheless, there are many which are emotional in nature and which are not at all peculiar to an old person. If we bear this in mind, we may be able to deal with some of the problems of the old individual with much more objectivity, expectation, and optimism.

Industry and Labor Look at Preparation for Retirement

(By Dr. Harold S. Roberts, chairman, director, Industrial Relations Center, University of Hawaii)

A great deal of attention is currently being given to the problem of retirement. Much of this interest results from the increasing number of persons who have retired and those who are getting close to retirement. The estimates of individuals of age 65 and over which is close to 16 million and will reach close to 20 million by 1975, poses a problem for local, State and National governments, as well as for labor and management.

Recent negotiations have included health and welfare programs, pension plans, and deferred profit-sharing plans designed to provide additional regular income for employees when they retire from active industrial employment. Recognition by labor and management has manifested itself not only in collective bargaining and contract provisions, but also in specific educational programs directed toward individuals who are close to retirement and those who have already left active employment. The problems which labor and management face and which they seek to resolve will be presented by our very able panel members this afternoon. Questions from the floor will be accepted after all the panel members have made their presentation.

Our first speaker is Mr. Earle R. Ross, director of industrial relations of the Hawaiian Telephone Co. He is a graduate of Punahou and received his B.A. in economics and business administration from Washington State College. He is active in many community groups—Kiwanis, Punahou alumni, chamber of commerce, junior achievement program, to mention only a few. He is thoroughly versed in personnel administration having held many positions with the Hawaiian Telephone Co. during the last 20 years.

Our second speaker is Mr. A. S. Reile, AFL–CIO representative of the Hawaii-Pacific area. He has spent 7 years in that position which provides wide opportunity to understand the Hawaiian labor relations scene. For 7 years prior to that post he was secretary-treasurer of the Central Labor Council and business agent for the Ironworkers Union, Local 625. He has served as a member of the Charter Commission, the Hawaii Employment Relations Board, the Advisory Council on Adult Education, the White House Conference on Education and taken part in community work among such groups as the Red Cross, Community Chest, Vocational Rehabilitation, Children and Youth, and many others.

Our next speaker will be Richard E. Robb, vice president and industrial relations director of the Honolulu Gas Co. He attended the Pennsylvania State University, is a graduate of the Naval Academy, completed his M.A. degree at Stanford University and has taken graduate work at the University of Hawaii. Mr. Robb is an active member of our community and well-versed in the industrial relations and management area.

Our final speaker will be Mr. Alvin Shim, a partner in the law firm of Gill, Doi, Shim, Naito and McClung. He is a part-time lecturer in the department of economics and business at the University of Hawaii. He earned his B.A. degree from the University of Hawaii and his law degree from George Washington University. He has had broad experience in the industrial relations area, including work with the Wage Stabilization Board of the Federal Government and as business agent for Unity House. Mr. Shim is well versed in labor law and contract administration.

Industry's Interest in the Older Worker

(By Earle R. Ross, Director of Industrial Relations, Hawaiian Telephone Co.)

The subject which Mr. Robb and I have is "Industry's Interest in the Older Worker." Aside from the purely social aspects of this question whereby industry recognizes its deep responsibility to the Nation, industry knows that being interested in the older worker is just good business. Probably one of the most important reasons is that the older worker's attitude toward the company can be helpful or harmful. If his attitude is negative his productivity can be greatly affected in several ways. The amount of output could be reduced, either voluntarily or subconsciously, or the quality of his work may be affected. It may show in his attendance, and minor illnesses and other excuses may be used as reasons for being away from the job more often. In addition, the employees safety record may suffer. Also, if the employee has a negative attitude toward the company, it could have a significant influence on his coworkers. This

influence may be reflected in discontentment and their work performance would likewise suffer. The employee's negative attitude could also have serious consequences on outside sources. He could damage the company's reputation as a good place to work or he might injure the company's competitive position in the sales of its products.

Because of these reasons it is obvious that it is important to keep all employees in the right frame of mind. It is also important to the company to be interested in the older worker because the older worker is usually a trained and skilled employee who has made a large contribution to the company. Hence, the company recognizes a real obligation to the older employee. In some areas the older citizens are the only ones available in the labor market. Obviously in such situations the older citizens are of prime importance to the companies operating in those areas. Because of the aging population this problem could become more acute as time goes on.

Industry is attempting to do a number of things to meet the problem of the older worker. Some of these things are:

(1) *More companies are establishing private pension plans.*—At the present time approximately 19 million people are covered by private pension plans. It is expected that there will be constant growth in the number of private pension plans and persons covered in the near future.

(2) *Many companies are looking at their normal retirement ages.*—Some are raising them from age 65 to age 70 or 75 or even 80. Some are removing the normal retirement age requirements entirely and are establishing late compulsory retirement ages; others are not changing the normal retirement age but are extending employment to those who wish to continue working beyond the normal retirement age, based solely on their ability to continue to perform.

(3) *Companies are helping employees to prepare in advance for retirement by various means.*—As examples, some companies are helping employees with budgets as an encouragement to provide a basic income after retirement. They are also regularly advising employees as to the size of their expected pensions. Other companies are advising employees of their benefits under the Social Security Act. Some companies will help employees with their income taxes and estate planning where requested. These programs are voluntary and in all companies are open to all employees. Although I am not at all sure how effective these programs are, nevertheless, they are indications of concern by industry with the older worker and his problems.

(4) *Companies are taking other steps regarding retirement.*—Some companies permit their senior citizens to retire gradually over a period of years. There is also a distinct trend in industry to broaden the basic pension plans to provide for disability pensions and more liberal deferred vesting features. Other companies have gone into stock purchase plans which for all intents and purposes are deferred income plans.

Another matter pertaining to the senior citizens which greatly concerns industry is medical aid for the senior citizens after retirement. Because of this concern, approximately half of all Americans 65 or over now have health insurance protection. Industry feels strongly that medical costs for the aged should be financed privately rather than through an amendment to the Social Security Act. Consequently, the chamber of commerce is supporting the growth of private Blue Shield and Blue Cross types of plans for the aged. In the State of Hawaii the Hawaii Medical Service Association offers a liberal plan V program to the retiring employees of all companies who carry HMSA plans. If the employee upon retiring signs for this plan within 30 days after retirement, he is acceptable regardless of age.

Another effort being made by industry is in the field of employment. More companies are hiring employees on a part-time and temporary basis. Others are liberalizing their maximum hiring age so that older applicants can be hired if they have the ability to perform the work.

Although the problem of an aging population is serious, it might not be as serious as the politicians who are interested in more Government control make it out to be. Industry is aware of the problem and is moving forward to meet it. From an article in Nation's Business, November 1960, come these facts:

"In Vermont, the State with the highest percentage of residents 65 and older, the State medical society decided earlier this year to find out just how older

people pay their medical bills. Vermont doctors reported on 5,172 patients aged from 65 to 106.

"The survey found that only 13 perecnt were bed bound or chair bound, that 66 percent live with spouse or relatives as part of a family group, that 20 percent are still working, that 50 percent are on social security, 16 percent receive old-age assistance and 13 percent get pensions from retirement plans.

"Some 52 percent of these patients have some sort of prepaid medical plan. Another 29 percent said they pay medical bills from savings or income. The patient's family planned to pick up the bill in another 12 percent of the cases. For the few remaining patients, the city or town welfare agency paid the bill or the doctor made no charge. The medical society concluded that its survey results 'indicate a substantial measure of financial independence among elderly Vermonters for their own professional medical care requirements."

"University of Kentucky researchers, in a study of rural Casey County, Ky., found that even in this depressed farming area relatively few old persons had serious medical-financial troubles.

"Of the 627 men and women interviewed, four out of five of the men and two out of three of the women considered themselves retired or unable to work. The average annual money income reported by the men was only $815 and by the women only $715.

"The elderly men and women were asked whether there were things they had to do without because of lack of money. In spite of the low income, half the men and a little more than half the women said 'No.' Only about 10 percent of those who said they felt deprived—which is only five percent of the total—said they lacked health services because they did not have enough money.

"In still another recent survey of the aging, these elders were seen to be solving their medical care problems themselves. This study was made by the National Conference of Catholic Charities. Everyone older than 60 was surveyed in the St. Rose of Lima Parish of Milwaukee, Wis. This is what was found:

"Only 6 percent of the men and 9 percent of the women thought of themselves as having poor health. All those who were too ill to leave their homes had some member of the family to take care of them.

"When asked who would take care of them when they got sick, all but 4 percent said they would be able to make some arrangements for care. Of those widowed or single or childless, about 1 in 10 said he could count on a friend or neighbor in time of sickness, and a few said they would get hired help.

"Nine out of ten in the study said they had enough to live on or were comfortably fixed financially. In the normal give and take of family life, the older people were counting on giving as well as getting help when illness struck, the study made clear.

"In earlier studies in St. Louis, Cleveland and Buffalo, the National Conference of Catholic Charities asked elderly persons who would pay for hospitalization if it were necessary. Between 80 and 90 percent said they had hospitalization insurance, savings, or potential help from relatives."

To further support my conclusions, here are a few authenticated statistics from the chamber of commerce:

(*a*) There are now 19 million persons covered by private pension plans.
(*b*) There are now 10,600,000 persons receiving social security checks.
(*c*) There are now 1 million-plus persons receiving veterans' checks.
(*d*) There are now 1 million-plus persons receiving Government pensions-civil service railroad retirement.
(*e*) There are now 1,500,000-plus persons receiving business pensions.
(*f*) There are now 1 million-plus persons receiving annuity income.
(*g*) Three-fourths of all social security pensioners own their own homes, nine-tenths of them mortgage free.

Labor's Interest in the Older Worker

By A. S. Reile, representative, AFL–CIO, Hawaii-Pacific area

Organized labor is, of course, interested in the problems of the older worker. These problems, by and large, are the same as for all workers, with probably more emphasis being placed on keeping the older worker employed and preparing him for retirement.

Retirement for the older worker, without special preparation and provision, can be an ordeal and not the pleasant experience that the average layman, who is 20 or 30 years away from retirement, envisions.

Organized labor, in its collective bargaining agreements, incorporates provisions designed to look after the economic and physical welfare of workers from the time they enter employment until they reach retirement age. A worker upon being employed in a plant under union contract finds that he not only enjoys the higher wages and the shorter number of hours in a workweek, but also conditions of employment that will insure his continued employment, up to the time of his retirement, in spite of the many hazards that may beset him or the industry he is employed in. He finds that the collective bargaining agreement between his employer and his union generally provides for job security, paid vacations and holidays, sick leave, group health and life insurance, and pension benefits. If he is in the automobile industry, where there is seasonal unemployment, he finds an added benefit called supplemental unemployment benefits, which insure that he will be able to maintain a decent standard of living during the period of time that his plant changes over to produce a new model.

Some collective bargaining agreements make provision for severance pay in cases where a plant decides to change its location, for one reason or another. The conflict of ideology and the terrible range and power of the weapons that have been developed in the last 15 years, has made it necessary to decentralize our country's key industries, a process which has been quietly going on for a number of years. Workers affected by such moves have either been moved, together with their families, to the new sites, or in cases where an employee is unable, or unwilling, to make the change, he is given early retirement or severance pay. In either case, it acts as a cushion in preparing him for new employment, or in adjusting to retirement.

The needs of the retired worker are:

(1) an adequate income;
(2) decent housing;
(3) continued health care; and
(4) planned activities that will sustain the retired worker's interest and enable him to live out his allotted span of years in health and happiness.

Labor unions are active in attempting to fulfill these needs, through collective bargaining, legislation, and education.

Many pension plans negotiated with employers provide for pension payments which are in addition to social security payments or income derived from investments. A number of the unions themselves provide for pension payments to those members who have maintained their membership in the union for a stated number of years, and who are 65 years of age. A few even provide for pension payments for those of their members who become disabled on the job.

Labor unions have been the greatest supporters of public housing for persons of low income, including specially designed housing units for retired senior citizens. Some of the larger labor unions have built housing for their members, both working and retired. The Amalgamated Clothing Workers of America and the International Ladies Garment Workers Union, both AFL–CIO affiliates, are two of the most active in this area, and there are others.

The health needs of retired workers are recognized by labor organizations, and increasingly there are provisions in the health insurance programs negotiated with employers, that provide for continued medical care after retirement. The AFL–CIO is extremely active in trying to bring about the passage of the Forand bill, which would provide medical care for the aged, through additional contributions into our present social security system. The American Medical Association vigorously opposes this bill, but recognizes the need. Their apporach to the problem, however, is totally unacceptable to organized labor, who brand it as being both unworkable and inadequate.

The last need, that of planned programs for retired workers, is one which the labor movement is cognizant of and is attempting, through various means, to do something about. Representatives of labor all over the country are actively participating in organizations concerning themselves with the problems of the aging. A number of unions have also taken upon themselves the task of providing educational programs to prepare older workers for retirement. Tied in with this are courses in art, dramatics and the like, which they either provide their membership, or arrange to make available to them through such existing facilities as schools, churches, neighborhood settlement houses, etc.

The programs and efforts by labor organizations, on behalf of the older and retired worker, are far from perfect, or universal. However, they do point up their interest in the welfare of these people, and hold out a promise of a healthier and happier life for all senior citizens in our country.

A Different Aspect of Retirement

(By Richard E. Robb, industrial relations director, Honolulu Gas Co., Ltd.)

Modern American man is developing a facet of his character which the American Catholic bishops deplored at the conclusion of their annual meeting in Washington early in November 1960. This character deficit is his lack of "personal responsibility"—which can be found in his family life, in his concept of the international order, and in his business and economic life.

Validation of this theory, as regards his business and economic life, can be found in my own company. The management, concerned with the economic status of its retired employee, unilaterally installed a pension plan in 1938. Subsequent to the unionization of our employees in 1942, this program, which was, and is, on a contributory basis, was liberalized during the 1949 negotiations by providing larger benefits at retirement. These increased benefits required larger contributions by both the employer and the employees.

From its inception, all employees were enrolled in the plan upon completion of 1 year's service with the company. Until 1953, the program had been considered a condition of employment—when in effect, it never had been. When this information became known generally, we have had withdrawals from our plan on a continuing and increasing rate. Today more than a third of our employees are not participating in the pension plan for hourly paid employees. Some withdrawals were for valid reasons; however, most of these employees withdrawing remarked that social security would take care of them after retirement. Rather than join with the company in assuring themselves of a comfortable and dignified life in retirement, many of our employees then are willing to limit their retirement incomes solely to social security benefits—which, incidentally, since that program is not a pay-as-you-go basis, will be paid for by people who have not joined the labor force. Certainly this lends credence to the validity of the bishop's charge of "lack of personal responsibility."

One solution is to negotiate a revised pension plan—with enrollment a condition of employment—with our union representatives. This will be attempted at our next negotiation.

The incoming administration is committed to the establishment of a medical care program for the aged, tied into and supported by social security taxes. No need has been shown for this program; the private insurance industry has partially solved this problem. The politicians have proceeded on the fallacious assumption that all retired employees over age 65 need public assistance of this nature. This approach by Government to take over the medical care of retired employees will have the corroding effect of lessening the American man's sense of personal responsibility.

Labor's Interest in the Older Worker

(By Alvin T. Shim, attorney, Gill, Doi, Shim, Naito & McClung)

GENERAL OUTLINE

I. Background and assumptions:
  A. "Labor" means labor unions.
  B. "Older worker" means a person retired or unemployed because of old age.
  C. Older worker is:
    1. An economic man who needs food, housing, clothing, medical care and other material goods; and
    2. A spiritual man who needs recognition, response, respect and freedom.

II. Objective: To satisfy the economic and spiritual needs of the older worker in a free society.

III. Problem: The economic and spiritual needs for a great number of older workers are not being satisfied. A better description of the problem is found in the "Selected Readings of the Problems of the Aged and Aging," prepared by the Industrial Relations Center of the University of Hawaii.

IV. Labor's interest: What has been labor's interest in solving the problems of the aged?
  A. Interest of the federation and international unions is greater than that of local unions, but still inadequate. Local unions have a difficult time just trying to cope with the day-to-day problems of

unionism. Consequently their activity concerning problems of the aged is quite restricted.

