NURSING HOMES

HEARINGS

BEFORE THE

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SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

EIGHTY-SEVENTH CONGRESS

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NOTE.—Six hearings on nursing homes were held and they are identified as follows:

Part 1.—Portland, Oreg.
Part 2.—Walla Walla, Wash.
Part 3.—Hartford, Conn.
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NURSING HOMES

FRIDAY, DECEMBER 1, 1961

U.S. SENATE,
SUBCOMMITTEE ON NURSING HOMES
OF THE SPECIAL COMMITTEE ON AGING,
Boston, Mass.

The subcommittee met, pursuant to call, at 10 a.m., in the Gardner Auditorium, statehouse, Senator Benjamin A. Smith presiding.

Present: Senator Benjamin A. Smith and Senator Leverett Saltonstall.

Committee staff members present: Dr. Frank Atelsek, research director; Frank C. Frantz, professional staff member; and Edith Robins, professional staff member.

Senator SMITH. The public hearing of the Senate Special Committee on Aging will please come to order.

It is a great pleasure for me to welcome all of you to this subcommittee hearing of the Senate Committee on Aging.

The Special Committee on Aging was established last February by a Senate resolution which called for a year of study and information gathering on the full range of problems of our older citizens. The resolution also charges us with making reports of our findings and recommendations to the Congress next year.

To do this job the committee has scheduled more than 30 hearings in all parts of the country this fall. These subcommittee hearings are inquiring into four subject areas: retirement income, housing for the elderly, nursing home care, and Federal and State activities in the field of aging.

When these hearings are completed, the committee will have the most extensive collection of up-to-date information ever assembled on the problems of the aging and the aged. The record of testimony and discussion will be studied by the committee members and the staff, and will form the basis for our reports and recommendations to the Congress.

The hearing this morning is on the subject of nursing homes. We will hear from public officials concerned with nursing home services, representatives of nursing homes, and from other experts who have special knowledge of problems in this field.

This is not at all an investigation of nursing homes in Massachusetts. We hope to learn of the progress that has been made and the goals that have been set in expanding and improving nursing home care in the Commonwealth. We expect that this information will be of interest to other States which have the same kinds of problems. And the experience of other States where we are having hearings on nursing homes will be of interest to us here in Massachusetts. The results of these hearings, taken together, may point to some ways in

which Federal programs may help advance nursing home care in this country.

The nursing home has an increasingly important role to play in the whole complex of medical and related services to older people. It is in this kind of institution that much of the new knowledge in geriatrics and in restorative medicine can be made to benefit people of advanced years who suffer from long-term or chronic illnesses. The problems that must be solved before nursing homes can fulfill their potential in this role are nationwide and extremely urgent. They are deserving of our most careful study and diligent efforts.

I would like to announce at this time that Senator Saltonstall will be here later on this morning and he, too, is extremely interested in this great problem that faces this Nation today.

There will be one change in our schedule of appearances of witnesses due to the fact that Dr. Taubenhaus has an important engagement in a classroom at Harvard this morning. Our first witness, then, will be Dr. Leon J. Taubenhaus, director of the Brookline Health Department.

Doctor, it is a great pleasure to have you with us this morning.

STATEMENT OF DR. LEON J. TAUBENHAUS, DIRECTOR, BROOKLINE HEALTH DEPARTMENT

Dr. TAUBENHAUS. Thank you, Senator. If I may, I would like to read my statement, sir, because it is brief and then I will be glad to answer any questions you may wish to ask.

Senator SMITH. Thank you.

Dr. TAUBENHAUS. I am Dr. Leon Taubenhaus, director of public health for the town of Brookline, Mass., and lecturer on public health practice at the Harvard School of Public Health. The testimony I am about to give is based on the knowledge and experience I have gained as a local health officer with an active interest in the field of nursing homes.

In the town of Brookline, which I represent, nursing homes are a major public health concern. Although we are a community of about 54,000 people, 16.5 percent are age 65 or older. We have more people above age 65 than we have children in our public schools. Proprietary nursing homes are a major industry in our otherwise residential community. We have 27 licensed nursing homes with a total of 698 beds. More than half of our nursing home patients come from other communities, and more than half are recipients of public welfare.

It is only natural then, that our health department is interested in nursing homes. When I first entered the field of public health, I believed more stringent regulations were all that were needed to improve nursing home care. I now know that I was wrong. Regulations are, of course, important, but one cannot enforce a high level of nursing home care by regulation alone. I have found that many proprietary nursing home operators would like to raise the level of care, but they do not have the training nor resources to do this. I feel that to raise standards of nursing home care, one must mobilize community resources to assist the nursing homes in this task.

Although there are many deficiencies in present nursing home services, we do not know the maximum level of care that one can expect from a nursing home serving patients at current welfare rates. We equate nursing home care with chronic hospital care, but we pay the nursing home much less than we pay the chronic hospital. This is an unrealistic point of view. We must, through research, learn what is the best care we can expect from a nursing home at any level of payment. Then we can estimate what resources or assistance are needed to meet our desired level of patient care.

In our desire to help nursing homes raise standards, we are often inhibited by the philosophy that nursing homes are proprietary institutions and therefore should not receive any public support. We forget that most of the patients in nursing homes are financed by tax dollars and that a few extra dollars might be a good public investment if better patient care is assured.

Proprietary nursing homes, unlike almost any other type of medical care institution, are isolated from community health resources. This is due to their historical development. Because they originated as commercial enterprises set up by nonmedical entrepreneurs, they were ignored and looked down on by the medical profession and hospitals. As a result of this original rejection they are still insulated from the hospital and the medical profession. They are often regarded by those who could help the most as a necessary evil.

Stricter regulation is often proposed as the only solution. The need for ways to break down this isolation from the mainstream of medical care is quite urgent. Much improvement can be credited to the efforts of the nursing homes themselves and to their association. I do believe, however, that with outside help from governmental and voluntary agencies at all levels (local, State, and National) higher standards of nursing home care can be reached and maintained.

I would like to describe, as an example, what we are doing in Brookline. For the past 5 years we have had an informal committee of local nursing home operators and health department personnel. We met from time to time to try to identify the problems of nursing homes and to see if we could provide solutions, and these were solutions at a local level only.

Our first effort was a failure. We identified the need for recreational programs for patients in nursing homes as an urgent one, but we were unable to obtain the necessary funds. After this we had better luck. With the assistance of the American Red Cross and the visiting nurse service, we gave several courses for nursing home attendants. The nursing homes sent their personnel on paid time. The results were gratifying. We have evidence of improved patient care given by those who took the course.

Although nursing homes are licensed by the State, we inspect for sanitation and safety. We have added a nurse to the inspection team who is available to advise the home on problems she notes during her inspection.

We deliver and loan, without charge, portable dental equipment, including X-ray for use by practicing dentists in treating their shut-in and nursing home patients. Now, for the first time a Brookline dentist can treat a case in a nursing home using adequate equipment.

More recently we were approached by Dr. James E. C. Walter, as-

sistant director of the Peter Bent Brigham Hospital, who was concerned about the current level of patient care in nursing homes and willing to work with us to raise standards. Together with him we have developed a plan for a demonstration program which will be supported for 3 years by the U.S. Public Health Service.

This program envisages a local health department developing an administrative structure that will allow the mobilization of community resources to help raise nursing home standards. The voluntary hospital will help by supplying needed technical, medical, and professional supervision. We hope eventually to involve as many other resources as possible including voluntary health agencies, other hospitals and schools of nursing, social work, medicine, and public health.

As our demonstration progresses, we will try to do four things:

(1) Develop continuing training courses for all levels of nursing home personnel.

(2) Provide consultation services to nursing homes. These will include medical care, nursing, nutrition, administration, housekeeping, bookkeeping, purchasing, et cetera. We will lean heavily on the Peter Bent Brigham Hospital for many of these services, but will also utilize personnel from the health department as well as other organizations.

(3) Coordination of community health agencies to help nursing homes develop programs leading to better patent care. Many categorical health agencies such as those interested in diabetes, cancer, heart disease, arthritis, and tuberculosis share an interest in nursing homes along with such general agencies as hospitals, visiting nurse associations, and rehabilitiation groups. We will try to utilize their interests to develop specific demonstration programs in individual homes.

(4) Train selected patients for self-help projects within the home. This will not only be beneficial to the patient as a form of occupational therapy, but it will also free trained personnel to carry out other patient care duties in the home. This type of program has been quite successful in veterans' hospitals and should apply to nursing homes as well.

In conclusion, we feel that there are two major areas of activity in which the Federal Government can be of great help. The Community Health Services and Facilities Act of 1961 will be extremely helpful when it gets into operation and should be continued and expanded. We also feel that federally directed programs aimed at encouraging local medical and health resources such as physicians, hospitals, and health agencies to take the leadership and bring nursing homes back into the mainstream of medical care are also urgently needed. Thank you, sir.

Senator SMITH. Thank you very much, Dr. Taubenhaus. We certainly appreciate this testimony. Let me say at this time that I realize the very fine work that Brookline is doing in this field and I urge you to keep up the splendid efforts.

I have just one question that I would like to ask you. What approach is your program taking to the problems of proper placement of patients in homes and the free transfer between nursing homes and acute hospitals?

Dr. TAUBENHAUS. Well, we have built our program primarily around a hospital. We are starting out and we have not got in full operation yet, Senator, but what we have done is to have the hospital people come into the nursing homes and spend some time there so they can see what it is like in a nursing home. It is very easy for the hospital people on one side to say what the nursing home should be doing and the nursing home on the other to say what the hospital should be doing.

We felt the first thing to do was to bring them together. We have had nurses from the hospitals go in and visit nursing patients. We have tried to have nursing home personnel come into the hospital. We hope that the hospital will have some chance to follow their cases when they get within the home. Using the hospital as a resource in this way we feel that we may be able to bridge this gap. The details will have to be worked out by experience.

Senator SMITH. I see. One other question, Doctor, in regard to nutrition. Could you tell me what steps are being taken there?

Dr. TAUBENHAUS. We have already had a nutritionist come in and review the menus in one nursing home. We found out, for example, in this home that they were buying only dietetic foods. This is not necessary. We showed the nursing home, for example, how by bringing the hospital nutritionist in as a consultant, she was able to save them money by setting up their diets more economically, but still providing better diets.

Senator SMITH. I think this is a most important part of it.

Dr. TAUBENHAUS. One of the things we hope will come out of this project is that the nursing home people will learn where and how to look for this kind of help. There is plenty of help available, but the communication barrier has been one of the obstructions. This we are trying to break down.

Senator SMITH. One last question, Doctor. Do you suggest any new Federal programs?

Dr. TAUBENHAUS. I don't think so much that new programs are needed as much as strengthening the existing ones, particularly the community facilities. I would like to see the Public Health Service put more emphasis on the responsibility of local medical and professional resources to remember the nursing homes. I think we need leadership more than we need anything else.

Senator SMITH. Thank you very much, Doctor.

Dr. TAUBENHAUS. Thank you.

Senator SMITH. Our next witness will be Mr. Robert P. Curran, deputy commissioner of public welfare, Commonwealth of Massachusetts. He is presenting the testimony of Commissioner Patrick A. Tompkins who will not be here this morning.

Mr. Curran.

STATEMENT OF ROBERT P. CURRAN, DEPUTY COMMISSIONER OF PUBLIC WELFARE, COMMONWEALTH OF MASSACHUSETTS

Mr. CURRAN. Mr. Chairman and members of the committee, my name is Robert P. Curran, deputy commissioner of public welfare, Commonwealth of Massachusetts. I wish to read the testimony of Mr. Patrick A. Tompkins, commissioner of the department.

It has been my informal understanding that the subject matter of today's hearing is confined to the authorized nursing home program within the Commonwealth of Massachusetts. The State department of public welfare has no official authoritative responsibility with respect to such homes other than its authority to visit, on its own motion, any recipient of public assistance who is a patient in such a home. The department has, however, collaborated with both the official licensing agency of the department of public health, boards and managers of voluntary and charitable nursing homes, and officers and managers of proprietary nursing homes on a variety of matters affecting the interest, health, and welfare of patients in such homes, both patients on public assistance and nonassistance patients.

It is unnecessary at this time to dwell on the fact that responsible governmental and nongovernmental leaders in the health and welfare fields for many years have been concerned about the growing population of aged people and the accelerating numbers of sick aged people in need of continuing medical institutional care. The numbers of such sick aged people receiving either old-age assistance or medical assistance for the aged in Massachusetts have increased markedly in the last 5 years.

Despite inferences and allegations to the contrary, this concern of both governmental and nongovernmental leaders has resulted in a number of progressive and salutary efforts to improve the quality of nursing home care and guarantee both to the community and to the relatives of the sick aged that skilled nursing care, plus kindly, sympathetic, and understanding treatment of the sick aged person will, in fact, be available in all such nursing home facilities within the Commonwealth.

Let me cite some of these efforts:

(1) Many years ago the General Court of the Commonwealth of Massachusetts, to be specific in 1948, enacted legislation establishing the State department of public health as the standard setting and licensing agency for all nursing homes offering nursing home care to more than two paying patients.

(2) The problem of adequate staffing of the division of licensing has been continuously brought to the attention of a succession of chief executives and a succession of different sessions of the General Court with moderate successful results.

(3) Some years ago, the general court vested in the division of hospital costs and finances of the Commonwealth the responsibility for determining reasonable, equitable, and adequate payments for public assistance recipients who needed and received nursing home care in an authorized and licensed nursing home. The per diem payment for such public assistance patients has been increased three times in the last several years.

(4) The Boston College School of Nursing is conducting a research study, supported by a grant from the National Institutes of Health, to estimate the nursing needs of nursing home patients in Massachusetts. This project was undertaken initially at the request of the Massachusetts Department of Public Health and the Massachusetts Federation of Proprietary Nursing Homes.

(5) The Massachusetts Federation has also sponsored a series of seminars at Northeastern University in the city of Boston for improv-

ing management techniques and services to patients in such nursing homes.

(6) The great Peter Bent Brigham Hospital, in collaboration with Brandeis University and the Brookline Public Health Department, has sponsored a research project for purposes of evaluating quality of care in proprietary nursing homes.

(7) The Greater Boston Jewish community has under construction at the immediate moment a new nursing home which has, as its objective, the finest such facility in the country. Other denominations—Unitarian, Episcopalian, Baptist, and Lutheran groups—for long years past managed outstanding homes for the aged, most of which have been converted, because of the prolongation of age, into nursing homes of the finest type for the aged of their denominations. The several Roman Catholic dioceses within the Commonwealth of Massachusetts have a multiple number of outstanding homes for the aged, virtually all of which are licensed also to provide nursing home care.

Many of these religious groups admit patients irrespective of creed, color or national origin. Many have contemplated expansion plans, either in action or under consideration and, in turn, are supplemented by a number of eleemosynary charitable nonsectarian institutions. The department of public health has also instituted a regulation that all new nursing home facilities must be of original construction, rather than the traditional conversion of old mansions no longer usable for home or family into nursing home facilities.

All of these collective individual efforts augur well for the professional protection and care of the sick aged, the improvement of the quality of such care, and the continued interest of both governmental and nongovernmental leaders concerned with the adequate provision of a variety of services to our aging population.

Since other witnesses have a greater competence to testify and comment on specific problems with respect to such nursing homes and the quality of care presently provided, I shall conclude my testimony by stating that I believe that the organized community of Massachusetts and the organized leadership of the several metropolitan areas, wherein the great majority of our aged people are located, are alert to, and progressively planning for, protective medical and nursing services for the aging population of the Commonwealth.

Senator SMITH. Thank you very much, Mr. Curran.

I have a question, Mr. Curran. How difficult are the problems of your staff in finding the appropriate placements for their clients in nursing homes? How difficult is that? How much of a problem is that for your people now?

Mr. CURRAN. I am not able to answer that, being on the State level. That is handled by the local board of public welfare.

Senator SMITH. It does not affect you, that problem?

Mr. CURRAN. They have that problem. We help if we can but generally they do it.

Senator SMITH. Tell me, Mr. Curran, when you find a situation in a nursing home that is not up to your standards, what action do you take?

Mr. CURRAN. We bring it to the attention of the department of public health. They are the licensing authority for those homes.

Senator SMITH. I see. So you make recommendations?

Mr. CURRAN. That is true.

Senator SMITH. Thank you very much, Mr. Curran, for this testimony.

At this time, ladies and gentlemen, I would like to remind you that the afternoon session, commencing at 2 p.m., will be open to suggestions and remarks from any of those people in the audience, who are not listed as speakers this morning, to give their opinions and their views on any of the problems that confront the aged. I will look forward to hearing from as many of you as possible.

Our next witness this morning will be Dr. A. Daniel Rubenstein, deputy commissioner of public health and director of the division of hospital facilities, Commonwealth of Massachusetts.

Dr. Rubenstein, it is a great pleasure to see you here this morning.

STATEMENT OF DR. A. DANIEL RUBENSTEIN, DEPUTY COMMISSIONER OF PUBLIC HEALTH AND DIRECTOR, DIVISION OF HOSPITAL FACILITIES, COMMONWEALTH OF MASSACHUSETTS

Dr. RUBENSTEIN. Thank you, Senator Smith; it is a pleasure to be here.

Senator Smith and members of the committee, I am Dr. Daniel Rubenstein, deputy commissioner of public health, and I am appearing here at the request of the commissioner of public health.

In Massachusetts the responsibility for the licensure of medical care facilities, including nursing homes and rest homes, is the function of the division of hospital facilities of the department of public health under sections 71–73 of chapter 111 of the General Laws. Prior to 1948 a program of hospital licensure by the department of public health had been in existence in the Commonwealth since 1941, and it was not until 1948 that this law was amended to establish a program for the licensure of nursing homes and to transfer the licensing of boarding homes for the aged, currently designated as rest homes, from the department of public welfare to the department of public health.

Since 1948 there has been a tremendous expansion in the number of nursing homes throughout the commonwealth. At the present time, there are 738 nursing homes with 21,915 beds and 510 rest homes with 7,731 beds. Standards in nursing homes in the Commonwealth have improved at a fairly constant rate in spite of insufficient inspectional personnel and also bearing in mind the financial limitation set by the rate of reimbursement for public assistance patients as established by statutory requirements.

When the department assumed responsibility for the licensing of nursing homes and rest homes it soon became apparent that this was to be no easy task. Although there were a number of good homes, many were obviously poor. Among the more pressing problems in such homes were shortages of personnel, poor sanitation, and patient accommodations, inadequate medical supervision, nursing care, nutrition, and equipment. There were those who felt that lack of adequate facilities for rehabilitation was a serious inadequacy in such homes. While this was true in general, it became apparent to the staff of the division that, since the average age of patients in nursing

homes and residents in rest homes was in the vicinity of 70 years, rehabilitation in the sense of physical restoration for job training and employment was an unrealistic goal; therefore, emphasis was directed toward promotion of self-help and prevention of further disability.

While there was an acute need for better recreational facilities and diversional activities in these homes, the most urgent need was to improve the environment and to provide a clean, comfortable home with adequate, nutritious, well-balanced diet, good medical supervision and nursing care, and a pleasant, happy, homelike environment. The achievement of this goal became the immediate objective of the staff of the division of hospital facilities.

When it was established by study that 60 percent of the persons in nursing homes and rest homes were cared for by public assistance and that many homes would accept but a small proportion of public assistance patients because of the low rates paid for their care, difficulties in this regard became apparent. If standards were to be pushed too rapidly by the department of public health, greater limitations on the number of public assistance patients would have been imposed by some homeowners.

When the general court enacted legislation requiring licensing of city and town infirmaries by the department of public health this soon constituted a considerable portion of the division's activites. Prior to 1953 the department of public welfare could only make recommendations to local welfare boards regarding these infirmaries. Rarely were this department's recommendations carried out. If the status of nursing and rest homes in 1948 were to be described as poor, then conditions with very few exceptions in city and town infirmaries in 1953 utilizing the same standards would have to be considered deplorable. It is difficult to put into words the sorry conditions found in many of these infirmaries. In one such institution erected early in the 19th century, bricks falling from a crumbling wall constituted a hazard not only to the residents of the home but to persons passing by in the neighborhood while falling ceilings were observed in the residents' rooms and wards. In some instances the department of public safety had refused to issue certificates of inspection indicating compliance with minimum standards in regard to fire and egress. In one community the local board of health had made violent protests to the welfare department in regard to the continued occupancy of the local infirmary by human beings. No attention had been paid to the pleas of the board of health because no licensing law was in effect. Life in many of these institutions may properly be described as a bare existence.

When the division became responsible for the licensing of these infirmaries many closed and, as time went on, 30 city and town infirmaries, or slightly more than 50 percent, ceased to operate either as a result of action instituted by the department of public health or by voluntary closure. Currently in operation are 27 infirmaries with 1,769 beds and 14 public medical institutions with 1,327 beds.

Improvement in all phases of nursing and resthome operation has become apparent during the past 12 years. This has been most marked in areas where the staff has been concentrating its activities; namely, in medical supervision, nursing care, dietary service, records, patient accommodations and equipment, housekeeping and general maintenance. It is expected that recent revisions of nursing home regulations will result in additional improvement in nursing home care, equipment, and facilities. Increases in the rate of payment for public assistance patients, as indicated by Mr. Curran, have been of considerable value in bettering conditions in many of these homes.

In general, the program of the division of hospital facilities has had two facets, one regulatory and the other educational. Examples of the kinds of educational activities carried on by the division are the following:

(1) Seminars at the annual meetings of the Massachusetts Federation of Nursing Homes, and at this point I would like to say the Massachusetts Federation of Nursing Homes has been very cooperative in this whole area.

(2) Institutes for nursing home personnel conducted in cooperation with universities, colleges, local hospitals and nursing homes throughout the State. We have just had an institute of that type at Northeastern University yesterday.

(3) Institutes and refresher courses in cooperation with schools of nursing and schools for practical nurses in Massachusetts.

(4) On a demonstration basis to improve rehabilitative and restorative services in a limited number of nursing homes in certain areas of the State.

Through the years, however, it has been extremely difficult to offer sufficient services in this area commensurate with the growth of the nursing home movement. The division's program has been very definitely limited by insufficient personnel, both professional and clerical. Since it has been the responsibility of the division of hospital facilities to carry out its legal mandate, first consideration had to be given, of necessity, to the regulatory phase of the program while maintaining as much activity as possible in the educational phase. It soon became apparent that nursing home administrators were extremely interested in all educational activities offered by the division. For example, one institute, 1 day a week for 10 weeks which was to be limited to 50 persons, finally, because of the great demand, was made available to 100 nursing home operators by scheduling a second session. Similar situations prevail when other institutes are arranged.

It is expected that as the immediate result of additional funds made available to the Department of Public Health by the U.S. Public Health Service for the improvement of nursing home care, the division's program aimed at raising standards in nursing homes will be considerably improved. With these additional funds one additional inspector and three clerks have been provided—this money having come from Federal grant—and greater attention will be given to the educational phase of our program. These additional personnel, together with our revised regulations, will raise even to a greater degree the level of nursing home care in the Commonwealth.

It must be emphasized at this point that nursing home licensure is a relatively new activity for most health departments. We in Massachusetts are fortunate that our program which has been in existence since 1948 has progressed more rapidly than in most other States. However, it wasn't until this year, actually 1961, that any Federal funds have been specially earmarked for nursing home programs. I would like to emphasize this as a very important point, Senator. It is in this area that the States can use additional assistance from the Federal Government and the Public Health Service. Additional Federal funds are urgently needed to support the licensure program.

As Mr. Curran mentioned, in cooperation with the Boston College School of Nursing a Federal grant has been assigned to the latter institution to study intensively standards of nursing care in nursing homes in Massachusetts. It is anticipated that when these standards have been defined it will be possible for an agency, definitely established for the purpose, and with broad representation of physicians, hospitals, nurses, and regulatory agencies to formulate a voluntary joint accreditation program for nursing homes similar in function to the Joint Commission on Hospital Accreditation. Such an accreditation program will supplement the activities of the State agency as well as that of the Massachusetts Federation of Nursing Homes.

It is my definite impression that standards of nursing home care and operation in Massachusetts, because of our long established program, have been many years ahead of similar programs in most other States. It is hoped that by the use of additional funds previously mentioned and increased professional and clerical staffs that the standard of nursing home care and operation will progress even more.

In Massachusetts the rate of reimbursement of care for public assistance patients is established by the division of hospital costs and finances in the commission on administration and finance in accordance with the statutory requirements. As standards are raised it follows, naturally, that costs of operation will rise proportionately. Similarly, it is to be expected that the rate of reimbursement will reflect the increased costs of operation.

As additional programs in rehabilitation and recreation become an integral part of nursing home care, nursing home operators will be entitled to additional reimbursement to compensate for the cost of such programs. Under the Kerr-Mills legislation which is being implemented in Massachusetts, the Federal Government will, of course, underwrite a substantial portion of this care. It is my opinion that within the next few years standards of care will rise as a result of the joint activity of State and Federal programs in the field of nursing home care and operation.

At this point, Senator Smith, I would like to clarify the misconception which arose as a result of the statement in connection with unacceptable beds in Massachusetts. Considerable confusion has arisen from material published in the State plan for the administration of the Hill-Burton program that there are more unacceptable beds in nursing homes in Massachusetts than in many other sections of the country. In setting up criteria for unacceptable beds in nursing homes the recommendation of the U.S. Public Health Service was

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adopted in this connection; namely, that all frame buildings be considered as unacceptable. Since most nursing homes in Massachusetts, as well as everywhere else in the country, were converted frame residences, it is obvious that the problem of unacceptable beds is no greater in Massachusetts than it is in other parts of the country.