B. Interest of labor evidenced mainly in three areas; namely, in collective bargaining, legislative activity and consumer activity.

1. Collective bargaining. Labor negotiates provisions affecting the older worker, e.g., pension plans, funeral benefits, seniority clauses and training programs.

2. Legislative activity. Labor lobbies for legislation affecting the older worker, e.g., social security, medical care for the aged, low-income housing for the aged, tax exemptions for the aged and fair employment practices for the aged.

3. Consumer activity. This is an area of relatively new interest on the part of labor. The purpose of this activity is to organize the purchasing power of labor and its members to obtain volume economies for the benefit of its members and thereby increase the purchasing power of wages and fixed incomes of the aged.

C. Labor's general attitude has been to let private enterprise resolve social problems if possible. When, however, private enterprise is unable to resolve major social problems, labor is inclined toward soliciting governmental aid in the form of social legislation and programs.

D. In a society where legislative decision making is influenced by countervailing social, economic and political forces, labor is probably the greatest single force pushing for social legislation to correct social problems. Labor, however, still has a great need for improvement and effectiveness in this area. The problem of the aged is so great and so complex that legislative action is required. The aged will find labor sympathetic to its problems and will probably get more support from labor once labor's leaders are made sufficiently aware of the problems of the aged.

Dr. ROBERTS. I would like to thank the members of our panel for a very interesting and stimulating presentation of our subject, and the members of the audience for their active participation during the discussion period.

In behalf of the university I would like to thank all those who have helped to make this Conference a success—the panel chairmen and speakers, the press, the delegates to the Conference. and our active audience. Special thanks go to Mrs. Alexander Faye, the executive secretary of the Commission on Aging, who participated so ably at all stages of the conference.

(Questions and answers presented during the panel discussions have not been included.)

Dr. ROBERTS. Senator Oren E. Long had agreed to take part in our institute. Those of you who are familiar with Senator Long know that he has had a continuing interest in this vital community problem and that he has been active in promoting legislation designed to meet some of the problems of the older worker. His schedule as a member of a Senate subcommittee has made it impossible for him to be here this afternoon. He has asked me to convey his continuing interest and his support for the older worker.

As you know he was cosponsor of Senate bill 3807 [1] to establish the U.S. Office of Aging. Among the members proposing this legislation were Senator McNamara, chairman of the Special Senate Committee on Aging, as well as Senators Humphrey, Randolph, Murray, and others.

In concluding my remarks, I thought you would be interested in the statement by Senator McNamara on the floor of the Senate when he introduced the bill establishing a separate Office of Aging to coordinate the various Federal programs as well as to keep informed on State developments. Senator McNamara summarizes very effectively the thinking of his committee as well as many citizens on the overall objectives of the national program. He said in part, and I quote:

"Mr. President, it is one of the great achievements of history that there are now 16 million Americans over age 65 and 20 million will be over 65 just 15 years from now. We are faced with a population explosion at the far end of life's cycle.

"Instead of boasting of machines and gimmicks, let us boast of human beings. Let us boast that while once even the wealth of monarchs could not prevent early mortality, people of every income and social level now can expect long lives. Of all the revolutions wrought in this revolutionary 20th century, this is one of the most profound.

[1] Senate bill 3807 is to be found in app. A.

"It brings us to a new frontier in the history of man's development, a frontier roughly comparable to the human territory opened up by the invention of psychology and psychiatry.

"Living longer means that the entire territory of innate resources must be cultivated to their fullest. They must be given the setting and climate in which to flower.

"Let us bend some of the ingenuity which has devised so many marvelous machines—electronic brains, stereophonic phonographs, weather satellites—to the greater task of making life worth living for the millions of us who are reaching retirement age."

APPENDIX. A. SENATE BILL 3807 TO ESTABLISH THE U.S. OFFICE OF AGING

THE U.S. OFFICE OF AGING

1. The act establishes the U.S. Office of Aging in the Department of Health, Education, and Welfare.

2. It creates a new position of the Assistant Secretary of Health, Education, and Welfare for Aging to be head of the Office of Aging and to be appointed by the President, by and with the advice and consent of the Senate.

3. Functions of the Office: (a) A clearinghouse of information related to problems of the aged and aging; (b) assist the Secretary in all matters pertaining to the aging; (c) administer grants provided by the act; (d) conduct research and demonstration programs in the field of aging; (e) provide technical assistance and consultation to States and localities; (f) prepare and publish educational materials dealing with welfare of older persons; (g) gather statistics in the field of aging.

Grant programs

The act provides for three types of grant programs to be administered by the U.S. Office of Aging within the Department of Health, Education, and Welfare.

1. Planning grants of $2,090,000 ($40,000 to each State—$10,000 to the Virgin Islands) to assist each State to conduct studies, develop plans for new programs, and improve and coordinate existing programs.

2. Project grants to the States to initiate and operate projects to further the policies set forth in the declaration of objectives for senior Americans.

(a) For the fiscal year ending June 30, 1961, $10 million are authorized for appropriation, rising to $15 million in 1962, $20 million in 1963, and $25 million for fiscal year 1964.

(b) These funds are to be granted to the States in accordance with a Hill-Burton formula of matching grants, with a minimum of $50,000 to each State.

(c) State plans for such project grants shall be approved by the Secretary.

3. The act authorizes grants to nonprofit institutions and organizations to conduct research and training programs. The sum of $2 million is authorized for this purpose.

An Advisory Committee on the Aged and Aging

The Secretary is authorized to establish an Advisory Committee on the Aged and Aging composed of professional and public members.

An Interdepartmental Committee on Problems of Aging

The act authorizes the creation of an Interdepartmental Committee on Aging composed of the Secretary of HEW as chairman, and the Secretaries of Labor, Commerce, Treasury, and Agriculture, and the Administrators of HHFA, VA, and the Civil Service Commission.

1. Functions of the Interdepartmental Committee: (a) To strengthen and coordinate existing programs in the departments; (b) advise the President with respect to executive and legislative action; (c) facilitate Federal, State, local relationships across departmental lines.

2. The Assistant Secretary of Health, Education, and Welfare for Aging is to be the Executive Director of the Committee and he would utilize the services of the U.S. Office of Aging as the staff of the Interdepartmental Committee.

Reports to the President and the Congress

The Secretary of HEW is to submit to the President and the Congress a report of programs under this act in the field of aging by January 1, 1962.

SECTION-BY-SECTION ANALYSIS

TITLE I. DECLARATION OF OBJECTIVES; DEFINITIONS

Section 101: The Congress finds and sets forth as the policy of the United States a declaration of objectives for senior Americans as follows:

(1) An adequate income; (2) the best possible physical and mental health; (3) suitable housing; (4) full restorative services; (5) equal opportunity to employment; (6) retirement in health, honor, and dignity; (7) pursuit of meaningful activity; (8) efficient community services when needed; (9) immediate benefit from proven research knowledge; (10) freedom, independence, and the free exercise of initiative.

Section 102: Defines the "Secretary" as Secretary of Health, Education, and Welfare.

Defines "Assistant Secretary" as the Assistant Secretary of Health, Education, and Welfare for Aging.

TITLE II. U.S. OFFICE OF AGING

Section 201: (a) This section creates the U.S. Office of Aging in the Department of Health, Education, and Welfare.

(b) It authorizes the appointment of an Assistant Secretary of Health, Education, and Welfare to head the Office of Aging.

Section 202: Lists the function of the Office of Aging as follows: (1) Clearinghouse for information; (2) assist the Secretary of HEW on all matters of aging; (3) administer grants provided in the act; (4) conduct and arrange for research and demonstration programs; (5) provide technical assistance and consultation to States and localities; (6) prepare and publish educational materials; (7) gather statistics in the field of aging.

TITLE III. PLANNING GRANTS

Section 301: Authorizes an appropriation of $2,090,000 to assist the States in conducting studies and developing plans for new programs, or improving existing programs in aging.

Section 302: Sets forth the conditions under which the Secretary shall approve plans for planning grants. The plans should include: (1) Designation of a State officer or agency with responsibility for developing plans; (2) evidence that consultation has taken place with other State agencies; (3) provision for an analysis of needs and potentialities in the State and a set of priorities; (4) reports by the designated State agency to the Secretary.

Section 303: The appropriation for planning grants is to be allotted in equal shares among the States, except that the Virgin Islands shall be allotted $10,000.

TITLE IV. PROJECT GRANTS

Section 401: (a) Authorizes appropriations to assist the States to initiate and operate projects to fulfill the objectives of the declaration of objectives for senior Americans. Authorized appropriations are: $10 million for the fiscal year ending June 30, 1961; $15 million, June 30, 1962; $20 million, June 30, 1963; and $25 million, June 30, 1964.

(b) Plans are to be submitted by the States to the Secretary and he shall approve a State plan if he finds that it includes provision for: (1) Projects which will further one or more policies of the declaration of objectives for senior Americans. (2) Administrative responsibility in a single State officer or agency. (3) Coordination of State and local programs. (4) Consultation with voluntary organizations. (5) Financial participation by the State in each major category of service and the method of allocating funds among participating agencies. (6) Proper methods of administration. (7) Reports by the State officer or agency administering the plan.

Section 403: The sums appropriated for project grants are to be allotted to each State in accordance with the ratio of its population aged 65 or over to the total such population for the country. The allotment of no State shall be less than $50,000.

Funds not used by any State may be reallotted among other States for the succeeding fiscal year.

The Federal share of the grant varies in accordance with the per capita income of each State, except that the Federal share shall not be less than 33⅓ percent or more than 66⅔ percent.

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The Secretary of HEW is to announce the Federal shares between July 1 and September 30 of each odd-numbered year.

TITLE V. GRANTS TO INSTITUTIONS AND ORGANIZATIONS

Section 501. Grants are authorized amounting to $2 million to nonprofit institutions and organizations to train personnel in the field of aging and carry out research.

TITLE IV. GENERAL PROVISIONS

Section 601. (a) The Secretary of Health, Education, and Welfare shall cooperate with and give technical assistance to States and localities in matters relating to the needs of older persons.

(b) The Secretary is authorized to make rules and regulations for carrying out the act.

(c) There is an authorization for the necessary sums to administer the act for each fiscal year.

Section 602. The Secretary is authorized to establish an Advisory Committee on the Aged and Aging composed of professional and public members to advise and assist him in the administration of the act.

Section 603. Sets forth the method of computing payments by the Secretary under title IV of the act.

Section 604. Provides for conditions under which payment can be withheld and for judicial review.

Section 605. (a) The act establishes an Interdepartmental Committee on Problems of Aging composed of the Secretary of HEW as chairman, the Secretaries of Labor, Commerce, Treasury, and Agriculture, the Administrators of the Housing and Home Finance Agency and Veterans' Affairs, and the Chairman of the U.S. Civil Service Commission.

(b) Functions of the Interdepartmental Committee: (1) to strengthen and coordinate existing programs, (2) to advise the President on legislation, (3) to facilitate Federal-State-local relationships on an integrated basis.

(c) The Assistant Secretary of HEW for Aging is to serve as the Executive Director of the Committee and to use the Office of Aging as the staff for it.

Section 606. Directs the Secretary to transmit to the President and Congress a report on the administration of the act with recommendations as he deems advisable.

APPENDIX B. MEMBERS OF THE INSTITUTE

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Mrs. Katherine H. Allen
Cyrus E. Ambler
Mrs. Cyrus E. Ambler
Frank Ambler
James Andrews
Miss Lillian Austin
Mrs. Celestine S. Barbour
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Dr. Leo Bernstein
Mrs. Dora L. Beyer
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Carl Burghardt
Mrs. Bernice Burum
Mabel G. Butzke
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Mrs. Alexander Faye
Mrs. Eleanor Fern
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Mrs. Eureka Forbes
Boletha Frojen
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Mrs. Jeanette Gommo
Mrs. Alice M. Gordon
Mrs. Katharine Handley
Sigrid Hanenstad
Robert K. Hasegawa
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Helen M. Hoover
Mrs. Chiyo Izumi

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Lulu H. Johnson
Mrs. Sarah Kamakau
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Stanley T. Kudo
Eddie Lapa
Miss Millicent Larson
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Mrs. Shoyei Yamauchi
Dr. Shoyei Yamauchi
Richard Yawata
Riley L. B. Yee

HONOLULU, HAWAII, *December 14, 1961.*

DEAR SENATOR LONG: 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:

It is not necessary for me to remind the committee that because of the ever-mounting inflationary spiral, the income dollars of those of us who are retired has continually shrunk in purchasing power until we find ourselves, in many cases, unable to provide ourselves with sufficient food, and have had to "pull in our belts" and reduce our accustomed standard of living to a point we never had to endure before.

I think when we retired people, who have borne our share of taxes all our lives while employed, and who now cannot obtain a raise in income, or benefit by cost-of-living clauses found in union contracts today, that we should be afforded some tax relief, now that we have reached retirement age, and are no longer on salary. We did our share, and now, having no opportunity to offset this inflation, which is largely caused by excessive, wasteful, pork-barrel spending by Representatives and Senators who do not really represent us, but merely vote in Congress on the basis of political expediency, that we, who have done our share to build this country and raise a portion of the present and future generation, should have a right to enjoy our declining years, free from the worry of excessive taxation, and the inability to obtain rentals that are reasonable.

I am not in favor of socialized public health assistance either through the social security system, or by any other federally subsidized method. The States and county welfare setups should take care of this, who do not have enough money to provide their own medical care. There is too much Federal Government control now, on too many things, and thus we see creeping socialism taking our freedom and liberties away from us.

I think, in conclusion, that it is unfair for the Federal Government to demand and take as much of a percentage of income from us, as it does from a man who is still working and earning ever-increasing wages through new contracts his union negotiates for him. We have no such opportunity. In that connection, I have no hesitancy in saying that if I had my way, I would see to it that these trade unions were immediately and completely dissolved, as they too, as much as the Federal Government, are largely responsible for this strangling inflation. In the time of Samuel Gompers, they served a good purpose. But now, with the * * * and that snake, * * *, drawing down unheard-of and unwarranted salaries plus the graft they have access to on the side, the union movement is now only a racket for the benefit of the officers, and the local members merely suckers for their locals.

EDWARD C. SPENGEMAN,
2246 Kuhio Avenue.

STATEMENT BY ETHEL T. MORI, SUPERINTENDENT OF RECREATION, DEPARTMENT OF PARKS AND RECREATION, CITY AND COUNTY OF HONOLULU

Mr. Chairman, honored visitors, ladies and gentlemen, the late President Franklin Roosevelt said, "For adults, leisure wisely used is the difference between mere existence and fruitful living."

Over the years in my contacts and association with the semiretired and the retired, I have been constantly amazed at the therapeutic values of recreation and social group activities. There has been also confirmation of the fact that recreation can be geared to fit an individual at all economic levels.

Knowing the values of group activities, some of my concerns are:

First: How to reach the unreached, whether they are the retired or those preparing to retire and whose responsibility is it to get the inactive to become active?

Second: How are recreation and group work agencies going to meet the challenge of the changes taking place in our community during the next 20 years and how can recreation and group work services be geared to the evolving needs of the community?

Third: How will the need for increased numbers of trained professional, technical, and related personnel in all fields concerned with meeting the needs of older people be met?

The changes taking place in our community are bound to bring many problems. Some of these include crowding, congestion, tension, all of which will tend to upset the balance in the daily living of an individual. This I believe makes recreation even more important. This will be especially true for people in their productive years.

Although we are emphasizing the needs of the 65-plus, there is need to give more attention and scrutiny to the very large population of the 40 to 65. What are Americans going to do with the dilemma of "less and less work hours and more leisure hours"? If there is any preventive work to be done to insure "zest for living in the latter years," then recreation agencies face a challenge to help people find recreating experiences that give relaxation, balance, and keep them fit for their responsibilities.

How can this be done when we already face insufficient leadership funds to meet today's needs?

This is where the indigenous leaders in our community must take a more active role in leading and directing their own recreation and in assisting that of others.

This type of action also calls for different caliber as well as new emphasis in professional leadership. Instead of a doer, we need leaders who are able to encourage, enlist, and help others in the leadership role.

This also calls for change in attitude and values as well as better understanding of the benefits of participation. To quote Dr. William C. Menninger, the famous psychiatrist: "Recreation is an extremely important aid to growing older gracefully. People who stay young despite their years do so because of an active interest that provides satisfaction through participation." Recreation

can help older people to enjoy happy, dignified, self-respecting lives. Recreation can help the 40-plus to prepare for the vital golden years.

The public and private agencies combined make a strong team to serve the community as a whole. Public agencies provide the land, open spaces, large athletic fields and recreational centers, places of interest which are open to all people. Public agencies also provide leadership to assist people in their recreational pursuits.

Private agencies are free to organize as they choose. They serve the sex and age they were organized to serve. They have purposes of their own choosing. In addition, they provide a "plus" in group associations and spiritual values.

However, all agencies are more alike than diverse in purpose, leadership, and activities. Each performs its service for as many people as funds, leadership, and facilities permit. There is a growing need and awareness for more teamwork between public and private agencies. This would be one way of meeting the challenges of the future. It would also prove economical, I am sure.

To sum it up, the problems arising out of the changes in the future, in the recreation-leisuretime field will be the competition of the young versus the oldsters for a fair share of the community resources. How can the State of Hawaii give special aid to the city and county of Honolulu inasmuch as 80 percent of the present population resides in this county? This picture is not expected to change in the coming years. The specific aid in land acquisition must get started now and concerned citizens need to join the planners and voice their needs.

Another major area of need is trained leadership.

Public recreation leadership per se tries to meet the needs of those who are healthy and able bodied. What about the ill and the handicapped? What other occupational roles of professional workers in recreation for older people are there? Just to cite a few, what about the rest homes, hospitals, mental institutions, military installations, church and volunteer groups, private rest homes, nursing homes, boardinghouses for retired, etc.? Who will be responsible in the recruitment of these hordes of workers who will be needed?

The National Conference on Aging in the area of the role and training of professional personnel evolved the following policy statement:

All professional, technical, and related personnel working with older people should have specific knowledge of the processes of aging and needs, characteristics, and behavior of those in the later stages of life. Therefore, it is essential that the knowledge of both the individual and societal aspects of aging be extended as rapidly as possible; further, that appropriate elements of this knowledge must be built into the educational experience of every individual from early life onward."

Of course, one of the answers lies in an accelerated educational program within the professional curricula in all health fields, social work, recreation, education, religion, community organization, and environmental planning, just to name a few.

As a starter, the local university can offer in its undergraduate level courses on "recreation for special groups" directed specifically toward aging. Inservice training courses for those in the field can also be offered either by the university or through adult education courses.

We must not overlook the fact that in the ranks of our senior citizens are men and women well able to give leadership in the development of the much needed workers in our community.

Citizen participation is a part of our American way of life, whether that citizen is a youngster of 10 or an oldster of 80. To make it possible for the aging to continue to be active is a community responsibility.

To make this possible, plans must be made to reach the unreached, to gear for more coordinated group work and recreation services, and work toward increasing trained professional workers in the related fields to meet the needs in the years ahead.

PREPARED STATEMENT OF JOHN T. WARREN, HONOLULU, HAWAII

I attended the morning session of your committee on November 27, but because of my impaired hearing I was not able to hear anything that was said by anyone. Therefore, I decided it was not worth attending the afternoon session, where

citizens were allowed to witness before the committee. Accordingly, I have prepared my statement in the same form as was used by our Governor and others in addressing you.

I have understood that legislators pay little or no attention to reproduced letters, indicating that copies were sent to others. But in this case, as all of the witnesses during the morning session submitted their statements in printed, mimeographed, or other methods of reproduction, I hope that you will receive mine as well.

I was born in San Francisco, Calif., 83 years ago. I came to Honolulu 62½ years ago. After owning my own retail merchandising business on Fort Street for 28 years, I sold and retired. In 1930 I was appointed comptroller (business manager) of Kamehameha schools, the sole beneficiary of the B. P. Bishop Trust, probably the largest trust in Hawaii. I was retired in 1945 at age 66, and have remained retired since.

I lost heavily in the financial crash of 1929, but while connected with Kamehameha schools I purchased an annuity which, at the time, seemed adequate for the support of myself and wife for the rest of our days. However, its purchasing power has already dropped to about 40 cents to the dollar, and with the creeping inflation experienced since I purchased it, my annuity will soon be of practically no value at all. Similarly, the life insurance I provided for my wife after my death, will be worth about 25 cents on the dollar. These figures are from articles in the Economic News, published by the American Institute for Economic Research, Great Barrington, Mass. They state: "Life insurance buyers should not have any of their savings 'embezzled' by the subtle process of inflation."

There are a large percentage of retired "senior citizens" who are in much the same situation as am I. Yet when people speak of the needs of this segment of our society, they mention cheaper housing, medical and hospital care, more exemptions from taxation, increased social security benefits, financial security, and so forth. All of those remedies would cost State and/or Federal Governments millions—yes, billions—of dollars, which, of course, must come out of taxes.

My proposal is to stop inflation. That would benefit not only the senior citizens, but every citizen, and all State and Federal Governments as well. And the cost would be practically nothing, excepting the use of our courts to settle disputes between capital and labor.

The strikes of organized labor against public utilities, essential industries (like steel and motors) and agriculture, have cost millions of dollars annually, and get no better as the years come and go. As each demand (they never request) of labor is met, through the weapon of the strike, labor's income is greater, and mine is less, in purchasing power of my dollar. Why should this condition be permitted to continue?

The State and Federal Governments would benefit through a less cost of everything purchased. Every citizen would benefit (including labor itself), through reduced cost of everything.

How to stop strikes and the resulting steadily creeping inflation is the subject of the enclosed memorandum which I now submit herewith. Please read it carefully. How much longer are we as a great nation going to allow ourselves to be trampled upon by organized labor? I hope you will sponsor legislation in the coming session of our Congress, which will positively stop strikes against public utilities, essential industries, and agriculture. After collective bargaining has failed, all such disputes should be settled by a jury in a labor court.

HONOLULU, HAWAII, *November 27, 1961.*

DEAR SENATOR LONG: 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:

When social security came into effect, a large segment of our workingwomen were either unemployed or employed in work that was not covered or receiving pay at existence levels. Those of us in our early forties were forced out of productive employment and required to earn our own as practical nurses, housekeepers, maids, and other work that did not receive social security until many years later. In other words, the low-paid, service-type of employees were never able to qualify for social security at a level to permit us to maintain our independence and to feel not burdensome to our children. Strangely, in my ex-

perience, most of the senior citizens who receive the least return never rode the relief books, or made demands on others during our employable years.

I should like to point out that $41 a month is not sufficient for an existence level. As an individual who accepted any kind of work in order to maintain my independence for over 65 years, I was never in an income group that accumulated any savings or was under social security coverage. Yet, I know I have contributed just as much effort, worked probably longer hours and sacrificed just as much as those, who, by fortunate employment circumstances, now receive a more adequate income.

In other words, those of us who were not fortunately employed and whose life income barely covered absolutely essential needs do not have accumulated savings or social security to live as independently as we should.

I recognize that it was impossible in 1932 to foresee or provide for the low, low-income groups who were not initially covered. It is unlikely that much can be done in the near future since social security laws would require revision to provide more security for those who were unable to contribute during their employable years. In this connection, I would like to suggest that $41 per month might go a long way toward making ends meet in 1937—not in 1961.

I believe it is in order to call attention of the Congress to the plight of those of us who, despite many, many years of productive effort with nominal incomes, are not eligible for sufficient social security to live modestly. On the other hand, I want to express my gratitude to those who make possible developments like our Punchbowl Homes. I cannot overemphasize the basic importance of providing low rental, clean, decent living quarters for our older citizens at a minimum cost.

I believe assistance to the senior citizens of our country should follow the following priorities—low rentals, properly designed housing, sufficient income for modest needs, more and better public transportation, medical aid only for enforced hospitalization or complete immobility. Please note that I feel medical aid for day-to-day illness is not an essential. Most of us, as long as we can preserve our basic independence, will keep physically able not to require too much medical attention except in cases of severe accidents.

It would require $100 per month, plus rent, to care for basic needs.

Mrs. Lula Roberts,
730 Captain Cook Avenue.

Honolulu, Hawaii. *November 27, 1961.*

Dear Senator Long: 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:

Under social security a worker should receive his old-age benefit payment for any month in which he neither earns wages of more than $100, nor renders substantial services in self-employment. So says a pamphlet, "If You Work While You Get Social Security Payments," which is Document OASI–23, dated August 1961, page 3.

On page 5, working 45 hours in 1 month is declared substantial service. This restriction holds till the worker reaches age 72. All these restrictions on the worker from 65 to 72 ought to be removed from the social security program.

The 45-hour restriction interferes with activities of all self-employed people in that age group, and apparently serves no useful purpose. The money restriction is bad enough.

Aloha,

Edward R. Himrod,
1418 Gregory Street.

Honolulu, Hawaii, *November 27, 1961.*

Dear Senator Long: 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:

My wife and I came to Honolulu nearly 2 years ago and shipped our 1953 Plymouth automobile over from our home in Los Angeles, Calif.

Our rent here in a second story of a wooden house was $85 per month plus utilities of approximately $10 per month. Groceries are higher here than in Los Angeles and I paid 21⁹⁄₁₀ cents per gallon for regular gasoline in Los

Angeles. As soon as our car arrived here in Honolulu we started paying 42⁹⁄₁₀ cents per gallon for regular gas, nearly twice as much here as we paid in Los Angeles. I do not think it costs 21 cents per gallon to ship gasoline over here.

We drew on our small bank account to try to live here as we are not old time Orientals who live with our children as I heard at this p.m. meeting. The Punchbowl Homes saved us, as we now pay 20 percent of our income for rent, making our rent $48 per month including utilities of $10 or less. Now we can stay here and be near my wife's sister and our daughter and family who live here.

We in the Punchbowl Homes help each other when we can, but we find that doctor bills have a way of cutting down our funds pretty heavily at times.

One close neighbor of ours just lost his wife by death week before last. He is in a rather sad and financially embarrasing position. Some previous doctor bills and real estate and insurance losses broke him and his wife left some $3,000 in a joint will, which he expects to receive some time, minus expenses of handling it.

My recommendation is: Have a grocery and auto gasoline commissary for Punchbowl Homes and other retired people of limited fixed income and if residents in this group go to a nursing home for care, that this nursing home be staffed with doctors, or at least with a clinic of visiting doctors from Honolulu and possibly a resident doctor and his young assistant M.D.

I know what present day doctor bills can do to a U.S. citizen as I had arthritis from 1937 to 1947 and spent all I could earn and borrow for 10 years until I finally found an M.D. who cured me in 1 year's time. I gradually limbered up and eliminated my crutch and cane and got back into circulation. This doctor found the cause of my arthritis through a series of blood tests and eliminated the cause which was ordinary table sugar. Of course I had weekly shots of something and vitamin B_1 by mouth.

I have saved money on operations in Wadsworth Veterans' Hospital in Los Angeles, Calif., and also here at Tripler Army Hospital in March 1960 when we first came to Honolulu. There has been some talk of a cafeteria here at Punchbowl Homes, but I do not know what if anything has developed.

JOHN F. DONAHOO,
730 Captain Cook Avenue.

HONOLULU, HAWAII.

To the Senate Committee on Aging:

I'm Mrs. Agnes Truman, a medical social worker at one of our large chronically ill hospitals in Honolulu. My work constantly requires planning for placement of elderly persons. I find, as a community, Oahu lacks boarding homes especially needed for individuals who are incapacitated in some way but who do not require nursing or hospital care regularly.

Although private family placements would be ideal, if available, the demands of the incapacitated to which I refer are usually too extensive in the way of personal services and/or physical accommodations for an average family to assume.

I feel that such homes would help alleviate costly housing for custodial care only of such persons in hospitals and be a financial relief for the taxpayer.

Sincerely,

Mrs. AGNES TRUMAN, ACSW.

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Honolulu, Hawaii, January 2, 1962.

DEAR SENATOR LONG: 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:

As I did speak on Nov. 27, 1961, I received a call to come down to social security offices last Friday to review my testimony. Since it was so all inclusive, regarding housing and medical aid to the aged, who are not included on social security—the two subjects in which I am most interested—I did not make any changes. So am enclosing the written statements I prepared last Friday morning only in case changes were necessary. With the tape recorder, the recording was done verbatim.

However I would like to clarify that I have been able to travel extensively, because my husband held an executive position, with the railroad, and I have

free transportation on same. Secondly, because he belonged to no railroad organization, he had no pension, and consequently his widow got none. The railroads went into the present social security system, the year that Mr. Cooper died, Feb. 7, 1937; so though he had worked for the railroads 40 years, I was given only what he had paid in, in 1 month and 1 week; or as you are aware, the railroads alined Jan. 1, 1937. I was very seriously injured in a railroad crossing accident Jan. 18, 1941 (riding with a friend whose son was driving—he waited for an eastbound train to pass and we were struck by a westbound freight, traveling 50 miles per hour, so I'm just lucky to be here, to tell the tale); and unable to work for 5 years. Then no one would hire a woman over 50. So no social security.

Was able to sell my home in Florida, thus doubling my money.

Always had a desire to see Hawaii. My first trip over here was the great adventure of my lifetime. It has the most equable climate in the whole United States, which is a necessity in my case. Also Honolulu does more for its senior citizens than anywhere else. I feel better, am happier and more contented, so wish to live here for the rest of my days on earth (71 now).

Thank you kindly, Senator Long, for the good work you are doing.

Sincerely,

LOTA W. COOPER,
2470 Oleghorn Street.

NOVEMBER 29, 1961.

MY DEAR SENATOR: I listened with interest to the testimonies before your committee dealing with the medical problem of the aged. Although I was not asked to testify, I am taking the liberty to testify now in the hopes that it may help in some small way in the solution of this problem, especially as my observations are as one sitting on the bleachers after more than half a century as a member of the team.

Some of the things I say may be pedantic, axiomatic, and tautological, for which I apologize. But I consider it essential as a background for my deductions, like getting the family history of a patient before making a diagnosis and prognosis of the case under consideration.

In the 6,000 years of recorded history 21 attempts have been made toward community living under the shibboleth of civilization. Analogous to other forms of life, they have gone through the process of birth, growth, disintegration, and death. Fifteen of the twenty-one attempts have gone the way of all flesh. Six are extant, each of which are apparented or affiliated with its predecessors.

Each of these civilizations under the parochialized term of "a state," for functional purposes is divided into three groups of institutions, political, social, economic.

The function of the political group of institutions is to protect the state from macroscopic enemies from without and from within. The function of the social segment of institutions is to adjust and regulate the interpersonal relationships between members of the social complex. While the function of the economic segment of institutions is to provide the state with material necessities of life. As this social complex grew up without preconceived plans and specifications, there has never been a clear line of demarcation between the duties and the obligations of these various groups. But as long as there was apparent balance between them, the civilization or the state survived. However, if one segment assumed or acquired more of its share of the responsibilities and emoluments of the whole, the civilization or the state toppled and fell.

Moreover, there has never been a blueprint outlining and defining the duties and obligations of the political segment. Hence we have had governments all the way from an absolute monarchy to a pure democracy. Social laws have also varied from rules of reason laid down by those in authority to social laws based on cause and effect as the taboo laws of the old Hawaiians. And likewise our economic systems have varied from an autarchic agricultural economy, to the complex free enterprise, profit motive system under which we now live.

In view of the fact that we have never had a detailed blueprint for a perfectly constructed civilization, our efforts toward equality and balance have been more or less trial and error.

Unfortunately one of the characteristics of the human mind is a tendency to Hybris and egocentricity, because I believe it is this way and because I say that it is this way, there is no other alternative. This ethos was specially noticeable in the various testimonies before your committee.

Mutatis mutandis, returning to the immediate problem at hand, "Medical care for the aged," in our social complex, or state.