However, it must be borne in mind that no nursing home license is issued or renewed in Massachusetts unless all required safeguards against fire hazards have been observed by nursing home operators. This includes proper certification by the State department of public safety, approval by local fire departments and local wire inspectors. In Massachusetts there is the additional safeguard required by law; namely, that each nursing home must be inspected and approved by the local fire department four times a year.

It is apparent from this that legislators in Massachusetts have supplied nursing homes with as many safeguards as possible in this important area of medical care activity. It is anticipated that within the next few years a statewide law will be enacted requiring sprinkler systems in nursing homes. Such safeguards are already enforced in several large cities of the Commonwealth as a result of local ordinances. It is apparent that Massachusetts is better off in this respect than most other States in the country.

Another problem in nursing home care has to do with placement of patients in medical care facilities by some welfare departments. A small number of medical care facilities have been classified by the department of public health as particularly suited for care of patients requiring more than average nursing care, and have been given the classification "chronic hospital." The division of hospital cost and finances has set a higher rate for public assistance patients admitted to these facilities. However, when physicians and social workers in general hospitals have designated certain patients for care in these institutions, some welfare departments have refused to pay the additional costs and have reclassified candidates for admission as typical nursing home patients at the usual rate of reimbursement, thereby defeating the primary purpose of our plan. Clarification of this problem is necessary, since under the medical assistance to the aged program the Federal Government could participate in the extra costs for care of such patients. This is a problem, Senator, at the State level rather than the Federal level.

There are two additional Federal programs which have an impact on nursing home care. One is the Wolverton portion of the hospital survey and construction program in which Federal funds are available for the construction of nursing homes operated by voluntary or governmental agencies. Thus far, the bulk of these funds in Massachusetts have been used by existing voluntary agencies engaged in nursing home operation. Many of these have been religious organizations.

Many voluntary groups have been slow in applying for grants under this program, primarily because of lack of funds. Such groups not having the advantage of accumulated reserves to assist in the operation do not find it practical to engage in nursing home activities, and this is a primary reason that hospitals have not gone into this field.

At the currently established rate of reimbursement for public assistance patients, it would not be practical to accept patients on public assistance for nursing home care and such groups would have to limit their activities to private patients, thereby defeating one of the primary purposes of this legislation; namely, to provide care for all patients including those on public assistance. This means, therefore, that the usual proprietary nursing home must care for the greatest bulk of nursing home patients, and for this we are extremely grateful to them.

It is hoped that in the future the U.S. Public Health Service will continue to support by additional funds both regulatory and educational programs for nursing homes. By these established mechanisms the U.S. Public Health Service is recognizing the fact that supervision of medical care facilities and activities, although a relatively new responsibility of public health departments, is a rapidly growing and tremendously important one. It is apparent that national and State legislatures and the medical and allied professions are gradually learning the lesson that better medical care, including better medical care for the aged, means, in the long run, better public health.

Thank you, Senator.

Senator SMITH. Thank you very much, Dr. Rubenstein.

Now just a couple of questions here. Does the State have any special requirements for owners or operators in order to receive a license for running a nursing home?

Dr. RUBENSTEIN. According to our State law there is a requirement that the operator must be a suitable person and letters of recommendation must be submitted by persons who know the individual. However, there is no regular licensing program for administrators.

Senator SMITH. I see. Do you think this is adequately taken care of under the association setup that we have here now?

Dr. RUBENSTEIN. Yes. What we attempt to do is assure adequacy with respect to the nursing personnel who operate the home. In other words, we are interested more in the qualifications of the nursing personnel who run the nursing home.

Senator SMITH. Do State regulations require the homes to have certain medical supervision or is that left up to the——

Dr. RUBENSTEIN. No; that is all included in our regulations. We have a pamphlet, which I will be glad to supply copies of, including about 20 pages of regulations.

Senator SMITH. If you could furnish that, we would like to make it a part of the record.

Dr. RUBENSTEIN. I would be glad to. Incidentally, these regulations have been revised three times, and each time of course there is considerable upgrading, so that I believe our regulations here in Massachusetts are very good. As a matter of fact, I am constantly sending them to health departments all over the country at their request.

Senator SMITH. Fine. That will be made a part of your testimony.

Dr. RUBENSTEIN. Thank you.

(The documents referred to follow:)

RULES AND REGULATIONS FOR THE LICENSING OF CONVALESCENT OR NURSING HOMES IN MASSACHUSETTS

SECTION I

A. LEGAL AUTHORITY

1. General Laws, Chapter 111, Sections 71 to 73, inclusive, authorizes the Department of Public Health to issue, for a term of two years, a license, subject to revocation by it for cause, to any person whom it deems suitable and responsible, to establish or maintain a convalescent or nursing home which meets the requirements of the Department, established in accordance with its rules and regulations.
2. Convalescent or nursing homes conducted in accordance with the practice and principle of the body known as the Church of Christ, Scientist, shall be licensed and subject to the provisions for local board of health, fire, wire and zoning approval. The only inspection to be made in such homes by the Department of Public Health shall pertain to sanitation. The regular license fee is required.
3. In accordance with the authority granted by General Laws, Chapter 111, Sections 71 to 73, inclusive, the Department of Public Health herewith adopts the following rules and regulations for the conduct and supervision of convalescent or nursing homes.
4. *Penalty for Establishing or Maintaining a Convalescent or Nursing Home without a License.* Whoever establishes or maintains, or is concerned in establishing or maintaining a convalescent or nursing home, or is engaged in any such business, without a license granted under General Laws, Chapter 111, Section 71, shall for a first offense be punished by a fine of not more than five hundred dollars, and for a subsequent offense by a fine of not more than one thousand dollars or by imprisonment for not more than two years.

   Penalty for Violation of Any Provision of Licensing Act (General Laws, Chapter 111, Sections 71 - 73 inclusive) or any of the rules and regulations made under Section 72. Whoever, being licensed under Section 71 of the General Laws, Chapter 111, violates any provision of Sections 71 to 73, inclusive, of Chapter 111 of the General Laws or any rule or regulation made under Section 72, shall for a first offense be punished by a fine of not more than five hundred dollars; and for a subsequent offense by a fine of not more than one thousand dollars or by imprisonment for not more than two years.

B. DEFINITIONS

1. A convalescent or nursing home is defined as any institution, however named, whether conducted for charity or for profit, which is advertised, announced or maintained for the express or implied purpose of caring for three or more persons admitted thereto for the purpose of nursing or convalescent care.
2. A registered nurse is one who is currently registered by the Commonwealth of Massachusetts, Board of Registration in Nursing, to practice as a registered nurse.
3. A graduate nurse is one who has graduated from an approved school of nursing, or a school of nursing which was approved at the time the nurse was graduated.
4. A licensed practical nurse is one currently licensed by the Massachusetts State Board of Registration in Nursing to practice as a licensed practical nurse.
5. A graduate practical nurse is one who has satisfactorily completed the prescribed course of training in an approved school of nursing for practical nurses or a school of nursing for practical nurses currently approved or approved at the time the nurse was graduated, or in a hospital approved prior to July 1, 1956, by the Joint Commission on Hospital Accreditation or its predecessor, the American College of Surgeons. Proper credentials to certify the nurse as a graduate practical nurse shall be presented by the nurse.
6. An undergraduate nurse is one who has satisfactorily completed, in an approved school of nursing or a school of nursing which was approved at the time the nurse was in training, *sufficient time*

during which the nurse would have received theory and instruction comparable to that required for a graduate practical nurse. Proper credentials to certify the nurse as an undergraduate nurse shall be presented by the nurse.

7. The term "Department" as used in these regulations shall mean the Massachusetts Department of Public Health.
8. The term "Department of Public Safety" shall mean the Massachusetts Department of Public Safety.
9. The term "licensee" shall mean the individual or individuals, corporation, trust or governmental unit legally responsible for the conduct of the home.
10. The terms "local board of health," "local fire chief," "local wire inspector" and "local zoning authority" shall mean the individual or agency so designated in the city or town in which the convalescent or nursing home is located.
11. All adjectives and adverbs such as accessible, adequate, approved, attractively, clean, competent, good, proper, qualified, reasonable, reliable, reputable, responsible, safe, sanitary, satisfactory, sufficiently, and well, used in these rules and regulations to qualify a person, equipment or building shall be as determined by the Department.

C. PROCEDURE FOR LICENSURE OR LICENSE RENEWAL

1. *Issuance of License or License Renewal*
   a. Request for an application shall be made in writing to the Department.
   b. Application for a license or license renewal to establish or maintain a home shall be made in writing, and submitted to the Department upon the application forms secured from the Department.

      Structural changes in a proposed or existing home shall not be undertaken until notification has been made to the Department and plans for said structural changes have been approved by the Departments of Public Health and Public Safety.
   c. Two copies of the completed application shall be returned to the Department.
   d. Written zoning approval on a form provided by the Department is a prerequisite for an original license.
   e. Local board of health certification on a form provided by the Department that said convalescent or nursing home is suitable for this purpose is a prerequisite for licensure.
   f. A certificate of inspection of the egresses, the means of preventing the spread of fire and the apparatus for extinguishing fire issued by an inspector of the Division of Inspection of the Department of Public Safety is a prerequisite for licensure.
   g. The local wire inspector shall certify in writing on a form provided by the Department that, from his inspection of the premises, there is compliance with the local wiring codes; the corrected minor deficiencies shall be listed. In towns having no local wire inspector, the Department shall arrange with the state wire investigator for the same service and report. No license shall be issued or renewed without signed approval by the local wire inspector or state wire investigator.
   h. A certificate of inspection issued by the head of the local fire department, certifying compliance with the local ordinances is a prerequisite for licensure.
   i. A check or money order for the license fee payable to the Commonwealth of Massachusetts shall be forwarded to the Department when requested.
   j. The applicant shall be a suitable and responsible person.
2. *Name of Home*

   Every convalescent or nursing home shall be designated by a permanent and distinctive name which shall appear on the application for license, and which shall not be changed without first notifying the Department. The term "convalescent home" or "nursing home" shall appear in the name. The term "rest home" cannot be used.
3. *Quota*
   a. Each license issued by the Department of Public Health shall specify the maximum allowable number of beds on each floor in the home, which number shall not be exceeded. The number of beds allowed on each floor shall be determined by the Department of Public Health and shall so appear on the license issued by said Department.

b. Requests for quota increase shall be made in writing to the Department. No increase will be granted without written approval of the Director or the Chief Hospital Inspector of the Division of Hospital Facilities of the Department and the building inspector of the Department of Public Safety.

4. *Occupancy*
   a. Rooms below grade level shall not be used for patient occupancy.
   b. Occupancy of rooms above the second floor shall be restricted to employees and members of the immediate family of the licensee.
   c. Rooms without basement foundations shall not be used for patients unless there is proper heating and insulation.

D. POSTING OF THE DEPARTMENT LICENSE AND DEPARTMENT OF PUBLIC SAFETY CERTIFICATE OF INSPECTION
1. The license issued by the Department of Public Health and the inspection certificate issued by the Department of Public Safety shall be framed and posted conspicuously on the premises.

E. RETURN OF LICENSE
1. The license issued by the Department of Public Health shall be returned immediately by registered mail to the Department on:
   a. Receipt of renewal license
   b. Revocation
   c. Change of location
   d. Change of ownership
   e. Change of name
   f. Change of quota
   g. Voluntary closure of a home
   h. Change of classification
   i. Demise of licensee

F. CHANGE OF OWNERSHIP AND/OR LOCATION

The Department shall be notified immediately in writing of any proposed change in location, name or ownership of the home. A new application must be submitted at once in the instance of a change of location or ownership. A license cannot be transferred from one individual to another or from one location to another.

In the case of transfer of ownership, the application of the new home owner for a license to maintain a convalescent or nursing home shall have the effect of a license for a period of three months when acknowledged by the Department of Public Health. The quota granted to the former licensee shall not be exceeded until approved by the Director or Chief Hospital Inspector of the Division of Hospital Facilities of the Department and the building inspector of the Division of Inspection, Department of Public Safety, assigned to that district.

G. RESTRICTIONS
1. No home in which part of the premises is utilized for tenant occupancy or for business or professional purposes, including a commercial laboratory, shall be approved for licensure.
2. Office space is not permitted in the home for physicians, dentists or podiatrists or for physiotherapists or other paramedical persons.
3. Nursing services or medical treatment shall not be administered to non-residents.
4. Alterations and structural changes to the premises cannot be made until plans for proposed changes have been submitted to and approved by the Departments of Public Health and Public Safety.

H. RIGHT OF APPEAL
1. A licensee or an applicant aggrieved by the decision of the hospital inspector shall have the right of appeal to the Chief Hospital Inspector or the Director, Division of Hospital Facilities.
2. Any person aggrieved by the refusal of the local board of health to certify that the convalescent or nursing home is suitable for the purpose may, in writing, appeal to the Director, Division of

Hospital Facilities, Department of Public Health, for a public hearing. The Department shall hold said hearing and thereafter may modify, affirm or reverse the action of the local board of health.