Tautologically, our State is what we choose to call a democracy. A form of government in which there is putative freedom without equality. Our social laws are based on putative "Rules of reason laid down by those in authority," the alleged authority for the most part being prelets of the Christian religion. Our economic system is based on individual initiative, free enterprise, and profit motive. Whether this is a good system or a bad system, respice finem. Free enterprise and profit motive seem to work very well in the economic segment. But when it spills over into the political and the social segments is the problem with which we have to deal.

It is generally conceded from past experiences, that the political segment of the social complex, the state and all of its necessary institutions with which to articulate it its responsibilities must be supported by an equitable form of taxation on the economy. Likewise the institutions in the economc segment are supported and maintained by subtracting from the total output a fair share of that which is produced.

The social segment is the belt noir. The principal institutions in this regulatory segment are the schools, churches and amusements in various categories. Some of its institutions are supported by levying a tax on the economy, which is the only source of income for the public schools in particular, while other regulatory institutions the churches, recreational facilities, and care of the sick and afflicted are forced to employ a free enterprise system in order to run their institutions. This is where your committee enters the picture.

The most deadly and lethal enemies of a state or a civilization or of a man is not those beyond its borders, an external proletariat or within its borders in the form of dominant minority or a disgruntled internal proletariat. It is not the macroscopic enemies, but the microscopic ones, sickness and disease. We have set up an elaborate system of taxation with which to finance essential institutions for protection against macroscopic enemies, while no provision has been made by the state to protect itself from the more lethal enemies, the microscopic ones. And with all of the putative altruism ascribed to the medical profession, with few exceptions, a sick person is a commodity, a customer to be exploited for what ever the traffic will bear. It cannot be otherwise under our present system.

What is the solution? I do not profess to have all of the answers, hence I will make only a few suggestions as a result of my years of observation as a practicing physician and now as one of the aged not eligible for any of the benefits proposed for the aged.

Recently we made a trip around the world. We visited some 15 countries where I made a superficial study of their medical system. Only 2 of the 15, Great Britain and the U.S.S.R., considered the health of the people in the same category of national obligation responsibilities as "national defense and public education," and they were doing something about it. Name calling is one of the most common forms of defense for the weakling. Socialized medicine, creeping socialism, or Communists are epithets in common use in the vocabulary of those who subscribe to the policy of profit motive in the practice of medicine. Fortunately under the free enterprise system and profit motive the medical profession has evolved a multiplicity of medicinal and therapeutic devices and surgical procedures which in many cases have been life-saving. On the other hand these same devices in unskilled hands have done irreparable damage and pari passu, made paupers of the family after they had paid the doctor's bill.

It is my contention that there is only one lasting solution to the problem of medical care for the aged, a realistic empirical approach to the problem. National defense is a national problem. Education is a national problem. The health of the people is likewise a national problem. And there is only one source of income for the state, and that is its economy. If it is sensible and logical to support the institutions which are necessary to protect the state from its macroscopic enemies, it is equally as logical to support the institutions which are necessary to protect its people from microscopic enemies regardless of the shibboleths attached to these procedures.

The major defect, as I see it in the position of the proposed plans submitted to your committee, a sick person is still a commercial commodity. The only difference in the various propositions submitted is how "best to fleece him," the best way to kill the duck.

All essential institutions in the social segment of the state which are necessary to articulate its responsibilities should be supported and maintained by a suitable form of taxation on the economy similar to the way in which the institutions in the political segment are maintained.

Respectfully submitted.

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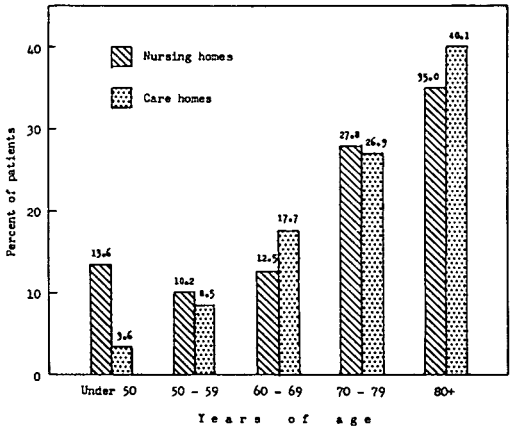
Nursing Homes and Care Homes in Hawaii

AGE DISTRIBUTION OF PATIENTS



Hospitals and Medical Facilities Branch
Medical Health Service Division
Hawaii State Department of Health

1961

1395

INTRODUCTION

In Hawaii, as across the Nation, increasing interest in nursing homes and care homes is evident. This is primarily due to an accelerated increase in the number of older people in the population. Every year there are more of the aged who need the type of care that these homes offer.

Although Hawaii has a smaller percentage of persons 65 and over than any other state except Alaska, we also have an above average increase of the aged. From 1950 to 1960, the increase was 42.8 percent compared to 34.7 percent for the country as a whole.(1) Since we no longer have a great influx of younger people to work on the plantations or elsewhere, the proportion of aged people in our population will continue to increase.

The existence in the State of single elderly men in considerable numbers without close family connections constitutes a special problem in Hawaii. Many of these men immigrated to the islands as plantation laborers without wives and never married.(2) Some have a limited educational background and are frequently handicapped by language difficulties. A considerable number are already retired.

The Hawaii Health Survey conducted in 1958 and 1959 showed the health level of our present population 65 and over remarkably good compared to the same age group on the Mainland and to the younger ages in Hawaii.(3) This may be due in large measure to the fact that the majority of old people here came as immigrants to work on the plantations. Only the most able-bodied were allowed to come. Therefore, our aged people today are a select group. It may well be that the same age group of the future being less highly selected for physical fitness will be more subject to the diseases and infirmities of old age.

Considered as medical care facilities, nursing homes, and to a lesser extent care homes, are being used more widely for post-hospital convalescent care and for the care of the long-term and chronically ill patient. Thereby, the load on hospitals of all types is reduced and such facilities can concentrate to a greater extent upon the more acute conditions of the short-term patient. In this way also, the cost of illness in the community may be kept down. Amendments to the federal Hospital Survey and Construction Act recognize this supplementary function of nursing homes by making matching funds available to assist in the construction of non-profit homes.

The planning of extramural programs directed toward providing a continuum of facilities and services, including nursing and care home programs, should be extended and expanded with respect to the development of different types of needed facilities and services. Although we are now faced with a shortage of homes and defects among some of those which exist, a few years from now without planning the problem could be even greater.

Planning now for the future is imperative. As an aid in such planning and to increase the community's understanding of where we stand in an important segment of medical care, this report gives the results of a survey of nursing homes and care homes made in 1960. It covers the distribution and some of the characteristics of homes, charges for patient care, sources of funds, personal characteristics of patients, medical condition of patients, and various topics related to patient care.

The report is primarily a source document for statistics on nursing and care homes. As such, it is one of the first of its kind in Hawaii.(4) No attempt was made to make a thorough-going analysis of the situation or to draw up a body of recommendations.

How the survey was made -- The survey was conducted using a questionnaire and specifications contained in a guide issued jointly by the U.S. Public Health Service and the Commission on Chronic Illness.(5) A national survey of similar design and methods was conducted in 1954; as a result, some data from it are available for comparison.

The questionnaire and instructions for its use were sent or delivered to the managers of all nursing and care homes. Wherever requested, assistance was given in completing the questionnaire. All homes, except one nursing home unwilling to give information, made a return. After the questionnaires were edited, additional information and clarifications were secured in order to make the entire body of data as complete and accurate as possible.

Definitions of what constitutes a "nursing home" and a "care home" as used in this report are as follows:

> Nursing home -- This type of home provides as its primary and predominant function skilled nursing care for adults. Skilled nursing care includes those procedures employed in caring for the sick which require some technical nursing skill beyond that which the ordinary untrained person can adequately administer. These may include full bed baths, enemas, irrigations, catheterizations, application of dressings or bandages, administration of medication by whatever method the physician orders (oral, rectal, hypodermic, intramuscular), and carrying out other treatments prescribed by the physician which involve a line level of complexity and skill in administration. They may be provided by either professional or practical nursing personnel, so long as they extend beyond "personal care" as described below.
>
> Care home -- This type of home provides "personal care" with little or no "skilled nursing care." Personal care includes such personal services as help in walking and getting in and out of bed, assistance with general bathing, help with dressing or feeding, preparation of special diet, supervision over medications which can be self-administered, and other types of personal assistance of this order. Minimum services of a domiciliary nature, such as laundry and personal courtesies are, of course, also included.

The Hospitals and Medical Facilities Branch in collaboration with the Research, Planning and Statistics Office and the Adult Health Branch conducted the survey and prepared this report. Mrs. Margaret Bennett, Hospital Nursing Consultant, directed the project.

Numbers in parenthesis refer to references listed at the end of the report. Asterisks refer to footnotes at the bottom of a page or table.

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I. DISTRIBUTION AND CHARACTERISTICS OF HOMES

Number of homes and bed capacity - At the time of the survey, 15 nursing homes and 32 care homes were operating in the State. They had a combined bed capacity of 1,057 beds or 1.8 beds per 1,000 population.

This rate is well above the minimum standard of one bed per 1,000 population specified in the Hill-Burton hospital and medical facilities construction program, but probably below the existing national average. A national survey in 1954, indicated an estimated 2.8 beds per 1,000 population in "nursing homes and related facilities."(6)

The State Health Department's annual "Construction Plan for Hospitals and Medical Facilities" issued in 1961 classifies more than 50 percent of the beds in nursing homes as unsuitable for occupancy due to fire or health hazards.* No comparable evaluation of beds in care homes was included in the Plan. However, the annual 1961 inspection of care homes classified all unsuitable for the above reason.

TABLE 1. NUMBER AND BED CAPACITY OF NURSING HOMES AND CARE HOMES BY GEOGRAPHIC AREA: STATE OF HAWAII, 1960

Area	Both types of homes		Nursing homes		Care homes	
	Number	Bed Capacity	Number	Bed Capacity	Number	Bed Capacity
State	47	1,057	15	653	32	404
Honolulu City	19	647	8	317	11	330
Balance of Oahu ..	6	157	3	148	3	9
Hawaii County	1	88	1	88	0	0
Maui County	1	95	1	95	0	0
Kauai County	20	70	2	5	18	65
Average number of beds per home ..	--	22.5	--	43.5	--	12.6

The same State publication indicates that nursing homes and chronic disease facilities together have 714 beds and estimates that 1,017 additional beds are needed -- an increase of 142 percent. For these two types of facilities combined, the publication specifies a desirable

* Four of the nursing homes included in this report were excluded as such from the Construction Plan for Hospitals and Medical Facilities.

goal of 3 beds per 1,000 population. However, this reflects a recommendation of the U.S. Public Health Service for the country as a whole and not specifically for Hawaii.

Table 1 indicates the distribution of nursing homes and care homes by county. As might be expected, the majority of beds were in Honolulu City. It will be noted that Hawaii and Maui Counties had no care homes.

Considering both types of homes together, Kauai had the largest number of beds per 1,000 population and Hawaii County the fewest (Figure 1).

Occupancy rates - Although bed capacity reported from the two types of homes was 1,004,* the number of patients reported was 833. Thus, the overall occupancy rate was 83 percent at the time of the survey. For nursing homes, it was 92 percent; for care homes, it was 70 percent.

TABLE 2. NUMBER AND PERCENT OF PATIENTS IN NURSING HOMES AND CARE HOMES BY GEOGRAPHIC AREA: STATE OF HAWAII, 1960

Area	Both types of homes		Nursing homes		Care homes	
	Number	Percent	Number	Percent	Number	Percent
State	886	100.0	604	100.0	282	100.0
Honolulu City	491	55.4	263	43.5	228	80.9
Balance of Oahu ...	161	18.2	155	25.7	6	2.1
Hawaii County	88	9.9	88	14.6	0	--
Maui County	95	10.7	95	15.7	0	--
Kauai County	51	5.8	3	0.5	48	17.0
Percent of beds occupied	83.8	--	92.5	--	69.8	--

Size of homes - Measured by bed capacity, nursing homes were generally much larger than care homes. The bed capacity average for nursing homes was 43.5 compared to only 12.6 for care homes (Table 1).

* From this point, data for one nursing home which failed to report for survey purposes are omitted.

Years of operation - In general, nursing homes were longer established than care homes (Table 3). More than one-half in the nursing home category had been established five or more years, while only about one-third of the care homes had been established that long. The growth in the number of care homes on Kauai within the four year period preceding the survey is notable.

TABLE 3. NUMBER OF NURSING HOMES AND CARE HOMES BY GEOGRAPHIC AREA AND YEARS OF OPERATION: STATE OF HAWAII, 1960

Area	Nursing homes			Care homes		
	1 year or less	2-4 years	5 years or more	1 year or less	2-4 years	5 years or more
State	2	4	8	4	18	10
Honolulu City	--	3	4	--	4	7
Balance of Oahu	1	--	2	2	1	--
Hawaii County	--	--	1	--	--	--
Maui County	--	--	1	--	--	--
Kauai County	1	1	--	2	13	3

Type of ownership - Considering the two types of homes as one group, 80 percent were privately operated and 17 percent by a non-profit organization other than religious (Table 4). One home was church related.

TABLE 4. NUMBER AND BED CAPACITY OF NURSING HOMES AND CARE HOMES BY COUNTY AND OWNERSHIP: STATE OF HAWAII, 1960

County	Private		Church related		Other non-profit organization	
	Number	Bed Capacity	Number	Bed Capacity	Number	Bed Capacity
State	37	406	1	32	8	566
Honolulu	17	336	1	32	6	383
Hawaii	0	--	0	--	1	88
Maui	0	--	0	--	1	95
Kauai	20	70	0	--	0	--

Using bed capacity rather than number of homes, proportions appeared quite different. In this case, homes of non-profit organizations had 56.4 percent of the beds and privately operated homes only 40.4 percent. This, of course, reflects the larger capacity of the non-profit organization establishments. An additional 3.2 percent of all beds were in the one church related home.

Admission requirements - Twelve or 26 percent of the 46 homes reporting specified age requirements for admission; 15 homes (33 percent) had sex requirements; only one home (2 percent) had religious requirements; and 5 homes (11

percent) specified racial requirements (Table 5). Nursing homes appeared more likely than care homes to have age requirements and less likely to have those related to sex of patient and race. However, all data on admission requirements are approximate only, since 8 homes (17 percent) failed to give complete information.

TABLE 5. NUMBER OF NURSING AND CARE HOMES BY ADMISSION REQUIREMENT: STATE OF HAWAII, 1960

Admission Requirement	Nursing homes				Care homes			
	Total homes	Yes	No	Unknown	Total homes	Yes	No	Unknown
Age	14	6	2	6	32	6	24	2
Sex	14	3	9	2	32	12	20	--
Religion	14	1	7	6	32	0	30	2
Race	14	1	7	6	32	4	26	2

Staffing - The two classes of homes employed 292 persons either full-time or part-time (Table 6). The overall number of patients per employee was 2.9. This was 2.7 patients in nursing homes and 3.3 patients in care homes.

Nearly 50 percent of the employees in care homes were part-time; in contrast, only 12 percent in nursing homes were part-time.

Table 7 shows the percentage distribution of personnel by categories. In nursing homes, 63 percent of the personnel were in nursing categories compared to 28 percent in care homes.

Nursing homes had an average of 21.2 patients to each registered professional nurse. This average in care homes was negligible, since only two part-time registered nurses were employed.

Considering all categories of nursing help as a group, the ratio was 4.3 patients to each nurse in nursing homes and 11.8 patients to each nurse in care homes.

II. RATES FOR CARE AND PATIENT FINANCING

Monthly rates - Monthly rates in nursing homes ranged from less than $100 to $400 and over. The median rate amounted to $167.