3. Any applicant for an original license who is aggrieved by rejection of his application by the Department of Public Health on the basis of written disapproval, by the head of the local fire department or by the inspector of the Division of Inspection of the Department of Public Safety may, within thirty days, make an appeal in writing from such refusal to a board of review. The board shall, within twenty days of the receipt of such appeal, give the parties in interest an opportunity to be heard and shall, within thirty days after such hearing, render a decision, which shall be a matter of public record.

   Within thirty days after action by the board of review, a person who is aggrieved by the refusal of said board to approve his application may bring a petition in the district court within the judicial district where the premises on which the application was based are located, addressed to the justice of the court, praying that the action of the board in refusing to approve his application may be reviewed, and after such notice as said court shall direct to all parties interested a hearing may be had before the court at an early and convenient time fixed by it; or the court may appoint three disinterested persons conversant with the subject matter of the controversy to examine the matter and hear the parties. The decisions of said court or the written decision under oath of a majority of those appointed by the court filed in the office of the clerk of courts in said county within ten days after such hearing may annul or affirm such refusal. Such decision, or a certified copy thereof, shall have the same authority, force and effect as an original refusal or approval by the board. If such decision results in the approval of an application for a license which the board has denied, the court shall order said license to be issued.

4. Upon written request by an applicant who is aggrieved by the refusal to renew such a license, or by a holder who is aggrieved by the revocation of such a license, as the case may be, the Commissioner of Public Health and the Public Health Council shall hold a public hearing after due notice and thereafter may modify, affirm or reverse the action of the Department.

I. REVOCATION OF LICENSE

A license to operate a convalescent or nursing home may be revoked by the Department in accordance with General Laws, Chapter 111, Sections 71 to 73, inclusive, as amended for any of the following reasons:

1. Violation of the provisions of the licensing act or of the standards, rules or regulations of the Department adopted thereunder.
2. Permitting, aiding or abetting the commission of any illegal act in such home.

SECTION II

A. GENERAL REGULATIONS FOR CONVALESCENT OR NURSING HOMES

1. *Fire Protection*
   a. Employees of the home shall be instructed by the head of the local fire department or his representative as to their duties in case of fire.
   b. Fire extinguishers shall be recharged and so labeled at least once a year.
   c. Where sprinkler systems are installed, the water pressure shall be checked weekly by the individual in charge of the home.
   d. Lighting facilities shall be available in all common halls and inside and outside stairways.
   e. Emergency lights shall be checked weekly by the individual in charge of the home.
   f. All exits shall be clearly identified by exit signs, adequately lighted, and shall be free from obstruction.
   g. Gas dryers shall be inspected by the proper authorities.
   h. All fires involving patients, personnel or property shall be reported to the Department.
   i. There shall be at least one telephone on each floor where patients or personnel reside. All telephones shall be available for use in any emergency, for both incoming and outgoing calls.

j. Smoking is prohibited in all rooms, wards and adjacent areas where oxygen is being administered, or in rooms where oxygen is stored.
k. Carriers for oxygen tanks must be provided when oxygen is used.
l. Signs indicating that oxygen is available, currently in use or stored shall be conspicuously posted.
m. Oxygen tanks must be safely stored and labeled when empty.

2. *Sanitation*
a. Water Supply
(1) The water shall be of sanitary quality and shall be obtained from a source approved by the Department.
(2) There shall be sufficient water pressure to meet the sanitary needs of the home at all times.
(3) If the water is not from a municipal system, said supply shall meet the approval of the Department.
b. Milk Supply
(1) Milk and cream shall be pasteurized, and shall be delivered to the home and stored in the home in containers approved by the Department.
(2) All milk and cream products used for patients and employed personnel shall be made from pasteurized milk.
c. Ice Supply
Ice which comes in contact with food or drink shall be delivered, stored, handled and dispensed in a sanitary manner.
d. Sewage Disposal
All sewage shall be discharged into a municipal sewage system where such is available; otherwise, the sewage shall be collected, treated and disposed of by means of an independent sewerage system approved by the Department.
e. Toilet, Handwashing and Bathing Facilities
(1) Adequate toilet, handwashing and bathing facilities shall be provided on each floor in a reasonable ratio according to the number and sex of patients and personnel in the home.
(2) Toilets, baths or shower compartments shall be separated from all rooms by solid walls or partitions. Adequate provisions to insure patient privacy shall be made.
(3) Toilets for patients' use may not be located off the kitchen.
(4) Toilet, handwashing and bathing facilities must be kept in good repair, and the floor area surrounding the toilet must be maintained in a sanitary manner and in good repair.
(5) Handrails or grab bars shall be provided near showers, tubs and toilets.
f. Waste Disposal
(1) All accumulated soiled dressings and other waste shall be stored, indoors and out of doors, in covered, sanitary, fireproof containers and subsequently disposed of at proper intervals in a manner to prevent fire hazard, contamination and nuisance.
(2) All homes shall provide facilities for proper disinfection of these containers at all times of the year.
g. Garbage Disposal
(1) Suitable sanitary facilities shall be provided for the collection, storage and disposal of garbage.
(2) Garbage shall be stored, indoors and out of doors, in clean, watertight containers with tight-fitting covers.
(3) All homes shall provide facilities for proper disinfection of these containers at all times of the year.

3. *Physical Plant - Household and Property*
On and after the effective date of these regulations, all buildings not previously licensed as convalescent or nursing homes shall be of new construction or of such construction that upon suitable alterations they will meet the standards established by the Department.

a. The buildings, equipment and surroundings shall be maintained in a condition of good repair, neat, clean and free from all accumulation of dirt and rubbish and foul, stale or musty odors. The type of construction shall be in conformity with existing local and state building, electrical and plumbing codes. All plumbing, including pipes carrying water for drinking and culinary purposes and all pipes installed for the disposal of sewage and wastes, shall be in accordance with the rules of the city or town having jurisdiction over such installations. In the absence of such rules relative to plumbing, these installations must conform to the rules established in accordance with G.L. Ch. 142-section 21. The entire building shall be open without prior notice by authorized agents of the Department of Public Health and Department of Public Safety.

b. A utility room with a separate entrance and physically partitioned from any toilet and/or bathing facility shall be provided in homes with 10 or more patients.

c. The floors of the following areas shall be waterproof, grease proof and resistant to heavy wear:
   Kitchens (main and auxiliary)
   Food preparation and food storage areas
   Bathrooms and toilets
   Utility room
   Laundry

d. The walls of the following areas shall have a waterproof, glazed, painted or similar surface which will withstand washing:
   Kitchens (main and auxiliary)
   Food preparation area and areas where food is served
   Bathrooms and toilets
   Utility room

e. Adequate provision shall be made for the storage of housekeeping supplies and equipment, separate from any toilet or utility room. This area shall be adequately lighted and ventilated. A slop sink shall be provided.

f. The premises shall be maintained in such a manner as to prevent infestation by rodents and insects.

g. Screens, Doors and Windows
   (1) Outside doors, windows and openings shall be protected against flies and other insects by the seasonal use of screens.
   (2) Weather stripping shall be used on windows and doors when necessary to avoid drafts.
   (3) All windows, including combination windows, shall be washed inside and outside at least twice a year.

h. Heating
   (1) Adequate heating shall be provided in all rooms used by patients in order to maintain a minimum temperature of 78°F. in cold weather.
   (2) The heating system shall be in conformity with the rules and regulations outlined by the Department of Public Safety under Chapter 148, as amended.

i. Lighting and Ventilation
   (1) Each patient's room shall have direct outside exposure with adequate unobstructed natural light and adequate ventilation.
   (2) Adequate artificial lighting shall be available in all rooms, stairways and hallways of buildings. Night lights shall be provided in all patients' rooms and in all hallways, stairways, bathrooms and front and back porches.
   (3) No electric bulb under 40 watts shall be used for illumination for patients' use. Night lights for hallways, stairways and bathrooms shall be at least 15-watt bulbs.
   (4) Kitchens and other areas when located below grade level and used for the preparation and serving of food shall have direct access to the outside by means of suitable windows. Otherwise, ventilation shall be provided to permit an air supply and exhaust of at least

ten air changes an hour. Ventilating units shall be maintained in a sanitary manner and kept in good repair.

(5) All main kitchens shall be provided with a mechanical ventilator.

(6) Kitchens (main and auxiliary), food preparation and food storage areas, bathrooms, toilets and utility room shall have adequate artificial lighting, which shall be maintained in a sanitary manner and kept in good repair.

(7) Bathrooms, toilets and utility room shall have direct access to the outside by means of suitable windows or a forced system of exhaust, which shall be maintained in a sanitary manner and kept in good repair.

4. *Laundry*

a. Location

The laundry shall be situated in an area separate and apart from any facility used for the storage, preparation or serving of food.

b. Physical Facility

The laundry area shall be well lighted and ventilated and adequate in size for the needs of the home, and shall be maintained in a sanitary manner and kept in good repair.

c. Commercial Laundries

(1) When adequate facilities are not available on the premises for the proper and sanitary washing of linen and other washable goods, the services of a commercial laundry or laundry rental service shall be utilized.

d. Equipment

(1) All homes must provide set tubs equipped with hot and cold running water in the laundry.

(2) Automatic washers and drying and ironing facilities shall be provided to meet the needs of the home.

e. Handling of Soiled Linen

(1) All soiled linen shall be placed in a bag and stored in a manner to prevent contamination and odors.

(2) All soiled linen shall be collected and transported to the laundry in the washable containers in which it was collected, in a sanitary manner.

(3) Handwashing facilities shall be available in the laundry area where soiled linen is handled and/or sorted.

(4) Soiled linen shall be handled and stored in such a manner as to prevent contamination of clean linen.

(5) Facilities used to collect, transport and store soiled linen shall not be used for the handling of clean linen.

(6) Adequate facilities shall be provided for the proper and sanitary washing of linen and other washable goods.

f. Handling of Clean Linen

(1) Clean linen shall be sorted, dried, ironed and folded in a sanitary manner in a specified area.

(2) Clean linen shall be transported, stored and distributed in a sanitary manner.

(3) Closets conveniently located shall be provided on each floor for the storage of clean linen, and shall not be used for any other purpose.

g. Personal Laundry

(1) Patients' and personnel's laundry shall be collected, transported, sorted, washed and dried in a sanitary manner.

(2) Personal laundry shall not be washed with bed linens.

h. Laundry Personnel

(1) Laundry personnel shall be properly clothed so as to prevent contamination of clean linen.

(2) Adequate closet space shall be provided for the storage of their street clothing.

5. *Food Sanitation*

a. There shall be adequate facilities and equipment for the proper storage of all food supplies, for

both patients and personnel, maintained in a sanitary manner and kept in good repair.

b. Refrigeration

(1) All perishable food, including milk and milk products, shall be adequately refrigerated, stored in a sanitary manner and properly spaced for adequate refrigeration.

(2) There shall be a reliable thermometer in each refrigerator and storeroom used for perishable foods.

(3) All foods shall be dated before being stored in a deep freeze.

c. Dishwashing

All dishes, including glasses and utensils used for eating, drinking, preparing and serving food and drink shall be cleansed and sanitized after each usage. If a dishwashing machine is provided, a single-section sink is acceptable; otherwise double-section sinks are a requirement. If dishes are washed by hand, the temperature of the wash water shall be between 110° and 120°F. This shall be followed by immersion in racks in water at a temperature of 170°F. for thirty seconds. If a dishwashing machine is used, the temperature of the wash water shall be between 140°and 160°F., with a final rinse at a temperature of 170°F. or higher. After sanitization, all dishes shall be allowed to drain and dry in racks or baskets on a nonabsorbent surface.

d. Handwashing Facilities for Food Handlers

There shall be adequate handwashing facilities with soap or detergent, running hot and cold water, and an adequate supply of individual disposable towels in all kitchens, and in washrooms used by food handlers.

6. *Dietary Services and Facilities*

a. Kitchens

(1) The main kitchen shall be located in a suitable area. There shall be adequate work space for the preparation and serving of meals for the patients and personnel, in accordance with the size of the home.

(2) There shall be adequate sanitary storage facilities provided for all equipment used for the preparation and serving of food.

b. Auxiliary Kitchens

Auxiliary kitchens shall be provided and adequately equipped when the size of the home or the physical plant indicates the need, as determined by the Department.

c. Dumb-Waiter

A dumb-waiter when provided for the transportation of food shall be suitably located and used exclusively for the transportation of food. It shall be cleaned daily and kept in good repair.

d. Equipment

(1) Stoves, sinks, counters, cabinets, shelves, tables, refrigerating equipment and all other equipment necessary for the preparation and serving of food shall be provided in accordance with the size of the home. This equipment shall be so constructed that it can be easily cleaned, maintained in a sanitary manner and kept in good repair.

(2) Food shall be prepared and served so that hot food shall be hot and cold food shall be cold when served to the patients.

(3) There shall be an adequate supply of trays, glassware, dishes and silverware for individual patient use. Discolored, chipped or cracked dishes or glassware shall not be used. Silverware that is of good quality shall be provided and kept in good condition.