TABLE 6. PERSONNEL IN NURSING HOMES AND CARE HOMES BY CATEGORY AND COUNTY: STATE OF HAWAII, 1960

Category of personnel	Both types of homes		Nursing homes		Care homes	
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
	State					
All personnel	239	53	182	25	57	28
Registered professional nurse	23	5	23	3	--	2
Licensed practical nurse	49	4	47	2	2	2
Other nursing personnel	59	11	46	6	13	5
All other personnel ...	108	33	66	14	42	19
	Honolulu County					
All personnel	158	33	121	17	37	16
Registered professional nurse	18	5	18	3	--	2
Licensed practical nurse	24	2	23	1	1	1
Other nursing personnel	42	7	29	3	13	4
All other personnel ...	74	19	51	10	23	9
	Hawaii County					
All personnel	24	--	24	--	--	--
Registered professional nurse	2	--	2	--	--	--
Licensed practical nurse	15	--	15	--	--	--
Other nursing personnel	--	--	--	--	--	--
All other personnel ...	7	--	7	--	--	--
	Maui County					
All personnel	34	8	34	8	--	--
Registered professional nurse	3	--	3	--	--	--
Licensed practical nurse	6	1	6	1	--	--
Other nursing personnel	17	3	17	3	--	--
All other personnel ...	8	4	8	4	--	--
	Kauai County					
All personnel	23	12	3	--	20	12
Registered professional nurse	--	--	--	--	--	--
Licensed practical nurse	4	1	3	--	1	1
Other nursing personnel	--	1	--	--	--	1
All other personnel ...	19	10	--	--	19	10

TABLE 7. PERCENTAGE DISTRIBUTION OF FULL-TIME AND PART-TIME PERSONNEL IN NURSING HOMES AND CARE HOMES BY TYPE OF PERSONNEL: STATE OF HAWAII, 1960

Type of Personnel	Both types of homes	Nursing homes	Care homes
Number	292	207	85
Total:			
Percent	100.0	100.0	100.0
Registered Professional nurse	9.6	12.6	2.4
Licensed practical nurse	18.2	23.7	4.7
Other nursing personnel	24.0	25.1	21.2
All other personnel	48.2	38.6	71.7

FIGURE 1. BED CAPACITY OF NURSING AND CARE HOMES COMBINED PER 1,000 CIVILIAN POPULATION BY AREAS: STATE OF HAWAII, 1960

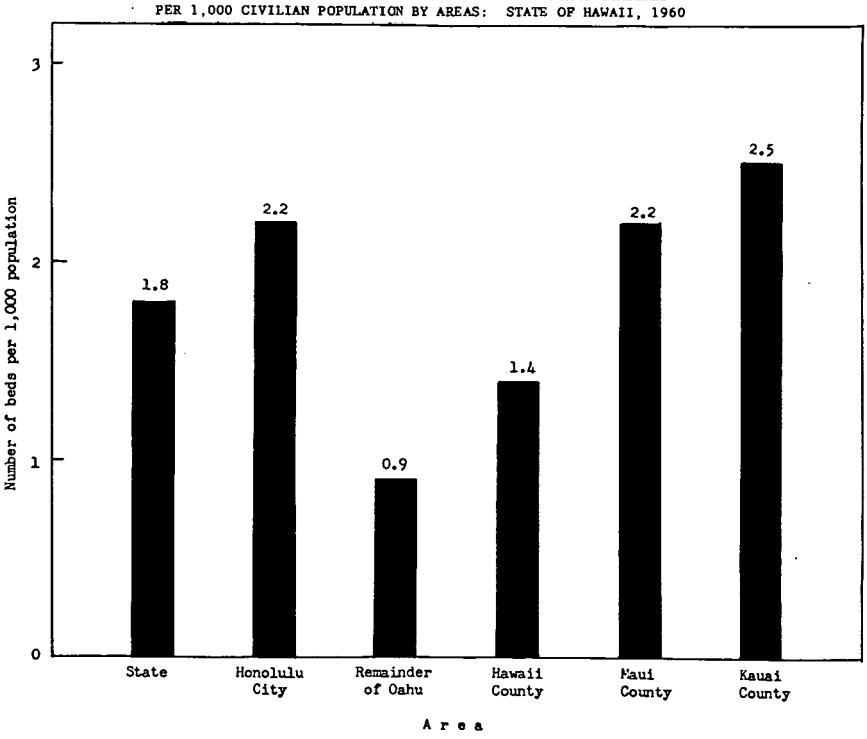


TABLE 8. NUMBER OF PATIENTS IN NURSING HOMES BY MONTHLY CHARGE AND GEOGRAPHIC AREA: STATE OF HAWAII, 1960

Charge per month	State	Honolulu City	Balance of Oahu	Hawaii County	Maui County	Kauai County
Total patients included	538*	197	155	88	95	3
Less than $100	71	--	4	34	33	--
$100-149	128	1	105	--	21	1
$150-199	211	120	85	40	24	2
$200-249	35	8	10	--	17	--
$250-299	13	5	8	--	--	--
$300-349	33	31	2	--	--	--
$350-399	22	7	1	14	--	--
$400 and over .	25	25	--	--	--	--
Median charge..	$167	$191	$135	$163	$135	--

* 15 patients omitted.

As indicated in Table 8, the median rate was higher in the City of Honolulu than for the balance of Oahu or on Hawaii and Maui. There being only 3 nursing home patients on Kauai, the median was not completed.

In contrast, the median monthly rate in care homes of Honolulu was much lower than outside the city on Oahu or on Kauai (Table 9). The median rate of $83 for the State was half that for nursing homes, reflecting the much lower charges in care homes. More than 75 percent of the care home patients, but only 13 percent of those in nursing homes, paid less than $100 per month (Table 8).

Based on average monthly charges, rates for females in nursing homes were somewhat higher than for males, while the reverse was true in care homes where rates for males appeared higher (Table 10). By age, average charges in nursing homes were noticeably less for patients under 60; in care homes, the rates appeared substantially lower only for those under 40.

TABLE 9. NUMBER OF PATIENTS IN CARE HOMES BY MONTHLY CHARGE AND GEOGRAPHIC AREA: STATE OF HAWAII, 1960

Charge per month	State*	Honolulu City	Balance of Oahu	Kauai County
Total patients included	282	228	6	48
Less than $100..	214	214	--	--
$100-149	53	12	4	37
$150-199	13	1	1	11
$200 and over ..	2	1	1	--
Median charge ..	$83	$77	$137	$132

* The counties of Hawaii and Maui had no care homes.

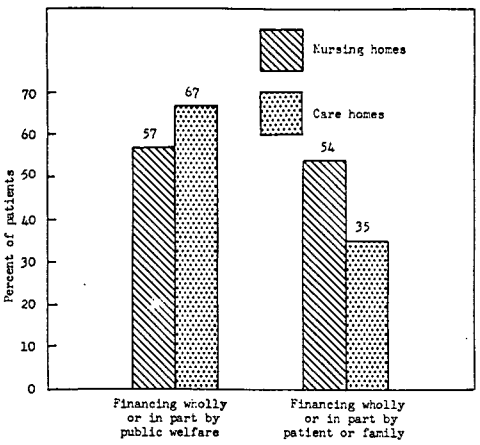
Sources of funds - An outstanding fact relative to patient financing in nursing homes and care homes is the extensive part played by public welfare funds. In nursing homes, 57.3 percent, and in care homes, 66.6 percent of the patients were financed wholly or in part by the State Department of Social Services (Table 11 and Figure 2). In both types of homes, public assistance funds paid the full bill, rather than only part, in the majority of cases.

TABLE 10. AVERAGE MONTHLY CHARGE IN NURSING HOMES AND CARE HOMES BY AGE AND SEX: STATE OF HAWAII, 1960

Sex and age		Nursing homes	Care homes
Average for all patients included*		$167	$78
Sex:	Male	155	79
	Female	182	68
Age:	Under 40 years	147	69
	40-59 years	146	82
	60-79 years	172	80
	80 and over	176	77

* Based on 429 patients in nursing homes and 267 in care homes.

FIGURE 2. EXTENT OF PUBLIC WELFARE AND PATIENT OR FAMILY FINANCING IN NURSING HOMES AND CARE HOMES: STATE OF HAWAII, 1960



A similar situation exists in most other states in varying degrees. Approximate national figures secured in 1954 indicated that 50 percent of nursing home patients and 46 percent of care home patients received public assistance funds.(6) Thus, it appears that Hawaii is above average in public assistance participation, especially with regard to care home patients.

This high degree of public assistance financing has important implications for the future development of both nursing and care homes. To a large extent, the number of homes and the type of services they offer will be linked with the amounts that the Department of Social Services is able to pay for patient care.

TABLE 11. NUMBER AND PERCENT OF PATIENTS IN NURSING HOMES AND CARE HOMES BY SOURCE OF FUNDS FOR CARE: STATE OF HAWAII, 1960

Source of funds for care	Both types of homes		Nursing homes		Care homes	
	Number	Percent	Number	Percent	Number	Percent
Total patients	833	100.0	551	100.0	282	100.0
Patient or family only	268	32.2	202	36.7	66	23.4
Public welfare only...	371	44.5	221	40.1	150	53.2
Other agency only	38	4.6	25	4.5	13	4.6
Patient or family and public welfare	118	14.2	90	16.3	28	9.9
Patient and family and other agency	10	1.2	5	.9	5	1.8
Public welfare and other agency	15	1.8	5	.9	10	3.5
Other type of sources	2	.2	1	.2	1	.4
Unknown	11	1.3	2	.4	9	3.2

Charges for 36.7 percent of the patients in nursing homes and for 23.4 percent in care homes were being paid wholly by the patients or their families. In another group, 17.2 percent in nursing homes and 11.7 percent in care homes, the patient or family contributed some part of the costs.

In Hawaii and elsewhere, the tendency is to charge more for patients financing their own way than for those wholly financed by public assistance. Although local data are not available, results of the 1954 national survey referred to above, indicated that public assistance patients in proprietary nursing homes and domiciliary care homes were charged about one-third less than private pay patients.

Table 12 shows the number of patients having income for care divided by source of income. In nursing homes, 72.4 percent of this group had a private source of income and 26.6 percent some form of pension. In

TABLE 12. NUMBER AND PERCENT OF PATIENTS IN NURSING AND CARE HOMES WITH EARNED OR PURCHASED INCOME FOR CARE BY TYPE OF SUCH INCOME: STATE OF HAWAII, 1960

Type of earned or purchased income	Both types of homes		Nursing homes		Care homes	
	Number	Percent	Number	Percent	Number	Percent
Total patients with income for care	396	100.0	297	100.0	99	100.0
Private	234	59.1	215	72.4	19	19.2
Pension, total	159	40.1	79	26.6	80	80.8
Old-age retirement	96	24.2	44	14.8	52	52.5
Veteran's pension	38	9.6	25	8.4	13	13.1
Other pension	25	6.3	10	3.4	15	15.2
Insurance policy	3	.8	3	1.0	--	--

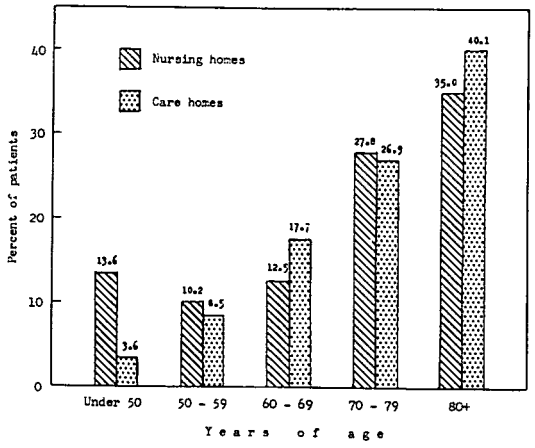
care homes, only 19.2 percent had private sources of income while 80.8 percent had pensions. In both categories of homes, the most usual type of pension was old age retirement.

III. PERSONAL CHARACTERISTICS OF PATIENTS

As indicated in previous tables, the survey included 551 patients in nursing homes and 282 in care homes. This constituted a complete patient census at the time of the survey, except for about 50 patients in one nursing home of Honolulu which failed to return the required information.

Personal data presented here for the patients included in the survey pertain to age, sex, marital status, race, residence before admission, and home and family status.

FIGURE 5. PERCENTAGE DISTRIBUTION OF PATIENTS IN NURSING HOMES AND CARE HOMES BY AGE: STATE OF HAWAII, 1960



Age and Sex - As throughout the country, patients in both nursing and care homes of Hawaii are predominately aged people. However, the median age here appears considerably lower than in a national survey conducted in 13 states.(6) In Hawaii, the median age was 74.8 years in nursing homes and 76.8 years in care homes. In the national survey, median age was 79 in "proprietary nursing homes," 78 in "voluntary and public nursing homes," and 79 in "domiciliary care homes."

In line with a lower median age, nursing homes of Hawaii had a higher proportion of younger people than care homes. For example, 13.6 percent in nursing homes and only 3.5 percent in care homes were under 50 years of age. About 63 percent in nursing homes and 67 percent in care homes were 70 and over (Table 13 and Figure 3).

Patients in nursing homes were far more evenly divided between the sexes. About 51 percent were males and 48.6 percent females. Only 9.2 percent of those in care homes (26 patients) were females. In the nursing homes, females

TABLE 13. NUMBER AND PERCENTAGE DISTRIBUTION OF PATIENTS IN NURSING HOMES AND CARE HOMES BY AGE AND SEX: STATE OF HAWAII, 1960

Age	Nursing homes			Care homes		
	Both sexes	Male	Female	Both sexes	Male	Female
	Number					
All ages.....	551	283	268	282	256	26
Under 30	7	5	2	--	--	--
30 - 39	26	9	17	5	5	--
40 - 49	42	19	23	5	5	--
50 - 59	56	31	25	24	22	2
60 - 69	69	43	26	50	47	3
70 - 79	153	77	76	76	66	10
80+	193	97	96	113	105	8
Unknown	5	2	3	9	6	3
Median age	74.8	74.4	75.2	76.9	77.0	76.5
	Percent distribution					
All ages	100.0	100.0	100.0	100.0	100.0	100.0
Under 30	1.3	1.8	0.8	--	--	--
30 - 39	4.7	3.2	6.3	1.8	2.0	--
40 - 49	7.6	6.7	8.6	1.8	2.0	--
50 - 59	10.2	10.9	9.3	8.5	8.6	7.7
60 - 69	12.5	15.2	9.7	17.7	18.3	11.5
70 - 79	27.8	27.2	28.4	26.9	25.8	38.5
80+	35.0	34.3	35.8	40.1	41.0	30.8
Unknown	.9	.7	1.1	3.2	2.3	11.5

averaged slightly older than males, while in care homes, the males were slightly older.

It is notable that among younger patients under 50 in nursing homes, females predominated; among those 50 to 69, males were in the majority; at 70 and over, the sexes were almost evenly divided (Table 13).

Marital status - In nursing homes, 29.2 percent of all patients were widowed females. Single men were next in importance, constituting 24.1 percent of all patients (Table 14).

TABLE 14. NUMBER AND PERCENTAGE DISTRIBUTION OF PATIENTS IN NURSING HOMES AND CARE HOMES BY MARITAL STATUS AND SEX STATE OF HAWAII. 1960

Marital status	Nursing homes			Care homes		
	Both sexes	Male	Female	Both sexes	Male	Female
	Number					
Total	551	283	268	282	256	26
Single	191	133	58	150	149	1
Married	39	25	14	7	7	--
Widowed	229	68	161	83	63	20
Separated or divorced	50	24	26	13	12	1
Unknown	42	33	9	29	25	4
	Percent distribution					
Total	100.0	100.0	100.0	100.0	100.0	100.0
Single	34.7	47.0	21.6	53.2	58.2	3.9
Married	7.1	8.8	5.2	2.5	2.7	--
Widowed	41.5	24.0	60.1	29.4	24.6	76.9
Separated or divorced	9.1	8.5	9.7	4.6	4.7	3.8
Unknown	7.6	11.7	3.4	10.3	9.8	15.4

In care homes, single men were by far the predominant group, constituting 53.2 percent of all patients. Widowers were second in importance -- 22.3 percent.

Seven percent of the nursing home patients and only 2.5 percent of the care home patients were married with spouses living. Similarly, nursing homes were more likely to have divorced or separated patients.

A major difference between homes of the country as a whole and of Hawaii is the much higher proportion of single men in Hawaii. No doubt, this is due to the considerable numbers of immigrant laborers who came to the Islands in the past without wives and who never married. Many of them are now retired from work on the sugar and pineapple plantations.