(4) Food shall be transported from main kitchens to auxiliary kitchens in suitable containers and/or conveyors.

(5) Trays

(a) Individual tray service shall be provided for patients.

(b) Trays shall be washable and of a type that can be sanitized.

(c) No tray shall be served without a washable or disposable tray cover.

(d) Trays shall be large enough to accommodate all of the dishes necessary for a complete meal, served attractively.

(e) Clean napkins shall be provided for all patients at all meals or between-meal nourishment.
(f) All trays set up in advance of meal time must be adequately covered to prevent contamination.
(g) Suitable tray racks shall be provided.
(h) At the main meal, the main course shall be served on a standard-size dinner plate.

e. Food
(1) There shall be an adequate supply of food of good quality on hand at all times to meet the needs of the home. All food shall be served attractively in dishes.
(2) Meals for the patients shall be of adequate quantity, well planned, well balanced and sufficiently varied. Weekly diet menus shall be maintained.
(3) Special diets when prescribed must be prepared and served under competent supervision. These menus shall be posted conspicuously.
(4) Breakfast shall not be served before 7:00 a.m. Supper shall not be served before 5:00 p.m. Night nourishment shall be provided as indicated.

f. Kitchen Waste and Garbage
Kitchen waste and garbage shall be emptied after each meal, and the containers and covers shall be washed, dried and aired before being returned to the kitchen.

7. *Dining Room* (Optional)
a. Location and Equipment
(1) Dining room facilities when provided shall be:
(a) Suitably located in a well lighted, ventilated and heated area, and attractive.
(b) Equipped with tables of sturdy construction with a hard-surfaced, washable top.
(c) Equipped with comfortable chairs of sturdy construction and of a sanitary type.

8. *General Maintenance and Housekeeping*
a. The home shall be kept in good repair, clean and sanitary at all times, and in a manner so as to prevent the entrance and harborage of rats, other rodents, vermin and insects.
b. There shall be separate facilities and equipment provided for housekeeping of the following:
(1) Basement
(2) Laundry
(3) Kitchen
(4) Each floor
c. Equipment shall include an adequate supply of:
(1) Wet and dry mops (improvised mops shall be prohibited)
(2) Mop pails
(3) Radiator brushes
(4) Cleaning supplies
d. Nonskid floor wax shall be used.
e. A vacuum cleaner shall be provided for each home, and kept in good repair.
f. All housekeeping equipment and cleaning supplies shall be kept in good condition, maintained in a sanitary manner and stored in suitable storage areas. Such equipment shall not be stored in lavatories, bathrooms, utility rooms or halls or on stairs.
g. Wet mops shall be laundered daily.
h. Dry mops, if washable, shall be laundered twice a week.
i. Dusters and cleaning cloths shall be laundered daily.
j. All facilities and equipment in the home shall be maintained in a safe manner.

B. PATIENTS' ACCOMMODATIONS AND EQUIPMENT
1. *Floor Area*
For licenses in existence on the effective date of these regulations,
a. Single rooms shall have a minimum of 60 square feet of floor area.
b. Multi-bed rooms shall have a minimum of 60 square feet of floor area per adult bed, with at least 3 feet between beds.

2. *Floor Area*
   For all new licenses issued after the effective date of these regulations,
   a. Single rooms shall have a minimum of 100 square feet of floor area.
   b. Multi-bed rooms shall have a minimum of 70 square feet of floor area per adult bed, with at least 3 feet between beds.
3. *Quota Increase*
   Any increase in quota granted after the effective date of these regulations must provide in the room or rooms under consideration:
   a. 100 square feet of floor area in single rooms.
   b. 70 square feet of floor area per adult bed, with at least 3 feet between beds, in multi-bed rooms.
4. *Window Area*
   For new licenses issued after the effective date of these regulations, the minimum window area shall be at least one-eighth of the floor area.
5. *Rooms for Patients*
   a. All rooms or wards used for patients shall be outside rooms.
   b. No room or ward off a kitchen shall be used for patient care unless another acceptable means of entrance to this room is provided.
   c. A well lighted and ventilated sitting room shall be provided for ambulatory patients. A reception hall or any other facility cannot be used if it blocks an egress.
   d. Each home shall make adequate provisions to insure reasonable privacy at time of death.
   e. Washable window curtains or draperies shall be provided for all patient bedrooms and shall be kept clean and in good condition.
6. *Equipment*
   a. Beds of household height or hospital beds shall be used and spaced 3 feet apart. Beds shall be arranged so as to avoid drafts, heat from radiators and other discomforts. Cots and folding beds are not permitted.
   b. Each patient shall be provided with:
      (1) A comfortable bed, bed spring and mattress, which shall be maintained in a sanitary condition and kept in good repair. The mattress shall be protected by a cover and/or pad.
      (2) An adequate number of bed pillows of good quality for each patient, maintained in a sanitary condition and in good repair.
      (3) An adequate supply of bed linen, bed rubbers, blankets, bedspreads, washcloths and towels of good quality for each patient, maintained in a sanitary manner and kept in good condition.
      (4) An adequate number of bed rails of a standard type, maintained in a sanitary manner and kept in good repair.
      (5) A bedside cabinet with a hard-surface, washable top adequate for individual patient needs, maintained in a sanitary manner and kept in good repair.
      (6) A comfortable chair suited to individual patient needs, maintained in a sanitary manner and kept in good repair.
      (7) Footstools according to patients' needs, maintained in a sanitary manner and kept in good repair.
      (8) Adequate artificial lighting in each room to meet individual patient needs, kept in good repair.
      (9) A bureau or other adequate provision for the storage of patients' clothing, maintained in a sanitary manner and kept in good repair.
      (10) An individual mouthwash cup, a toothbrush and dentifrice, and containers for the care of patients' dentures, maintained in a sanitary manner.
      (11) An individual soap dish and bar of soap.
      (12) Individual bedpans, urinals, hand wash basins, bath basins and emesis basins, maintained in a sanitary manner and kept in good condition, identified and stored in such a manner that they may not be interchanged between patients.

(13) Commode chairs when provided shall be of a sanitary type, maintained in a sanitary manner and kept in good repair.

(14) A signal system or a hand bell at each patient's bedside, in bathrooms and in sitting rooms. The method used for signaling shall be approved by the Department.

c. Individual sputum containers of a sanitary type shall be provided when needed and maintained in a sanitary manner.

d. All stairways used by ambulatory patients shall be well lighted and provided with hand rails on both sides.

e. Washable bedside curtains or portable screens shall be provided in all multi-bed rooms to insure patient privacy.

f. Grip bars, properly placed, shall be in all bathrooms, toilets and showers used by patients.

g. An adequate number of wastebaskets of a sanitary type shall be provided in each patient's room and sitting room and maintained in a sanitary manner.

C. MEDICAL SUPERVISION

(1) Each patient or his guardian or the agency responsible for his care shall on admission designate the name and address of a physician registered to practice medicine in Massachusetts to be responsible for his medical supervision, including periodic checkups.

(2) Each patient on admission shall have a completed medical referral form or shall have a physical examination within 7 days after admission. The physical findings with the treatment to be carried out shall be recorded, and signed by a physician registered to practice medicine in Massachusetts.

(3) No patient shall be transferred or discharged from the home without a dated, recorded signed statement of patient's physical condition made by the attending physician, at the time of the patient's transfer or discharge.

(4) All medical and psychiatric consultations shall be dated, recorded and signed by the examining physician at the time of examination.

(5) No medication, treatment or therapeutic diet shall be administered to a patient except on the written order of a physician registered to practice medicine in Massachusetts. (Exception: In an emergency the nurse in charge may carry out the verbal order of the physician provided that the order is entered in the Doctor's Order Book and indicates the patient's name, the date, the name of the prescribing physician and the signature of the nurse who takes the order. Furthermore, the prescribing physician must sign said order within 48 hours.)

D. SUPERVISION AND CARE OF MEDICATIONS

(1) A medicine cabinet or closet of a type approved by the Department shall be provided for the proper storage of all patients' drugs.

(2) The medicine cabinet or closet shall be located in an area that is inaccessible to patients or visitors.

(3) The medicine cabinet or closet shall be well lighted, shall have running water easily accessible and shall be provided with a suitable lock and kept locked at all times.

(4) There shall be a separate locked compartment within the locked medicine cabinet or closet for the proper storage of prescribed narcotics and sedatives.

(5) Poisons and medications for external use only shall be kept separate and apart from internal medications in a locked compartment.

(6) A responsible qualified person shall be in charge of and administer all medications to patients.

(7) The custody of the key to the medicine closet shall be assigned to a responsible person at all times.

(8) All medications shall be accurately recorded and accounted for at all times.

(9) No medication for a specific patient shall be administered to another patient.

(10) Medications shall not be stored in patients' rooms.

(11) Medicines shall not be removed from their original containers.

(12) Prescription labels shall not be defaced.

(13) Medications having a specific expiration date shall not be used after the date of expiration.

(14) Medicines shall be properly refrigerated when required.

(15) Following a patient's transfer or discharge, all drugs prescribed for said patient if not transferred with the patient shall be disposed of as follows:
   a. Narcotics and sedatives shall be destroyed in the home in the presence of the hospital inspector and the fact duly recorded, dated, timed, signed and witnessed in the Narcotic and Sedative Book (see K-2c).
   b. All other drugs shall be disposed of as directed by the hospital inspector.

(16) Upon the death of a patient, all drugs prescribed for said patient shall be disposed of as follows:
   a. Narcotics and sedatives shall be destroyed in the home in the presence of the hospital inspector, and the fact duly recorded, dated, timed, signed and witnessed in the Narcotic and Sedative Book.
   b. All other drugs shall be immediately disposed of as directed by the hospital inspector.

(17) The medicine cabinet or closet shall be used exclusively for the storage of medications and equipment required for their administration. This cabinet or closet shall be maintained in a sanitary manner.

(18) Rubbing alcohol shall be stored in a locked cabinet when not in use.

E. NURSING PERSONNEL

1. A registered nurse, a graduate nurse, a licensed practical nurse, an undergraduate nurse or a graduate practical nurse shall be at all times responsible for the supervision of the nursing service and patient care in the home.
2. There shall be adequate qualified nursing personnel at all times, including vacation and other relief periods.
3. Nursing homes having 50 or more beds shall employ a registered nurse or a graduate nurse.
4. A sufficient number of trained personnel shall be employed to give adequate care to all patients at all times. Adequacy of personnel shall be as determined by the Department.
5. Ancillary workers providing nursing care shall be supervised by qualified nursing personnel at all times.
6. The qualifications of the following personnel shall be verified as follows:
   a. The Massachusetts registration number of all registered nurses
   b. Training of all graduate nurses
   c. Training of all undergraduate nurses
   d. Massachusetts license of all licensed practical nurses
   e. Training of all graduate practical nurses
   f. Experience of unlicensed practical nurses who did not complete the prescribed course in an approved school for practical nurses
   g. Diplomas or certificates from correspondence schools of nursing are not acceptable.
7. The Department shall be promptly notified in writing of the resignation of any qualified nursing personnel, and of the name and qualifications of the new appointee.

F. OTHER PERSONNEL

1. There shall be a qualified person employed for the supervision of the dietary service in accordance with the size of the home.
2. There shall be adequate auxiliary personnel to keep the home in good repair, clean and sanitary at all times. These individuals shall not administer patient care.

G. EQUIPMENT AND FACILITIES FOR NURSING PROCEDURES

1. Complete facilities and equipment according to the number and type of patients in the home shall be provided for the administration of routine and special nursing care, as prescribed by the attending physician. All facilities and equipment shall be maintained in a sanitary manner and kept in good condition.
2. Basic equipment shall include all facilities necessary for the administration of routine nursing care.
3. Special equipment shall include equipment for:
   a. First aid
   b. Intravenous therapy

c. Blood pressure recordings
d. Urinalysis
e. Bladder irrigations, colonic irrigations and colostomies

4. Other equipment shall include:
   a. Flashlights
   b. Mouthbites
   c. Carrier for oxygen cylinder when oxygen therapy is ordered.
   d. Rubber rings, hot water bottles and ice caps
   e. Sandbags and other orthopedic equipment
   f. Standard scale for weighing patients
   g. Wheel chair
5. Adequate facilities and equipment shall be provided for the proper disinfection of:
   a. Beds
   b. Bedsprings
   c. Mattresses
   d. Bedsides
   e. Bed pillows
   f. Bed rubbers
6. Adequate facilities and equipment shall be provided for the proper sterilization of:
   a. Glassware
   b. Enamelware, monelware and stainless steel
   c. Instruments
   d. Syringes and needles
   e. Rubber goods
7. Technique for the care and cleansing of mouth and rectal thermometers shall be approved by the Department.
8. Adequate facilities for the proper storing of the following shall be provided:
   a. Patient's towels and washcloths when not in use
   b. Beds, bedsides, bedsprings, mattresses, bed pillows, blankets and rubber sheeting when not in use.
   c. Patient's clothing, personal effects and valuables
   d. Glassware, enamelware, instruments, syringes and needles, rubber goods, mouth and rectal thermometers
   e. Oxygen cylinders

H. UTILITY ROOM

1. The utility room shall not be equipped or used as a toilet or bathing facility for patients and/or personnel. It shall provide the following facilities:
   a. Slop sink with gooseneck faucet and hot and cold running water
   b. Adequate cupboard and work space
   c. Adequate facilities for the storage of clean equipment used in the administration of patient care
   d. Adequate space for the storage of individual patient equipment, properly labeled so that it cannot be interchanged between patients
   e. Adequate facilities for the cleansing, disinfection and sterilization of individual patient equipment
   f. Adequate facilities for emptying, cleansing and disinfecting bedpans and urinals
   g. An instrument sterilizer
   h. Adequate facilities for the proper storage of all rubber goods, such as hot water bottles, ice caps, rectal tubes, catheters, rubber gloves, rubber air rings, etc.