Racial groups - Caucasians were the largest group in nursing homes (38.5 percent) followed by Japanese (28.1 percent) and Filipinos (13.2 percent). A concentration of Caucasian females was especially noticeable. About one in four patients was in this category (Table 15).

Only 10.6 percent of the patients in care homes were Caucasian. The most numerous groups were Japanese and Chinese (Table 17). Filipinos, Hawaiians, and those in the "all other" classification were in more or less equal numbers. Most of the females were either Caucasian or Hawaiian.

Figure 4 shows the number of patients in both nursing and care homes combined per 100,000 population. This is only a rough measure because the criteria for race used by those who completed the survey forms probably differed somewhat from census definitions.

Aside from "all other," Chinese had the highest rate followed by Filipinos and Caucasians with almost equal rates. Japanese were intermediate with Hawaiians lowest. The Hawaiian* rate was only 74 compared to the Chinese rate of 232.

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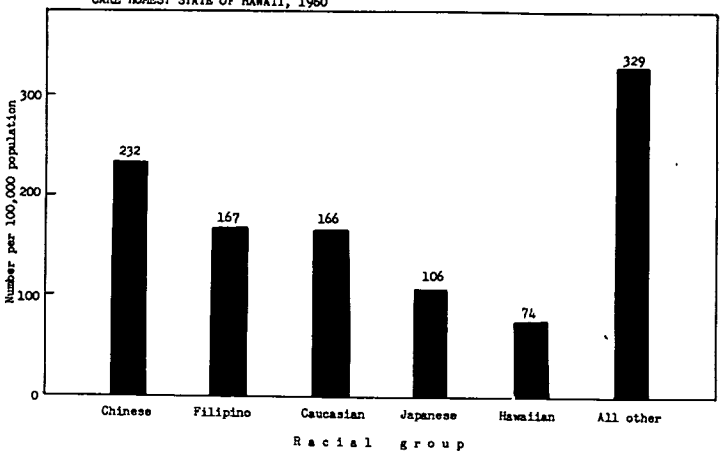
* This term includes both pure Hawaiians and part-Hawaiians.

The highest rate (329) was for those classified as "all other." This classification includes various racial groups, but according to the census Puerto Ricans and Koreans would be the most numerous.

FIGURE 4. RATES PER 100,000 POPULATION FOR RACIAL GROUPS IN NURSING HOMES AND CARE HOMES: STATE OF HAWAII, 1960



Residence before admission - About 87 percent of the patients in nursing homes resided in the same county before admission; about 11 percent came from another county of the State; and less than 2 percent (10 patients) came from another state or country. Females were more likely to come from outside the State than males (Table 16).

Only 6 percent of the patients in care homes were from another county and none out-of-state. Females were the most likely to come from another county, but the number was small (4 patients).

Home and family status - Home and family status were obtained for about four-fifths of the patients in nursing and care homes combined. About 19 percent of those for which the information was obtained had homes and more than half had families; 18 percent had both homes and families. As indicated in Table 17, nearly all of those with homes also had families.

TABLE 15. NUMBER AND PERCENTAGE DISTRIBUTION OF PATIENTS IN NURSING HOMES AND CARE HOMES BY RACE AND SEX: STATE OF HAWAII, 1960

Race	Nursing homes			Care homes		
	Both sexes	Male	Female	Both sexes	Male	Female
	Number					
All races	551	283	268	282	256	26
Japanese	155	85	70	61	57	4
Caucasian	212	67	145	30	21	9
Chinese	30	18	12	58	57	1
Hawaiian	40	17	23	41	30	11
Filipino	73	66	7	44	44	--
Other	41	30	11	48	47	1
	Percent distribution					
All races	100.0	100.0	100.0	100.0	100.0	100.0
Japanese	28.1	30.0	26.1	21.7	22.3	15.4
Caucasian	38.5	23.7	54.1	10.6	8.2	34.6
Chinese	5.4	6.4	4.5	20.6	22.3	3.9
Hawaiian	7.3	6.0	8.6	14.5	11.7	42.3
Filipino	13.2	23.3	2.6	15.6	17.2	--
Other	7.5	10.6	4.1	17.0	18.3	3.8

TABLE 16. NUMBER OF PATIENTS IN NURSING HOMES AND CARE HOMES BY RESIDENCE BEFORE ADMISSION AND SEX: STATE OF HAWAII, 1960

Residence before admission	Nursing homes			Care homes		
	Both sexes	Male	Female	Both sexes	Male	Female
Total	551	283	268	282	256	26
Same county	478	247	231	260	239	21
Another county .	58	30	28	17	13	4
Another state ..	5	1	4	0	0	0
Foreign	5	2	3	0	0	0
Unknown	5	3	2	5	4	1

As shown in Figure 5, females were much more likely to have homes or families or both than males. This emphasizes the fact that the State's population includes a considerable number of aged unmarried males without family connections and without established homes.

FIGURE 5. HOME AND FAMILY STATUS OF PATIENTS IN NURSING HOMES AND CARE HOMES COMBINED: STATE OF HAWAII, 1960

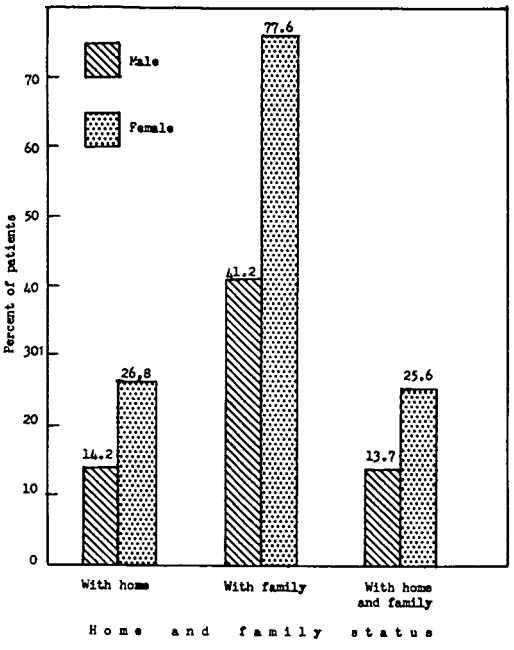


TABLE 17. NUMBER OF PATIENTS IN NURSING HOMES AND CARE HOMES BY HOME AND FAMILY STATUS, STATE OF HAWAII, 1960

Home status	Total patients*		With families		Without families	
	Male	Female	Male	Female	Male	Female
Total	451	250	186	194	265	56
With homes ..	64	67	62	64	2	3
Without homes	387	183	124	130	263	53

* Home and family status was not obtained for 132 patients.

IV. MEDICAL CONDITION OF PATIENTS

To ascertain the physical and mental condition of patients in nursing homes and care homes was a major objective of the survey. This information is essential in judging the adequacy of existing homes and in planning for the future. Medical diagnoses and the extent of selected types of disability among patients are the topics included.

The medical records in some homes, especially among the care homes, are inadequate and unrevealing. In many cases, a well considered diagnosis appears not to have been made. Consequently, the diagnostic data herein presented should not be taken as definitive in every respect. Only broad general categories of conditions are discussed.

Number of conditions in diagnoses - Informants were asked to "enter diagnoses reported by physicians and other long-term diseases or disabling conditions which you know the person has." Following these instructions, about 34 percent of the patients in nursing and care homes combined had one condition specified; 35.7 percent had two conditions specified; 27.3 percent had three or more; and 3.4 percent had no disability condition or were undiagnosed (Table 18).

TABLE 18. NUMBER AND PERCENTAGE DISTRIBUTION OF PATIENTS IN NURSING HOMES AND CARE HOMES BY NUMBER OF CONDITIONS SPECIFIED IN DIAGNOSES AND SEX: STATE OF HAWAII, 1960

Number of conditions specified in diagnoses	Nursing homes			Care homes		
	Both sexes	Male	Female	Both sexes	Male	Female
	Number					
Total patients	551	283	268	282	256	26
One condition	185	80	105	96	81	15
Two conditions	197	109	88	100	95	5
Three or more	149	89	60	78	75	3
Undiagnosed	20	5	15	8	5	3
	Percent distribution					
Total patients	100.0	100.0	100.0	100.0	100.0	100.0
One condition	33.6	28.3	39.2	34.0	31.6	57.7
Two conditions	35.8	38.5	32.8	35.5	37.1	19.3
Three or more	27.0	31.4	22.4	27.7	29.3	11.5
Undiagnosed	3.6	1.8	5.6	2.8	2.0	11.5

Much the same percentage distribution as to number of conditions prevailed in both

types of homes. In both types of homes also it is noticeable that females were more likely than males to have no disability condition specified; females were also less likely to have as many as three or more conditions specified (Table 18).

Primary diagnosis - Instructions to informants regarding the primary diagnosis were: "Enter in the first space, as the 'primary diagnosis,' the one which you consider primarily responsible for the person's need for nursing care." Therefore, for those patients having more than one diagnosis, an element of judgment on the part of the informant was involved in specifying the primary diagnosis.

It is clear from Table 19 that chronic disease as the major reason for the need of nursing care predominates in both types of homes with cardiovascular conditions* the leading diagnosis. This type of condition percentagewise was somewhat more evident in care homes and more pronounced for males than females.

In nursing homes, the second most prevalent category was neurological conditions,** while in care homes it was senility (Figure 6 and Table 19). The fact that two of the larger nursing homes included in the survey specialize in patients with mental disorders explains the high proportion (29.6 percent) of patients in nursing homes with neurological conditions as the primary diagnosis.

About one out of five patients in care homes (20.9 percent) and one out of ten (9.9 percent) in nursing homes had "senility" as the primary diagnosis. This category is frequently used because no more definitive diagnostic information is available. To a considerable extent, the frequency of its use measures the care with which diagnoses have been made and recorded. In this instance, the data appear to indicate superior diagnosing in nursing homes.

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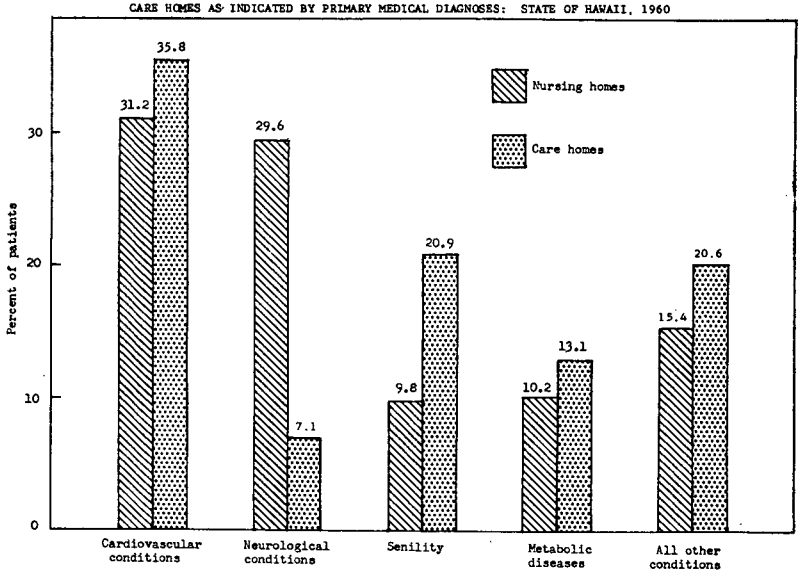
* "Cardiovascular conditions" include heart disease, cerebrovascular lesions, and other circulatory disease.

** "Neurological conditions" include psychoses, psychoneuroses, and other behavior disorders.

Metabolic diseases, with diabetes the most prominent, took third place in both types of homes -- 10.2 percent of the patients in nursing homes and 13.1 percent in care homes.

FIGURE 6. MAJOR CONDITIONS AMONG PATIENTS IN NURSING HOMES AND CARE HOMES AS INDICATED BY PRIMARY MEDICAL DIAGNOSES: STATE OF HAWAII, 1960



In a survey of proprietary nursing homes in 13 Mainland states,[6] cardiovascular conditions and senility appeared more prevalent than in Hawaii nursing homes; neurological conditions, on the other hand, were less in evidence on the mainland.

Considering patients in nursing and care homes as a group, it is evident in Table 20 that neurological conditions are found primarily among the younger patients. Almost 83 percent of those under 50 had these conditions as the primary diagnosis compared to only 8.4 percent of the oldest patients 80 and over. On the other hand, cardiovascular conditions and metabolic diseases

tended to increase with age. Senility, of course, was also more evident among the older patients. Nearly 24 percent of those 80 and over had senility as the primary diagnosis.

TABLE 19. NUMBER AND PERCENTAGE DISTRIBUTION OF PATIENTS IN NURSING HOMES AND CARE HOMES BY PRIMARY DIAGNOSIS AND SEX: STATE OF HAWAII, 1960

Primary diagnosis	Nursing homes			Care homes		
	Both sexes	Male	Female	Both sexes	Male	Female
	Number					
Total patients	551	283	268	282	256	26
Neurological conditions	163	73	90	20	19	1
Blood conditions	2	1	1	2	2	-
Cardiovascular conditions	172	98	74	101	96	5
Gastro-intestinal	8	5	3	2	2	-
Blindness	8	7	1	11	11	-
Other eye conditions	5	4	1	2	2	-
Metabolic diseases	56	28	28	37	31	6
Orthopedic conditions	26	8	18	11	11	-
Respiratory diseases	14	11	3	18	18	-
Chronic alcoholism	8	6	2	3	3	-
Senility	54	28	26	59	49	10
Misc. medical-surgical conditions	14	8	6	9	8	1
Undiagnosed	21	6	15	7	4	3
	Percent distribution					
Total patients	100.0	100.0	100.0	100.0	100.0	100.0
Neurological conditions	29.6	25.8	33.6	7.1	7.4	3.9
Blood conditions	0.4	0.3	0.4	0.7	0.8	0
Cardiovascular conditions	31.2	34.6	27.6	35.8	37.5	19.2
Gastro-intestinal	1.5	1.8	1.1	0.7	0.8	0
Blindness	1.5	2.5	0.4	3.9	4.3	0
Other eye conditions	0.9	1.4	0.4	0.7	0.8	0
Metabolic diseases	10.2	9.9	10.5	13.1	12.1	23.1
Orthopedic conditions	4.7	2.8	6.7	3.9	4.3	0
Respiratory diseases	2.5	3.9	1.1	6.4	7.0	0
Chronic alcoholism	1.4	2.1	0.7	1.1	1.2	0
Senility	9.8	9.9	9.7	20.9	19.1	38.5
Misc. medical-surgical conditions	2.5	2.8	2.2	3.2	3.1	3.8
Undiagnosed	3.8	2.2	5.6	2.5	1.6	11.5

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TABLE 20. PERCENTAGE DISTRIBUTION OF PATIENTS IN NURSING HOMES AND CARE HOMES COMBINED BY PRIMARY DIAGNOSIS AND AGE: STATE OF HAWAII, 1960*

Primary diagnosis	Years of age				
	Under 50	50-59	60-69	70-79	80+
Number	85	80	119	229	306
Total: Percent	100.0	100.0	100.0	100.0	100.0
Neurological conditions	.5	45.2	22.6	9.7	8.4
Cardiovascular diseases	2.3	38.1	34.7	40.5	34.4
Blindness and other eye conditions	0	2.4	4.0	2.6	3.5
Metabolic diseases	4.7	2.4	11.3	14.0	11.6
Orthopedic conditions	7.0	3.6	4.0	5.1	4.8
Respiratory diseases	1.2	0	3.2	3.4	5.8
Senility	0	0	10.5	11.5	23.5
All other	2.3	6.0	6.5	8.5	4.5
Undiagnosed	0	2.3	3.2	4.7	3.5

* Fourteen patients with unknown age omitted.

Secondary complications - Table 21 shows selected primary diagnosis for patients in both types of homes combined and the percentage distribution of secondary complications for each diagnosis. As will be noted, a part of the primary diagnosis groups contain only a small number of cases. For that reason, conclusions relative to the pattern of accompanying complications should be drawn with caution.

For patients having neurological conditions, no secondary complication was mentioned in 57 percent of the cases. For the remaining 43 percent, complications were well distributed among various condition categories.