I. ADMISSIONS

1. No convalescent or nursing home shall admit or care for persons who are suffering from insanity or persons who are addicted to the use of narcotics or stimulants.
2. Persons released by and under the supervision of the Department of Mental Health

are eligible for admission provided prior approvals have been received from the Department of Public Health.

3. No convalescent or nursing home shall admit a person suffering from a contagious disease, or a person requiring prenatal or maternity care.
4. Admission of children under 16 years of age to a convalescent or nursing home caring for adults shall be subject to the approval of the Department.
5. No shock therapy shall be administered in the home.

J. PATIENT TRANSFER OR DISCHARGE

a. No licensee shall arrange for the transfer of a patient from one home to another or for his or her discharge without either the written permission of the patient, a responsible individual or relative, or a responsible public or private agency.

K. RECORDS

1. Each home shall provide a suitable area, conveniently located, for the recording and storage of patient records. The following equipment shall be provided:
   a. Desk and chair
   b. Adequate lighting and ventilation
   c. File cabinets for storage of active and inactive records
2. Required record material for each home shall include:
   a. A standard-type bound Patient Register Book for the recording of admissions, transfers, discharges and deaths.
   b. A bound Doctor's Order Book with a stiff cover and numbered pages
   c. A bound Narcotic and Sedative Book with a stiff cover and numbered pages
   d. A bound Day and Night Report Book with a stiff cover and numbered pages
   e. Heavy cardboard folders for filing of individual patient records
   f. Record forms for all pertinent medical and nursing data as required by the Department.
   g. Record forms for listing patients' clothing, personal effects and valuables at time of admission.
3. All records shall be permanent, either typewritten or legibly written with pen and ink (no record shall be written in pencil). No erasures or ink eradicator shall be used. No pages shall be removed from bound books.
4. A complete and accurate record shall be maintained for each patient from the time of admission to the time of discharge. This record shall be kept in an individual folder filed in chronological order, and shall include all medical and nursing data. This record shall be filed in a manner approved by the Department, and kept in the convalescent or nursing home for not less than five years following the patient's discharge, transfer or death.
5. The following records shall be maintained in a form and manner acceptable to the Department:
   a. Daily census
   b. Personnel file on all employees
   c. Patient's day and night report
6. Patient's records shall include:
   a. Identification data

      Date and time of admission, patient's name, previous address, age, sex, color, race, marital status (married, separated, divorced or widowed) and religion; name and address of referring physician or hospital; name and address of attending physician; name, address and telephone number of person or agency responsible for patient.
   b. Medical records
      (1) A statement of the patient's physical and mental condition and diagnosis at the time of admission, transfer or discharge, dated and signed by the attending physician and incorporated in the patient's record.
      (2) A record of physical findings and patient progress, dated and signed by the attending physician at the time of each visit, and at the time of periodical physical examination.
      (3) All medical and psychiatric consultations shall be dated, recorded and signed by the consulting physician and incorporated in the patient's record.

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(4) All doctor's orders, including medications, treatments and diets, shall be dated, recorded and signed in the Doctor's Order Book by the attending physician. These orders shall be reviewed by the attending physician at least every six months and if indicated, renewed.
(5) A record of all accidents occurring to patients in the home, including the date and time of accident, physical findings and treatment prescribed. This record shall be signed by the attending physician and incorporated in the patient's record.
(6) All orders for restraining patients shall be specifically defined, dated, recorded in the Doctor's Order Book and signed by the attending physician.
(7) Statement with recommendations for discharge, reason for discharge and the patient's physical and mental condition at time of discharge shall be dated and signed by the attending physician, and incorporated in the patient's record.

c. Nursing records shall include:
(1) Admission data
(a) How admitted – by ambulance or ambulatory, referred by whom and accompanied by whom
(b) Date and time of admission
(c) Complete description of patient's condition upon admission, including weight of ambulatory patients. This record data shall be recorded and signed by admitting nurse.
(d) Date and time attending physician was notified of patient's admission.
(2) All physicians' orders for medication, treatment, diet, activity, etc., copied from the Doctor's Order Book by the nurse, and incorporated in the patient's record on an approved form.
(3) Date, time, dosage and method of administration of all medications administered; date and time of all treatments.
(4) The signature of the nurse administering treatments or medications.
(5) An accurate report of all factors pertaining to the patient's condition, including the monthly weight of ambulatory patients.
(6) A report of all accidents occurring to patients, date, time, circumstances involved, patient's symptoms and nurses' observations, time doctor was notified, and subsequent treatment given.
(7) A list of the patient's clothing, personal effects and valuables shall be entered at time of admission on a form approved by the Department, and dated and signed by the patient or responsible person and witnessed. A copy of this list shall be given to the patient or other responsible person.
(8) Discharge or transfer data
(a) Date and time of discharge or transfer
(b) Reason for discharge or transfer
(c) Condition of patient at time of discharge or transfer
(d) Address to which discharged or transferred
(e) Accompanied by whom
(9) An individual narcotic and sedative record shall be maintained for each narcotic or sedative prescribed for each patient. This record shall be kept in a bound book with numbered pages in a manner approved by the Department, and shall include:
(a) Patient's name
(b) Name of physician prescribing the medication
(c) Name of medication; strength of dosage prescribed
(d) Amount of medication received
(e) Date received, prescription number, name of pharmacy dispensing medication
(f) Date, time, dosage and method of administration and the signature of nurse who administered the medication to the patient
(g) There shall be a recorded, dated narcotic and sedative count checked by the nurse going off duty on each shift in the presence of the nurse reporting on duty. The count shall be signed by both individuals.

(10) There shall be a record kept on all drugs transferred with a patient at the time of discharge or transfer. This record shall include:
- (a) Date, name and new address of patient
- (b) Name of patient's physician
- (c) List and amount of medications
- (d) Prescription numbers
- (e) Name of pharmacy that dispensed medications
- (f) Signature of person taking medication from the home
- (g) Witnessed signature of the responsible individual on duty in the home at the time of discharge

L. RESPONSIBILITIES OF THE LICENSEE

1. To insure humane, understanding care of the patients. Their personal and spiritual rights and privileges shall be respected at all times by all employees.
2. To provide a form so that all applicants for employment shall submit the following:
   a. All pertinent information regarding identification (maiden name included)
   b. Social Security number
   c. Qualifications and experience. Professional employees shall identify school of nursing, date of graduation and name at time of graduation. If registered nurse: Massachusetts registration number and year of original registration. If licensed practical nurse: Massachusetts license number and year of original licensure. Signature shall include full title.
   d. Written confirmation of the professional qualifications of all professional employees shall be obtained by the licensee when the employee cannot present his bona fide credentials.
   e. All employee data shall be on file for inspection by the Department.
3. To accurately report all accidents occurring to patients to the Department. This report shall include:
   a. Date, time and circumstances involved in the accident
   b. Attending physician's name
   c. Attending physician's report, including physical findings and treatment prescribed,
   d. Patient's prognosis
   e. Name of nurse on duty at time of accident, and names of witnesses, if any
4. To arrange with responsible persons or agencies for the provision and maintenance of the following patient necessities:
   a. Proper clothing, night attire and footwear, legibly marked and for seasonal wear
   b. Eye examinations and eyeglasses
   c. Ear examinations and hearing aids
   d. Dental care and dentures
   e. Prosthetic devices and braces
5. To arrange with the Division of the Blind of the Massachusetts Department of Education for the provision of recreational therapy for blind patients, and for patients with impaired vision.
6. To provide adequate rehabilitation facilities for patients, as prescribed by the attending physician.
7. To notify the hospital inspector promptly in writing of the resignation of any qualified nursing personnel and of the name and qualifications of the new appointee.
8. To strictly supervise all personnel as to cleanliness of person and clothing. Food handlers shall wear caps or hair nets, and shall be suitably clothed. Facilities shall be provided for the storage of street clothing for non-resident personnel when employed.
9. To report immediately by telephone the occurrence of epidemic disease and poisoning, including food poisoning, to the Department. On week-ends or holidays, call State House, Capitol Police. (This verbal report is to be confirmed in writing within 24 hours.)
10. To report as soon as possible in writing all fires involving patients, personnel or property.
11. To submit an annual report. This form, which shall be furnished by the Department, is to be filled out for the calendar year January 1 through December 31, and returned in duplicate not later than January 15 of each year.
12. To instruct all personnel as to their duties in cases of fire or other emergencies. A first-aid kit shall be provided.

13. To provide adequate storage facilities for the following:
    a. Patient's towels and washcloths
    b. Clothing during all seasons of the year, personal effects and valuables
    c. Beds, bed springs, mattresses, bed pillows and blankets when not in use
14. To provide adequate facilities for the proper disinfection of beds, bed springs, mattresses and bed pillows.
15. To provide adequate facilities and equipment for the proper sterilization of equipment as needed.
16. To assure the patient's punctual attendance at clinics, out-patient departments and physicians' offices when such appointments have been made.
17. To arrange for religious benefits for patients of all denominations, if desired.
18. To check and identify patients' medications and personal belongings at time of change of ownership of the home.
19. That a complete narcotic and sedative count shall be made by the licensee and the new owner at change of ownership. This count shall be recorded in the Narcotic and Sedative Book and shall be signed by the licensee and the new owner.
20. Pets
    a. Pets shall not be allowed in any of the following areas:
        (1) Patient facilities
        (2) Kitchens and areas used for preparation, serving or storage of food
        (3) Laundries
    b. No commercial breeding of pets shall be allowed in the home.
    c. All pets shall be fed and maintained in a sanitary manner.

SECTION III – REHABILITATION

A. OCCUPATIONAL THERAPY

1. Homes contemplating the establishment of an occupational therapy unit shall submit to the Director, Division of Hospital Facilities, Massachusetts Department of Public Health, in duplicate, the following information:
    a. Name and address of the home
    b. Date license was issued and number of beds
    c. Name, address and qualifications of the registered occupational therapist to be employed
    d. A floor plan of the home, identifying the proposed location of the unit to be used for occupational therapy
2. This unit shall be well lighted, ventilated and heated, and shall be separate and apart from rooms used for patient facilities. There shall be a bell or signal system to summon aid in an emergency.
3. A prescription for patient participation in occupational therapy shall be recorded, dated and signed in the Doctor's Order Book by the attending physician. This prescription shall state specifically all details regarding the type of occupational therapy prescribed.
4. A record shall be kept of the physical progress made by the patient and his reactions to the occupational therapy prescribed. This shall be incorporated in the patient's individual record.
5. The occupational therapy program shall be supervised by a registered occupational therapist.
6. All storage and unit facilities shall be maintained in a sanitary manner and kept in good repair.

B. RECREATIONAL THERAPY

1. Homes contemplating an organized recreational therapy unit shall submit to the Department a floor plan of the home, identifying the specific area to be used. The Department reserves the right to disapprove the location of the unit when indicated.
2. This unit shall be well lighted, ventilated, heated and equipped with a bell or signal system to summon aid in an emergency.

C. PHYSICAL THERAPY

1. No home shall be permitted to establish a physical therapy unit for treating patients without the

approval of the Director of the Division of Hospital Facilities, Department of Public Health.

2. The request for such approval shall be written in duplicate, signed by the licensee, and shall include:
   a. Name and address of home
   b. Date license was issued, and number of beds
   c. Name and address of licensee
   d. Name, address and qualifications of the registered physical therapist who will administer physical therapy
   e. A floor plan of the home, identifying the specific area to be used for administering physical therapy and/or for the storage of the equipment. The Department reserves the right to disapprove the location.
3. This unit shall be well lighted, ventilated and heated, and handwashing facilities shall be separate and apart from rooms used for patient occupancy or other patient facilities.
4. This unit shall be used exclusively for the administration of physical therapy treatments to resident patients.
5. Equipment used for physical therapy shall be approved by the American Medical Association.
6. All physical therapy equipment shall be serviced at least annually by a qualified person. No repairs shall be made except by a qualified person.
7. The following basic equipment shall be provided for the physical therapy unit:
   a. Treatment table and footstool; chairs
   b. Adequate linen supply
   c. Supply closets
   d. Sanitary waste containers
   e. Hamper for soiled linen
   f. Disposable towels
   g. Curtains or cubicles to assure privacy
   h. Desk or table and chair for clerical use
   i. Bell or signal system to summon aid in an emergency
8. A prescription for the administration of physical therapy shall be recorded, dated and signed by the prescribing physician in the Doctor's Order Book. This prescription shall state specifically the type of treatment to be given, and all details regarding the treatment.
9. The physical therapist shall record, date and sign all pertinent data pertaining to the treatment. This shall be incorporated in the patient's individual record.
10. No patient shall be unattended while receiving physical therapy treatments.
11. Physical therapy shall be administered by a qualified person:
    a. A physician registered to practice medicine in Massachusetts, or
    b. A physical therapist currently registered in Massachusetts
12. All equipment and facilities shall be maintained in a sanitary, safe condition and kept in good repair.
13. All plumbing and electrical installations required for the administration of physical therapy shall be inspected and approved by the appropriate local or state authorities.

REVISION OF THE RULES AND REGULATIONS FOR THE LICENSING OF CONVALESCENT OR NURSING HOMES - EFFECTIVE JANUARY 1, 1961

OLD REGULATIONS EXISTING PRIOR TO 1.1.61	NEW REGULATIONS EFFECTIVE 1.1.61
SECTION II	
A. GENERAL REGULATIONS FOR CONVALESCENT OR NURSING HOMES	
3. Physical Plant - Household and Property (p.5.) On and after the effective date of these regulations, all buildings not previously licensed as convalescent or nursing homes shall be of new construction or of such construction that upon suitable alterations they will meet the standards established by the Department.	A manager or other principal representative shall be designated by the licensee for each licensed Convalescent or Nursing Home. 3. Physical Plant - Household and Property All buildings not previously licensed by the Department of Public Health as convalescent or nursing homes shall be of new construction and designed specifically for the purpose of operating a convalescent or nursing home.
7. Dining Room (optional) (p.9.) a. Location and Equipment (1) Dining room facilities when provided shall be: (a) Suitably located in a well lighted, ventilated and heated area, and attractive. (b) Equipped with tables of sturdy construction with a hard surfaced, washable top.	7. Dining Room (a) Dining room is optional for nursing homes presently in existence. (b) Dining room for patients is required for all homes not previously licensed as a convalescent or nursing homes.

OLD REGULATIONS

EXISTINC PRIOR TO 1.1.61

A. Location and equipment (continued)

(1) Dining Room Facilities when provided shall be:

(c) Equipped with comfortable chairs of sturdy construction and of a sanitary type.

B. PATIENTS' ACCOMMODATIONS AND EQUIPMENT

2. Floor Area (p.10.)

For all new licenses issued after the effective date of these regulations

a. Single rooms shall have a minimum of 100 square feet of floor area.

b. Multi-bed rooms shall have a minimum of 70 square feet of floor area per adult bed, with at least 3 feet between beds.

NEW RECULATIONS

EFFECTIVE 1.1.61

(c) Dining room facilities, when provided, shall be:

(1) Suitably located in a well lighted, ventilated and heated area, and attractive.

(2) Equipped with tables of sturdy construction with a a hard surfaced, washable top.

(3) Equipped with comfortable chairs of sturdy construction and of a sanitary type.

(4) The dining room floors shall be covered with a waterproof and grease-proof covering.

B. PATIENTS ACCOMMODATIONS AND EQUIPMENT

2. Floor Area

a. For all homes, presently in existence, upon change of ownership or classification:

(1) Single rooms shall have a minimum of 100 square feet of floor area.

(2) Multi-bed rooms shall have a minimum of 70 square feet of floor area per bed, with at least 3 feet between beds, in multi-bed rooms.

OLD REGULATIONS
EXISTING PRIOR TO 1.1.61

3. Quota Increase (p.10.)

Any increase in quota granted after the effective date of these regulations must provide in the room or rooms under consideration:

a. 100 square feet of floor area in single rooms.

b. 70 square feet of floor area per adult bed, with at least 3 feet between beds, in multi-bed rooms.

5. Rooms for Patients (p.10.)

c. A well lighted and ventilated sitting room shall be provided for ambulatory patients. A reception hall or other facility cannot be used if it blocks an egress.

NEW REGULATIONS
EFFECTIVE 1.1.61

2. Floor Area (continued)

b. For all nursing homes not previously in existence and all additions to existing nursing homes,

(1) Single rooms shall have a minimum of 110 square feet of floor area.

(2) Multi-bed rooms shall have a minimum of 80 square feet of floor area per bed, with at least 3 feet between beds.

3. Quota Increase

Any increase in quota must provide in the room or rooms under consideration:

a. Single rooms must have a minimum of 110 square feet of floor area.

b. Multi-bed rooms must have a minimum of 80 square feet of floor area per bed, with at least 3 feet between beds.

5. Rooms for Patients

c. A well lighted and ventilated sitting room with direct outside exposure shall be provided for ambulatory patients.

d. All two story homes not previously licensed as a nursing home shall provide at least one sitting room on each floor.

OLD REGULATIONS
EXISTING PRIOR TO 1.1.61

SECTION II (p. 6.)

A 3b. A utility room with a separate entrance and physically partitioned from any toilet and/or bathing facility shall be provided in homes with 10 or more patients.

H. Utility Room (p.13.)

1. The utility room shall not be equipped or used as a toilet or bathing facility for patients and/or personnel. It shall provide the following facilities:

a through h

NEW REGULATIONS
EFFECTIVE 1.1.61

A b. Delete

H. Utility Room

1. A utility room physically partitioned from any toilet and/or bathing facility for patients and/or personnel with a separate entrance directly from a corridor shall be provided in homes with 10 or more patients.

2. Nursing homes of one story construction with 40 or more beds must provide two utility rooms.

3. Nursing homes of two story construction must provide at least one utility room on each floor.

4. A minimum of 35 square feet of floor area must be provided for utility rooms in existing facilities and a minimum of 60 square feet of floor area for new construction or homes not presently in existence.

5. The utility room shall provide the following facilities:

a through h (unchanged)

i. (now) Handwashing facilities with hot and cold running water.

RULES AND REGULATIONS FOR THE LICENSING OF REST HOMES IN MASSACHUSETTS

SECTION I

A. LEGAL AUTHORITY

1. General Laws, Chapter 111, Sections 71 to 73, inclusive, authorizes the Department of Public Health to issue for a term of two years, a license, subject to revocation by it for cause, to any person whom it deems suitable and responsible, to establish or maintain a rest home which meets the requirements of the Department, established in accordance with its rules and regulations.

2. In accordance with the authority granted by General Laws, Chapter 111, Sections 71 to 73, inclusive, the Department of Public Health herewith adopts the following rules and regulations for the conduct and supervision of rest homes.

3. *Penalty for Establishing or Maintaining a Rest Home without a License.* Whoever establishes or maintains or is concerned in establishing or maintaining a rest home, or is engaged in any such business, without a license granted under General Laws, Chapter 111, Section 71, shall for a first offense be punished by a fine of not more than five hundred dollars, and for a subsequent offense by a fine of not more than one thousand dollars or by imprisonment for not more than two years.

Penalty for Violation of Any Provision of Licensing Act (General Laws, Chapter 111, Sections 71 -73 inclusive) or any of the rules and regulations made under Section 72. Whoever, being licensed under Section 71 of the General Laws, Chapter 111, violates any provision of Sections 71 to 73, inclusive, of Chapter 111 of the General Laws or any rule or regulation made under Section 72, shall for a first offense be punished by a fine of not more than five hundred dollars; and for a subsequent offense by a fine of not more than one thousand dollars or by imprisonment for not more than two years.

B. DEFINITIONS

1. A rest home is defined as any institution, however named, which is advertised, announced or maintained for the express or implied purpose of providing care incident to old age to three or more persons over sixty years of age, who are not acutely ill or in need of medical or nursing care.
2. The term "Department" as used in these regulations shall mean the Massachusetts Department of Public Health.
3. The term "Department of Public Safety" shall mean the Massachusetts Department of Public Safety.
4. The terms "local board of health," "head of the local fire department," "local wire inspector" and "local zoning authority" shall mean the individual or agency as designated in the city or town in which the rest home is located.
5. The term "licensee" shall mean the individual or corporation that owns the business, and, therefore, is legally responsible for the conduct of the rest home and the care of the residents admitted thereto.
6. All adjectives and adverbs, such as accessible, adequate, approved, attractively, clean, competent, good, proper, qualified, reasonable, reliable, reputable, responsible, safe, sanitary, satisfactory, sufficiently and well, used in these rules and regulations to qualify a person, equipment or building shall be as determined by the Department.

C. PROCEDURE FOR LICENSURE OR LICENSE RENEWAL

1. *Issuance of License or License Renewal*
   a. Request for an application shall be made in writing to the Department.
   b. Application for a license or license renewal to establish or maintain a rest home shall be made in writing and submitted to the Department upon the application forms secured from the Department.

      Structural changes in a proposed or existing home shall not be undertaken until notification has been made to the Department and plans for structural changes have been approved by the Departments of Public Health and Public Safety.

c. Two copies of the completed application shall be returned to the Department.
d. Written zoning approval on a form provided by the Department is a prerequisite for an original license.
e. Local board of health certification on a form provided by the Department that said rest home is suitable for the purpose is a prerequisite for licensure.
f. A certificate of inspection of the egresses, the means of preventing the spread of fire and the apparatus for extinguishing fire issued by an inspector of the Division of Inspection of the Department of Public Safety in a prerequisite for licensure.
g. The local wire inspector shall certify in writing on a form provided by the Department that, from his inspection of the premises, there is compliance with local wiring codes; the corrected minor deficiencies shall be listed. In towns having no local wire inspector, the Department shall arrange with the state wire investigator for the same service and report. No license shall be issued or renewed without signed approval by the wire inspector or state wire investigator.
h. A certificate of inspection issued by the head of the local fire department, certifying compliance with the local ordinances is a prerequisite for licensure.
i. A check or money order for the license fee payable to the Commonwealth of Massachusetts shall be forwarded to the Department when requested.
j. The applicant shall be a suitable and responsible person.

2. *Name of Home*

Every rest home shall be designated by a permanent and distinctive name which shall appear on the application for license, and which shall not be changed without first notifying the Department. The term "rest home" shall appear in the name. The term "boarding home for the aged" SHALL NOT be used in the name of the home.

3. *Quota*

a. Each license issued by the Department of Public Health shall specify the maximum allowable number of beds on each floor in the home, which shall not be exceeded. The number of beds allowed on each floor shall be determined by the Department of Public Health and shall so appear on the license issued by said Department.
b. Requests for quota increase shall be made in writing to the Department. No increase will be granted without written approval of the Director or the Chief Hospital Inspector of the Division of Hospital Facilities of the Department and the building inspector of the Department of Public Safety.

4. *Occupancy*

a. Rooms below grade level shall not be used for residents.
b. Occupancy of rooms above the second floor shall be restricted to employees and members of the immediate family of the licensee.
c. Rooms without basement foundations shall not be used for residents unless there is proper heating and insulation.

D. POSTING OF THE DEPARTMENT LICENSE AND THE DEPARTMENT OF PUBLIC SAFETY CERTIFICATE OF INSPECTION

1. The license issued by the Department of Public Health and the certificate of inspection issued by the Department of Public Safety shall be framed and posted conspicuously on the premises.

E. RETURN OF LICENSE

1. The license issued by the Department of Public Health shall be returned immediately by registered mail to the Department on
a. Receipt of renewal license
b. Revocation
c. Change of location
d. Change of ownership
e. Change of name
f. Change of quota
g. Voluntary closare
h. Change of classification
i. Demise of licensee

F. CHANGE OF OWNERSHIP AND/OR LOCATION

The Department shall be notified immediately in writing of any proposed change in location, name or ownership

of the home. A new application must be submitted at once in the instance of change of ownership or change of location. A license cannot be transferred from one individual to another or from one location to another. In the case of transfer of ownership, the application of the new owner for a license to maintain a rest home shall have the effect of a license for a period of three months, when acknowledged by the Department. The quota granted to the former licensee shall not be exceeded until approved by the Director or the Chief Hospital Inspector of the Division of Hospital Facilities of the Department and the building inspector of the Division of Inspection, Department of Public Safety.

G. RESTRICTIONS

1. No home in which part of the premises is utilized for tenant occupancy or for business or professional purposes shall be approved for licensure.
2. Alterations and structural changes to the premises cannot be made until plans for proposed changes have been submitted to and approved by the Departments of Public Health and Public Safety.

H. RIGHT OF APPEAL

1. A licensee or an applicant aggrieved by the decision of the hospital inspector shall have the right of appeal to the Chief Hospital Inspector or the Director, Division of Hospital Facilities.
2. Any person aggrieved by the refusal of the local board of health to certify that the rest home is suitable for the purpose may, in writing, appeal to the Director, Division of Hospital Facilities, Department of Public Health, for a public hearing. The Department shall hold said hearing and thereafter may modify, affirm or reverse the action of the local board of health.
3. Any applicant for an original license who is aggrieved by rejection of his application by the Department of Public Health on the basis of written disapproval, by the head of the local fire department or by the inspector of the Division of Inspection of the Department of Public Safety may, within thirty days, make an appeal in writing from such refusal to a board of review. The board shall, within twenty days of the receipt of such appeal, give the parties in interest an opportunity to be heard and shall, within thirty days after such hearing, render a decision, which shall be a matter of public record.