Among patients having cardiovascular disease as the primary diagnosis, 32.5 percent had another cardiovascular disease as a secondary complication. Other major complications included senility, metabolic diseases, and various medical-surgical conditions.

Where the primary diagnosis was a metabolic disease, the leading complication was cardiovascular. For respiratory diseases, the outstanding complication was also cardiovascular. Well over half the patients with primary

diagnosis senility had no complications mentioned.

Walking status - In nursing homes, 62.6 percent of the patients could walk alone or with no more help than a cane or crutch. Others (18.5 percent) needed personal assistance or some mechanical device for getting about. About as many (18.9 percent) could not walk or get about to any extent.

TABLE 21. PERCENTAGE DISTRIBUTION OF PATIENTS IN NURSING HOMES AND CARE HOMES BY PRIMARY DIAGNOSIS AND SECONDARY COMPLICATIONS, STATE OF HAWAII, 1960

Secondary Complications	Primary diagnosis								
	Neurological conditions	Cardiovascular diseases	Gastro-intestinal	Blindness and other eye conditions	Metabolic diseases	Orthopedic conditions	Respiratory diseases	Chronic alcoholism	Senility
Number.....	183	273	10	26	93	37	32	11	113
Total patients: Percent.....	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurological conditions	0	6.7	20.0	3.8	7.4	9.6	0	27.3	3.5
Cardiovascular diseases	7.5	32.5	0	15.4	23.4	7.3	18.8	0	8.7
Gastro-intestinal.....	0	0.7	0	3.8	3.2	0	0	0	0.9
Blindness and other eye conditions.....	3.8	6.4	0	0	7.4	0	3.1	0	6.9
Metabolic diseases.....	3.2	9.5	0	11.6	5.3	4.9	9.4	18.2	2.6
Orthopedic conditions..	2.7	4.2	10.0	0	9.6	0	6.2	0	3.5
Respiratory diseases...	4.3	1.8	0	3.8	4.3	2.5	6.2	0	5.2
Chronic alcoholism.....	1.1	0	0	0	1.1	2.5	0	0	0
Senility.....	3.2	9.9	20.0	7.7	7.4	17.1	12.5	0	0
All other.....	17.2	10.3	20.0	7.7	9.6	7.3	25.0	9.1	12.2
None mentioned.....	57.0	18.0	30.0	46.2	21.3	48.8	18.8	45.4	56.5

The situation was quite different in care homes. More than 85 percent could walk alone or with cane or crutch; less than 2 percent were unable to get about at all; and 13.1 percent needed major assistance (Table 22).

Bed status - Bed status differences were equally pronounced between nursing homes and care homes. About 61 percent in nursing homes contrasted to 77.0 percent in care homes were out of bed except to sleep or rest -- in other words, bed status was normal.

TABLE 22. NUMBER AND PERCENT OF PATIENTS IN NURSING HOMES AND CARE HOMES BY SELECTED TYPES OF DISABILITY: STATE OF HAWAII, 1960

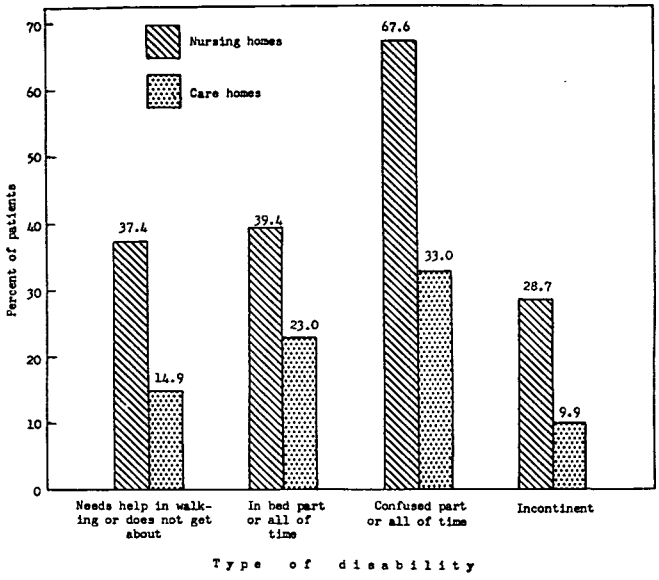
Type of disability	Nursing homes		Care homes	
	Number	Percent	Number	Percent
Total patients	550	100.0	282	100.0
Walking status:				
Alone or with cane or crutch	345	62.6	240	85.1
With walker, wheelchair or other mechanical aid	52	9.4	23	8.1
Only with attendant's help	50	9.1	14	5.0
Does not walk or get about	104	18.9	5	1.8
Bed status:				
Out of bed except to sleep or rest	334	60.6	217	77.0
In bed part of the time	77	14.0	44	15.6
In bed most of time	79	14.3	18	6.4
In bed all of the time	61	11.1	3	1.0
Mental condition:				
Always clear	176	31.9	189	67.0
Confused part of the time	229	41.6	82	29.1
Confused most or all of the time	143	26.0	11	3.9
Unknown	3	0.5	--	0
Continence:				
Continent	392	71.1	254	90.1
Incontinent, feces only	17	3.1	1	0.3
Incontinent, urine only	22	4.0	14	5.0
Incontinent, urine and feces	119	21.6	13	4.6
Unknown	1	0.2	--	0

In nursing homes, 28.3 percent of the patients and in care homes 22.0 percent were in bed part or most of the time. The greatest contrast appeared for patients in bed all of the time -- 11.1 percent in nursing homes and only 1.0 percent (3 patients) in care homes (Table 22).

Mental condition - More than two-thirds of nursing home patients and only one-third of care home patients were mentally confused at least part of the time. About 1 in 4 in nursing homes and 1 out of 25 in care homes were confused most or all of the time (Table 22).

More than 80 percent of the patients under 50 years of age in both types of homes combined were confused at least some of the time. Only about 50 percent of the older patients had some degree of mental confusion (Table 23).

FIGURE 7. SELECTED TYPES OF DISABILITY AMONG PATIENTS IN NURSING HOMES AND CARE HOMES: STATE OF HAWAII, 1960



This age difference is likely due to the fact that a higher proportion of the younger patients was suffering from mental disorders. Confusion among the older patients was more likely the result of arteriosclerotic conditions.

Continence - About 71 percent of nursing home patients and 90.1 percent of care home patients were continent. In nursing homes, about 1 patient in 5 was incontinent with respect to both urine and feces (Table 22).

As indicated in Table 23 showing patients in nursing and care homes as a single group, continence tends to decrease with age. Of those under 50, 91.9 percent were continent; at ages of 80 and over, only 71.9 were continent.

TABLE 23. PERCENTAGE DISTRIBUTION OF PATIENTS IN NURSING HOMES AND CARE HOMES COMBINED BY MENTAL CONDITION AND CONTINENCE IN RELATION TO AGE: STATE OF HAWAII, 1960

Condition	Under 50	50-59	60-69	70-79	80+
Number	85	80	119	229	306
Total patients:					
Percent	100.0	100.0	100.0	100.0	100.0
Mental condition:					
Always clear	17.4	47.6	47.6	48.7	40.3
Confused part of the time	54.7	34.5	39.5	32.2	37.4
Confused most or all of the time	27.9	17.9	11.3	16.5	21.0
Unknown	--	--	1.6	2.5	1.3
Continence:					
Continent	91.9	86.9	76.6	74.2	71.9
Incontinent, feces only	1.2	1.2	3.2	1.3	2.6
Incontinent, urine only	--	1.2	4.0	5.5	5.8
Incontinent, urine and feces	7.0	10.7	21.1	19.1	19.0
Unknown	--	--	--	--	.6

V. PATIENT CARE

With some exceptions, patient care in nursing and care homes of Hawaii, as elsewhere in the country, leaves much to be desired. A recent report of the U.S. Senate Subcommittee on Problems of the Aged and Aging comments as follows:

> "Much of the basic reasons for the present generally inadequate level of medical care and restorative services in nursing homes* lies in the traditional attitudes toward them. They have been regarded as the last stopping place for the old, the point of no return. The inertia of cultural lag leaves most of them far behind our modern concepts and knowledge. A realistic set of criteria for an effective nursing home should include: full-time professional nursing care, physical therapy, casework service, psychiatric attention, the attention of other medical specialists, recreational therapy, and a dynamic, uncompromising drive for

* The term "nursing home," as used in the Subcommittee report, appears to include care homes.

> restoration. This approach calls for a network of services, 'a complete approach, a systematic approach, and not a piecemeal approach.'"(7)

Relative to raising the level of patient care, the Subcommittee made the following recommendations:

> (1) "The Department of Health, Education, and Welfare develop suggested minimum standards for patient care in nursing homes designed to restore and maintain to a maximum degree the physical and mental independence of patients. These minimum standards should be considered as a 'floor' for state standards in their supervision of nursing homes, public and private, which care for patients receiving Federal public assistance grants.
>
> (2) "The Congress consider adoption of a program of financial assistance to nursing homes which meet the minimum standards for medical and restorative services. The Department of Health, Education, and Welfare should be requested to develop a suggested plan and formula for this assistance program."

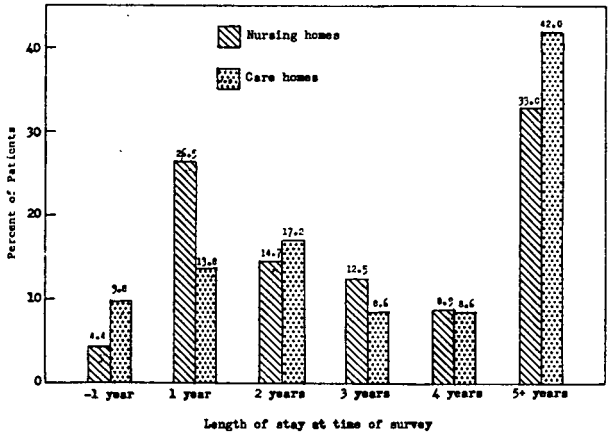
Although some of the data are meager, this section of the present report on nursing homes and care homes attempts to give some insight into the extent and quality of patient care in Hawaii. Subjects included are: The length of time that patients receive care in homes; an estimate of the level of nursing care needed; activity participation; some nursing and personal services patients receive; the categories of nurses rendering services; and the extent to which patients see a physician.

Length of stay - In calculating length of stay, only those homes in operation at least five years were used. Otherwise, homes recently established would necessarily show a large number of patients with only a short length of stay. Data did not include any period that a patient might have spent in some other home.

As of the time of the survey, 33.0 percent of the nursing home patients and 42.0 percent of those in care homes had resided there for 5 years or more. Relatively few in either type of home had come so recently as less than one

year ago (Table 24 and Figure 8). The median length of stay in nursing homes was 3.4 years and 4.1 years in care homes. In care homes, the small number of females included (18) averaged a much shorter stay than males; on the contrary, females in nursing homes stayed somewhat longer than males.

FIGURE 8. LENGTH OF STAY IN NURSING HOMES AND CARE HOMES: STATE OF HAWAII, 1960*



*Note: Percentages are based on patients in homes which had operated at least 5 years.

These data indicate that both types of homes are definitely establishments for long-term care. The characterization "home" is not misplaced in the sense that patients reside there for long periods.

Such lengthy care frequently imposes great financial strain on the patients and their families. It is, therefore, not surprising that public welfare funds wholly or in part must be used to support a high proportion of patients.

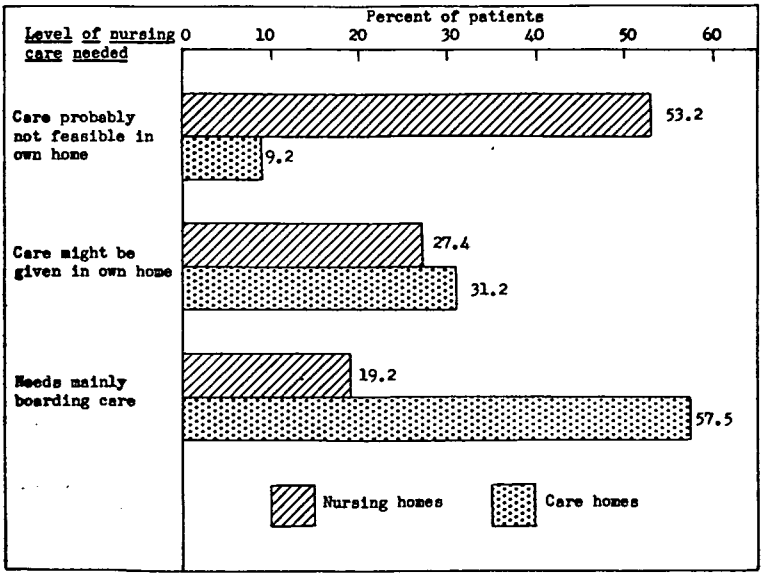
Level of nursing care needed - The home manager or other informant filling out the survey questionnaire was asked to evaluate the need of each patient with respect to the following levels of nursing care:

TABLE 24. NUMBER AND PERCENTAGE DISTRIBUTION OF PATIENTS IN NURSING HOMES AND CARE HOMES BY LENGTH OF STAY AND SEX: STATE OF HAWAII, 1960*

Length of stay	Nursing homes			Care homes		
	Both sexes	Male	Female	Both sexes	Male	Female
	Number					
Total	449	240	209	174	156	18
Less than 1 year	20	13	7	17	15	2
1 year	119	68	51	24	21	3
2 years	66	38	28	30	25	5
3 years	56	25	31	15	12	3
4 years	40	21	19	15	13	2
5+ years	148	75	73	73	70	3
Median	3.4	3.0	3.6	4.1	4.4	1.8
	Percent distribution					
Total	100.0	100.0	100.0	100.0	100.0	100.0
Less than 1 year	4.4	5.4	3.4	9.8	9.6	11.0
1 year	26.5	28.3	24.4	13.8	13.5	16.7
2 years	14.7	15.8	13.4	17.2	16.0	27.8
3 years	12.5	10.4	14.8	8.6	7.7	16.7
4 years	8.9	8.8	9.1	8.6	8.3	11.1
5+ years	33.0	31.3	34.9	42.0	44.9	16.7

* Includes only those patients in establishments in operation at least 5 years. Six patients with length of stay unknown are omitted.

FIGURE 9. ESTIMATED LEVEL OF NURSING CARE NEEDED BY PATIENTS IN NURSING HOMES AND CARE HOMES: STATE OF HAWAII, 1960*



*Note: Estimates are based on the judgment of survey informants. See text for explanation.

(a) Needs the kind of nursing care which you would not ordinarily expect could be given in a person's own home, even with relatives available.

(b) Needs the kind of nursing care which might have been given at home if he'd had such a home with relatives available to help.

(c) Needs mainly boarding care.

The information secured was, of course, subjective depending entirely upon the judgment of the informant. Nevertheless, the figures in Table 25 undoubtedly do have some value in showing the levels of nursing care needed in both types of homes. The considerable difference between the condition of most patients in care homes compared to that of patients in nursing homes is emphasized. The figures also indicate the diversity of patients found in both types of homes.

Somewhat more than half the nursing home patients were judged to be in such condition that adequate nursing care could not ordinarily be expected in their own homes. In care homes, 9.2 percent were placed in the same category. Possibly at least some of these should have been in

TABLE 25. NUMBER AND PERCENTAGE DISTRIBUTION OF PATIENTS IN NURSING HOMES AND CARE HOMES BY LEVEL OF NURSING CARE NEEDED AND SEX: STATE OF HAWAII, 1960

Level of nursing care needed	Nursing homes			Care homes		
	Both sexes	Male	Female	Both sexes	Male	Female
	Number					
Total patients	551	283	268	282	256	26
Could not ordinarily be given in patient's own home	293	136	157	26	18	8
Might be given in patient's own home..	151	95	56	88	82	6
Mainly boarding care..	106	52	54	162	151	11
Unknown	1	--	1	6	5	1
	Percent distribution					
Total patients	100.0	100.0	100.0	100.0	100.0	100.0
Could not ordinarily be given in patient's own home	53.2	48.0	58.6	9.2	7.0	30.8
Might be given in patient's own home..	27.4	33.6	20.9	31.2	32.0	23.1
Mainly boarding care..	19.2	18.4	20.1	57.5	59.0	42.3
Unknown	0.2	0	0.4	2.1	2.0	3.8

nursing homes where a higher level of nursing care is available.

About one out of five (19.2 percent) in nursing homes required mainly boarding care, whereas well over one-half (57.5 percent) in care homes needed only this kind of care. It would appear then that a considerable number of nursing home patients needing mainly boarding care might be transferred to care homes without ill effect.

TABLE 26. PERCENTAGE DISTRIBUTION OF PATIENTS IN NURSING HOMES AND CARE HOMES BY LEVEL OF NURSING CARE NEEDED IN RELATION TO AGE: STATE OF HAWAII, 1960

Level of nursing care needed	Under 50	50-59	60-69	70-79	80+
	Nursing homes				
Number	75	56	69	153	193
Total patients:					
Percent	100.0	100.0	100.0	100.0	100.0
Could not ordinarily be given in patient's own home	86.7	64.3	66.7	37.9	45.1
Might be given in patient's own home	13.3	30.4	21.7	35.9	25.9
Mainly boarding care	0	5.3	10.1	26.2	29.0
Unknown	0	0	1.5	0	0
	Care homes				
Number	10	24	50	76	113
Total patients:					
Percent	100.0	100.0	100.0	100.0	100.0
Could not ordinarily be given in patient's own home	20.0	8.3	16.0	10.5	4.4
Might be given in patient's own home	20.0	33.3	18.0	29.0	38.9
Mainly boarding care	60.0	54.2	66.0	59.2	54.9
Unknown	0	4.2	0	1.3	1.8

Table 26 indicates judgments on the level of nursing care needed by age. For younger patients under 50 in nursing homes, the great majority (86.7 percent) were thought to require nursing care not ordinarily expected in the home. This is related to the considerable number of nursing home patients having mental disorders. Patients 50 and over averaged only about 48 percent in the

same category. Older patients 70 and over were those most likely to need mainly boarding care.

In neither type of home does the level of nursing care appear to increase with age. In care homes, it is striking that at least 93.8 percent of those 80 years of age and over were judged to need only minimal care or care that might have been given in their own homes.

TABLE 27. PERCENTAGE DISTRIBUTION OF PATIENTS IN NURSING HOMES AND CARE HOMES BY ACTIVITY PARTICIPATION AND SEX: STATE OF HAWAII, 1960

Activity	Males			Females		
	Total	Does not perform activity	Does perform activity	Total	Does not perform activity	Does perform activity
	Nursing homes*					
Receives visitors	100.0	45.6	54.4	100.0	18.7	81.3
Receives and writes letters	100.0	85.2	14.8	100.0	70.9	29.1
Listens to radio or TV	100.0	34.3	65.7	100.0	33.2	55.6
Reads newspaper, magazines or books	100.0	54.4	45.6	100.0	53.0	47.0
Does handiwork, arts or crafts	100.0	93.6	6.4	100.0	69.0	31.0
Takes part in games	100.0	71.4	28.6	100.0	80.6	19.4
Helps with the work	100.0	89.4	10.6	100.0	80.2	19.8
Goes off the grounds	100.0	57.6	42.4	100.0	53.0	47.0
Works in garden	100.0	86.6	13.4	100.0	98.1	1.9
Walks about grounds	100.0	48.8	51.2	100.0	48.9	51.1
	Care homes **					
Receives visitors	100.0	61.3	38.7	100.0	34.6	65.4
Receives and writes letters	100.0	92.6	7.4	100.0	80.8	19.2
Listens to radio or TV	100.0	16.0	84.0	100.0	57.7	42.3
Reads newspaper, magazines or books	100.0	48.8	51.2	100.0	73.1	26.9
Does handiwork, arts or crafts	100.0	96.1	3.9	100.0	69.2	30.8
Takes part in games	100.0	64.5	35.5	100.0	84.6	15.4
Helps with the work	100.0	80.9	19.1	100.0	88.5	11.5
Goes off the grounds	100.0	48.0	52.0	100.0	61.5	38.5
Works in garden	100.0	87.9	12.1	100.0	96.2	3.8
Walks about grounds	100.0	37.5	62.5	100.0	80.8	19.2

* Of the males, 26.5 percent, and of the females, 22.8 percent did not participate in any of the activities listed.

** Nine percent of the males and 23.1 percent of the females did not engage in any of the activities listed.

Activity participation - Table 27 shows a selected list of activities in which patients of nursing homes and care homes do or do not participate. About one out of four (24.1 percent) in nursing homes and one out of 10 (10.8 percent) in care homes did not take part in any of the activities listed.

Due to a better medical condition, males in care homes were more likely than males in nursing homes to take part in activities requiring physical exertion, such as games, helping with the work, and walking about the grounds. On the other hand, females in care homes appeared less likely than nursing home females to participate in such activities.

Both males and females in nursing homes were much more likely than their care home counterparts to receive visitors and to write or receive letters. Males in care homes were the most avid listeners to radio or TV. Females in both types of homes did more handiwork, arts, and crafts than males, but were much less likely to work in the garden.

It is of particular note that 32.5 percent of those in nursing homes and 58.9 in care homes did not have visitors. This may indicate an opportunity on the part of appropriate volunteer agencies to arrange occasional social visits to nursing and care homes.

Services received - Some of the more common services rendered in homes and the proportion of patients receiving each service are shown in Table 28. As would be expected, a far higher percentage in nursing homes received most of the services. For example, 30.7 percent in nursing homes and only 7.4 in care homes required a special diet.

The frequency with which the services are given is indicated in Table 29. Table 30 shows the types of diet being followed.

TABLE 28. PROPORTION OF PATIENTS IN NURSING HOMES AND CARE HOMES RECEIVING SPECIFIED SERVICES: STATE OF HAWAII, 1960

Service received	Nursing homes	Care homes
Number of patients	551	282
	Percent of patients	
Help in feeding	22.1	8.9
Help in dressing	44.3	20.9
Care of hair	62.3	38.7
Shaving	34.5	31.2
Help with tub bath or shower	63.2	24.1
Full bed bath	20.0	9.2
Rub and massage	29.8	8.2
Bed pan	18.3	.7
Enema	27.4	4.3
Hyperdermic injection	5.4	8.9
Dressings	11.1	11.0
Medications	63.2	45.4
Take pulse, temperature or respiration	63.3	14.9
Special diet	30.7	7.4

Some additional services applying only to nursing homes not listed in Table 28 are as follows:

	Percent of Patients
"Tender loving care"	7.4
Vigilance	1.8
Physical therapy	4.0
Retention catheter	.2

With a high proportion of patients in nursing homes able to get about only with difficulty or not at all (Table 22) and with a large segment not participating in any of the activities listed in Table 27, it is of note that only 4.0 percent (22 patients) were receiving physical therapy. No mention was made of such treatment for any of the care home patients.

Table 31 indicates the category of nurse giving the majority of treatments and the greater part of care. As might be surmised from previous data on staffing, most patients in care homes (80.4 percent) receive services from nurse aides. On the other hand, in nursing homes, registered nurses and licensed practical nurses give the greater part of treatments and care.

TABLE 29. FREQUENCY OF RECEIVING SPECIFIED SERVICES IN NURSING HOMES AND CARE HOMES: STATE OF HAWAII, 1960

Service received	Number receiving specified service	Percent receiving specified service				
		Once a week	Several a week	Once a day	Several a day	Irregularly
		Nursing homes				
Help in feeding	122	--	0.8	1.6	88.6	9.0
Help in dressing	244	--	12.3	16.8	67.6	3.3
Care of hair	343	8.7	14.9	13.1	20.4	42.9
Shaving	190	1.1	93.2	4.7	--	1.0
Help with tub bath or shower	348	3.4	46.3	48.9	--	1.4
Full bed bath	110	--	34.6	61.8	3.6	--
Rub or massage	164	--	6.1	23.2	68.3	2.4
Bed pan	101	--	1.0	3.0	72.3	23.7
Enema	151	9.9	25.2	0.7	--	64.2
Hypodermic injection	30	--	16.7	50.0	3.3	30.0
Dressings	61	--	3.3	37.7	24.6	34.4
Medications	348	0.3	2.9	18.4	74.7	3.7
Take pulse, temperature or respiration	349	39.3	35.8	4.3	2.0	18.6
		Care homes				
Help in feeding	25	--	8.0	--	92.0	--
Help in dressing	59	--	3.4	30.5	47.5	18.6
Care of hair	108	26.8	2.8	6.5	2.8	61.1
Shaving	88	47.7	28.4	--	2.3	21.6
Help with tub bath or shower	68	8.8	33.8	35.3	4.4	17.7
Full bed bath	26	76.9	3.8	15.4	3.9	--
Rub or massage	23	--	17.4	60.9	13.0	8.7
Bed pan	2	--	--	--	100.0	--
Enema	12	--	8.3	--	--	91.7
Hypodermic injection	25	--	--	8.0	--	92.0
Dressings	31	--	6.5	12.9	--	80.6
Medications	128	3.1	5.5	20.3	32.8	38.3
Take pulse, temperature or respiration	42	--	--	4.8	2.4	92.8

Physician or clinic visits - About 60 percent of the patients in each type of home had a physician or clinic visit within the past 30 days (Table 32). In nursing homes, one out of four patients had seen a physician 5 or more times during this period; in care homes, only one out of 17 had seen a physician that many times. This, of course, reflects the better condition of care home patients healthwise.

TABLE 30. TYPES OF SPECIAL DIETS RECEIVED IN NURSING HOMES AND CARE HOMES: STATE OF HAWAII, 1960

Type of diet	Nursing homes	Care homes
Number receiving special diet	169	21
Low salt	58	9
Salt free	12	—
Soft	34	1
Bland	14	1
Diabetic	26	5
Low carbohydrates	2	—
Low calorie	5	—
High calorie	3	—
Low fat	3	1
Pureed or semi-liquid	3	2
High protein	1	2
Ulcer	1	—
Hypertension	1	—
Allergy	1	—
Underweight	1	—
Vegetarian	1	—
Junior food	1	—
Racial	1	—
Control	1	—

Tabulations by age showed that patients 60 years of age and over were more likely to require a physician than the younger patients. About 47 percent of those under 60 and 62.8 percent of those 60 and over had seen a physician within the past 30 days. Physician or clinic visits were also more frequent for the older patients. Of all those in nursing and care homes combined who were 60 and over, one out of five had seen a doctor five or more times within the past 30 days.

TABLE 31. PERCENTAGE DISTRIBUTION OF PATIENTS IN NURSING HOMES AND CARE HOMES BY CATEGORY OF NURSE GIVING MAJORITY OF TREATMENTS AND CARE: STATE OF HAWAII, 1960

Category of nurse	Nursing homes	Care homes
Number*	516	214
Total patients:		
Percent	100.0	100.0
Registered nurse	33.9	18.2
Licensed practical nurse	43.4	1.4
Aide	22.7	80.4

* In nursing homes, 42 patients and in care homes, 68 patients receiving no treatments are omitted.

Table 34 showing the reasons for physician or clinic visits is incomplete

TABLE 32. NUMBER AND PERCENTAGE DISTRIBUTION OF PATIENTS IN NURSING HOMES AND CARE HOMES BY NUMBER OF PHYSICIAN OR CLINIC VISITS DURING PAST 30 DAYS: STATE OF HAWAII, 1960

Number of physician or clinic visits	Number		Percent distribution	
	Nursing homes	Care homes	Nursing homes	Care homes
Total patients.....	551	282	100.0	100.0
None	224	112	40.7	39.7
1-2 visits	182	101	33.0	35.8
3-4 visits	9	53	1.6	18.8
5 or more	136	16	24.7	5.7

TABLE 33. PERCENTAGE DISTRIBUTION OF PATIENTS IN NURSING AND CARE HOMES COMBINED BY NUMBER OF PHYSICIAN OR CLINIC VISITS DURING PAST 30 DAYS AND AGE: STATE OF HAWAII, 1960

Number of physician or clinic visits	All ages	Under 40 years	40-59 years	60+ years
Number	833	47	120	666
Total patients:				
Percent	100.0	100.0	100.0	100.0
None	40.3	53.2	53.3	37.2
1-2 visits	34.0	29.8	31.7	34.4
3-4 visits	7.4	10.6	2.5	8.1
5 or more	18.3	6.4	12.5	20.3

in that the reason is not stated for more than half the patients who saw a physician within the past 30 days. Nevertheless, at least some information may be gleaned from the data. For example, it appears that nursing home patients were those most likely to have medical checkups.

TABLE 34. NUMBER OF PATIENTS ACCORDING TO REASON FOR LAST PHYSICIAN OR CLINIC VISIT: STATE OF HAWAII, 1960

Reason for last physician or clinic visit	Nursing homes	Care homes
Total patients with physician or clinic visit within past 30 days	327	170
Check-up	164	25
Rash	1	--
Fractures	3	--
Bladder infection	3	2
Gastric upsets	2	1
Pain in face	1	--
Leg swollen	--	3
Rheumatism	--	1
Virus	--	1
Fall	--	2
Infection	--	3
Cyst removed	--	1
Diarrhea	--	1
Blood pressure	1	4
Nervous condition	1	--
Abdominal pain	2	2
Pain in arm	--	1
Eye medication	--	2
Dressings changed	--	3
Blood transfusion	--	1
Catheter	--	2
Constipation	--	3
Cardiac	--	1
Dizziness	--	1
Removal of sutures from scalp	--	1
Not stated	149	109

SUMMARY

The Homes

Nursing homes and care homes of the state in 1960 had a combined bed capacity of 1,057 or 1.8 beds per 1,000 population.

The average number of beds per nursing home was 43.5 and per care home 12.6.

Nearly 50 percent of the employees in care homes were part-time; in contrast, only 12 percent in nursing homes were part-time.

Nursing homes had an average of 21.2 patients to each registered professional nurse employed. The use of this category of nurse was negligible in care homes.

The median monthly rate for care was $167 in nursing homes and $83 in care homes.

In nursing homes, 57.3 percent of the patients and in care homes 66.6 percent were financed wholly or in part by public assistance funds.

Patient Characteristics

The median age of patients was 74.8 years in nursing homes and 76.9 years in care homes.

Nursing homes had only a few more male than female patients. In care homes, patients were predominately male -- only 9.2 percent (26 patients) were females.

Nursing and care homes of Hawaii have a much higher proportion of single men than in similar homes in the country as a whole.

Caucasians constituted the largest group in nursing homes. In care homes, the most numerous groups were Japanese and Chinese in almost equal proportions.

About 87 percent in nursing homes and 92 percent in care homes resided in the same county before admission.

In nursing and care homes combined, 13.7 percent of the males and 25.6 percent of the females had homes and families.

Medical Condition

The major medical diagnosis for patients in both types of homes was a cardiovascular condition. Neurological conditions were also prominent in nursing homes and senility in care homes.

About one-fourth (25.4 percent) of the patients in nursing homes and 7.4 percent in care homes were in bed most or all of the time.

Twenty-nine percent of the nursing home patients and 9.9 percent of the care home patients were incontinent.

Patient Care

Median length of stay was 3.4 years in nursing homes and 4.1 years in care homes.

Survey informants estimated that 46.6 percent of the nursing home patients and 88.7 percent of the care home patients required only boarding care or the type of nursing care that might be given in the patients own home.

One-fourth (24.1 percent) of the nursing home patients and one-tenth (10.8 percent) of the care home patients did not participate in any of a selected list of activities, including such items as receiving visitors, walking about the grounds, and reading.

In nursing homes, registered nurses and licensed practical nurses gave the greater part of treatments and care; in care homes, most patients received care and treatments from nurse aides.

Only 4.0 percent (22 patients) were receiving physical therapy in nursing homes. No mention was made of such treatment for any of the care home patients.

About 60 percent of the patients in both types of homes had a physician or clinic visit within 30 days prior to the time of survey. However, for patients having them, such visits were more frequent in nursing homes -- reflecting the more serious medical conditions in this type of establishment.

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