   Within thirty days after action by the board of review, a person who is aggrieved by the refusal of said board to approve his application may bring a petition in the district court within the judicial district where the premises on which the application was based are located, addressed to the justice of the court, praying that the action of the board in refusing to approve his application may be reviewed, and after such notice as said court shall direct to all parties interested a hearing may be had before the court at an early and convenient time fixed by it; or the court may appoint three disinterested persons conversant with the subject matter of the controversy to examine the matter and hear the parties. The decisions of said court or the written decision under oath of a majority of those appointed by the court filed in the office of the clerk of courts in said county within ten days after such hearing may annul or affirm such refusal. Such decision, or a certified copy thereof, shall have the same authority, force and effect as an original refusal or approval by the board. If such decision results in the approval of an application for a license which the board has denied, the court shall order said license to be issued.
4. Upon written request by an applicant who is aggrieved by the refusal to renew such a license, or by a holder who is aggrieved by the revocation of such a license, as the case may be, the Commissioner of Public Health and the Public Health Council shall hold a public hearing after due notice and thereafter may modify, affirm or reverse the action of the Department.

I. REVOCATION OF LICENSE

A license to operate a rest home may be revoked by the Department in accordance with General Laws, Chapter 111, Sections 71 to 73, inclusive, for any of the following reasons:

1. Violation of the provisions of the licensing act or of the standards, rules or regulations of the Department adopted thereunder.
2. Permitting, aiding or abetting the commission of any illegal act in such home.

SECTION II

A. GENERAL REGULATIONS FOR REST HOMES

1. *Fire Protection*
   a. Employees of the home shall be instructed by the head of the local fire department or his representative as to their duties in case of fire.
   b. Fire extinguishers shall be recharged and so labeled at least once a year.

c. Where sprinkler systems are installed, the water pressure shall be checked weekly by the individual in charge of the home.
d. Lighting facilities shall be available in all common halls and inside and outside stairways.
e. Emergency lights shall be checked weekly by the individual in charge of the home.
f. All exits shall be clearly identified by exit signs, adequately lighted, and shall be free from obstruction.
g. Gas dryers shall be inspected by the proper authorities.
h. All fires involving residents, personnel or property shall be reported to the Department.
i. There shall be at least one telephone on each floor where personnel reside. All telephones shall be available for use in any emergency, for both incoming and outgoing calls.

.2. *Sanitation*

a. Water Supply
(1) The water shall be of sanitary quality and shall be obtained from a source approved by the Department.
(2) There shall be sufficient water pressure to meet the sanitary needs of the home at all times.
(3) If the water supply is not from a municipal system, said supply shall meet the approval of the Department.

b. Milk Supply
(1) Milk and cream shall be pasteurized and shall be delivered to the home and stored in the home in containers approved by the Department.
(2) All milk and cream products used for residents and employed personnel shall be made from pasteurized milk.

c. Ice Supply
Ice which comes in contact with food or drink shall be delivered, stored, handled and dispensed in a sanitary manner.

d. Sewage Disposal
All sewage shall be discharged into a municipal sewerage system where such is available; otherwise, the sewage shall be collected, treated and disposed of by means of an independent sewerage system approved by the Department.

e. Toilet, Handwashing and Bathing Facilities
(1) Adequate toilet, handwashing and bathing facilities shall be provided on each floor in a reasonable ratio to the number and sex of residents and personnel in the home.
(2) Toilets, baths or shower compartments shall be separated from all rooms by solid walls or partitions. Adequate provisions to insure resident privacy shall be made.
(3) Toilet, handwashing and bathing facilities must be kept in good repair, and the floor area surrounding the toilet must be maintained in a sanitary manner and in good repair.
(4) Handrails or grab bars shall be provided near showers, tubs and toilets.

f. Waste Disposal
(1) All waste shall be stored, indoors and out of doors, in covered, sanitary, fireproof containers, and subsequently disposed of at proper intervals in a manner to prevent fire hazard, contamination and nuisance.
(2) All homes shall provide proper facilities for disinfection of these containers at all times of the year.

g. Garbage Disposal
(1) Suitable sanitary facilities shall be provided for the collection, storage and disposal of garbage.
(2) Garbage shall be stored, indoors and out of doors, in clean, watertight containers with tight-fitting covers.
(3) All homes shall provide facilities for proper disinfection of these containers at all times of the year.

3. *Physical Plant - Household and Property*

On or after the effective date of these regulations, all buildings not previously licensed as rest homes shall be of new construction or of such construction that upon suitable alteration they will meet the standards established by the Department.

a. The buildings, equipment and surroundings shall be maintained in a condition of good repair, neat, clean and free from all accumulation of dirt and rubbish and foul, stale or musty odors. The type of construction shall be in conformity with existing local and State building, electrical and plumbing codes. All plumbing, including pipes carrying water for drinking and culinary purposes and all pipes installed for the disposal of sewage and wastes, shall be in accordance with the rules of the city or town having jurisdiction over such installations. In the absence of such rules relative to plumbing, these installations

must conform to the rules established in accordance with G.L. Ch. 142, section 21. The entire building shall be open for inspection without prior notice by authorized agents of the Department of Public Health and the Department of Public Safety.

b. The floors of the following areas shall be waterproof, grease proof and resistant to heavy wear:
   Kitchens (main and auxiliary)
   Food preparation and food storage areas
   Bathrooms and toilets
   Laundry

c. The walls of the following areas shall have a waterproof, glazed, painted or similar surface which will withstand washing:
   Kitchens (main and auxiliary)
   Food preparation area and areas where food is served
   Bathrooms and toilets

d. Adequate provision shall be made for the storage of housekeeping supplies and equipment, separate from any toilet.

e. The premises shall be maintained in such a manner as to prevent infestation by rodents and insects. Arrangements shall be made for extermination when required.

f. Screens, Doors and Windows
   (1) Outside doors, windows and openings shall be protected against flies and other insects by the seasonal use of screens.
   (2) Windows and doors shall be weather-stripped when necessary to avoid drafts.
   (3) All windows, including combination windows, shall be washed inside and outside at least twice a year.

g. Heating
   (1) Adequate heating shall be provided in all rooms used by residents to maintain a minimum temperature of 78°F. in cold weather.
   (2) The heating system shall be in conformity with the rules and regulations outlined by the Department of Public Safety under Chapter 148, as amended.

h. Lighting and Ventilation
   (1) Each resident's room shall have direct outside exposure with adequate unobstructed natural light and adequate ventilation.
   (2) Adequate artificial lighting shall be available in all rooms, stairways and hallways of buildings. Night lights shall be provided in all resident's rooms and in all hallways, stairways, bathrooms and front and back porches.
   (3) No electric bulb under 40 watts shall be used for illumination for residents' use. Hallways, stairways and bathrooms shall be illuminated at night by at least 7½ watt bulbs.
   (4) Kitchens and areas when located below grade level and used for the preparation and serving of food shall have direct access to the outside by means of suitable windows. Otherwise, ventilation shall be provided to permit an air supply and exhaust of at least ten air changes an hour. Ventilating units shall be maintained in a sanitary manner and kept in good repair.
   (5) All main kitchens shall be provided with a mechanical ventilator or a ventilating fan.
   (6) Kitchens (main and auxiliary), food preparation and food storage areas, bathrooms and toilets shall have adequate artificial lighting, kept in good repair.
   (7) Bathrooms and toilets shall have direct access to the outside by means of suitable windows or a forced system of exhaust, which shall be maintained in a sanitary manner and kept in good repair.

4. *Laundry*

a. Location
   The laundry shall be situated in an area separate and apart from any facility used for the storage, preparation or serving of food.

b. Physical Facility
   The laundry area shall be well lighted and ventilated and adequate in size for the needs of the home, and shall be maintained in a sanitary manner and kept in good repair.

c. Commercial Laundries
   (1) When adequate facilities are not available on the premises for the proper and sanitary washing of linen and other washable goods, the services of a commercial laundry or laundry rental service shall be utilized.

d. Equipment
(1) All homes shall provide a set tub equipped with hot and cold running water in the laundry.
(2) Automatic washers and drying and ironing facilities shall be provided to meet the needs of the home.

e. Handling of Soiled Linen
(1) All soiled linen shall be placed in a bag and stored in a manner to prevent contamination and odors.
(2) All soiled linen shall be collected and transported to the laundry in the washable containers in which it was collected.
(3) Handwashing facilities shall be available in the laundry area where soiled linen is handled and/or sorted.
(4) Soiled linen shall be handled and stored in such a manner as to prevent contamination of clean linen.
(5) Adequate facilities shall be provided for the proper and sanitary washing of linen and other washable goods.

f. Handling of Clean Linen
(1) Clean linen shall be sorted, dried, ironed and folded in a sanitary manner in a specified area.
(2) Clean linen shall be transported, stored and distributed in a sanitary manner.
(3) Closets conveniently located shall be provided for the storage of clean linen, and shall not be used for any other purpose.

g. Personal Laundry
(1) Residents' and personnel's personal laundry shall be collected, transported, sorted, washed and dried in a sanitary manner.
(2) Personal laundry shall not be washed with the bed linen.

h. Laundry Personnel
Laundry personnel shall be properly clothed so as to prevent contamination of clean linen.

5. *Food Sanitation*

a. There shall be adequate facilities and equipment for the proper storage of all food supplies, for both residents and personnel, maintained in a sanitary manner and kept in good repair.

b. Refrigeration
(1) All perishable food, including milk and milk products, shall be adequately refrigerated, stored in a sanitary manner and properly spaced for adequate refrigeration.
(2) There shall be a reliable thermometer in each refrigerator and storeroom used for perishable foods.
(3) All foods shall be dated before being stored in a deep freeze.

c. Dishwashing
All dishes, including glasses and utensils used for eating, drinking, preparing and serving food and drink, shall be cleansed and sanitized after each usage. If a dishwashing machine is provided, a single-section sink is acceptable, otherwise double-section sinks are a requirement. If dishes are washed by hand, the temperature of the wash water shall be between 110°and 120° F. This shall be followed by immersion in racks in water at a temperature of 170° F. for thirty seconds. If a dishwashing machine is used, the temperature of the wash water shall be between 140° and 160° F. with a final rinse at a temperature of 170° F. or higher. After sanitization, all dishes shall be allowed to drain and dry in racks or baskets on a nonabsorbent surface.

d. Handwashing Facilities for Food Handlers
There shall be adequate facilities with soap or detergent, running hot and cold water, and an adequate supply of individual disposable towels in all kitchens, and in washrooms used by food handlers.

6. *Dietary Services and Facilities*

a. Kitchens
(1) No new license shall be issued after the effective date of these regulations unless the main kitchen is located in a suitable area.
(2) The main kitchen shall provide adequate work space for the preparation and serving of meals for the residents and personnel, in accordance with the size of the home.
(3) There shall be adequate sanitary storage facilities provided for all equipment used for the preparation and serving of food.

b. Auxiliary Kitchens
Auxiliary kitchens shall be provided and adequately equipped when the size of the home or the physical plant indicates the need, as determined by the Department.

c. Dumb-Waiter

A dumb-waiter when provided for the transportation of food shall be suitably located and used exclusively for the transportation of food. It shall be cleaned daily and kept in good repair.

e. Equipment

(1) Stoves, sinks, counters, cabinets, shelves, tables, refrigerating equipment and all other equipment necessary for the preparation and serving of food shall be provided in accordance with the size of the home. This equipment shall be so constructed that it can be easily cleaned, maintained in a sanitary manner and kept in good repair.

(2) Food shall be prepared and served so that hot food shall be hot and cold food shall be cold when served to the resident.

(3) There shall be an adequate supply of trays, glassware, dishes and silverware for individual resident use. Discolored, chipped or cracked dishes or glassware shall not be used. Silverware of good quality shall be provided and kept in good condition.

(4) Food shall be transported from main kitchens to auxiliary kitchens in suitable containers and/or conveyors.

(5) Trays

(a) Individual tray service shall be provided for residents if satisfactory dining facilities are not available.

(b) Trays shall be washable and of a type that can be sanitized.

(c) No tray shall be served without a washable or disposable tray cover.

(d) Trays shall be large enough to accommodate all of the dishes necessary for a complete meal, served attractively.

(e) Clean napkins shall be provided for all boarders at all meals or between-meal nourishment.

(f) All trays set up in advance of meal time must be adequately covered to prevent contamination.

(g) Suitable tray racks shall be provided.

(h) At the main meal, the main course shall be served on a standard-size dinner plate.

e. Food

(1) There shall be an adequate supply of food of good quality on hand at all times to meet the needs of the home. All food shall be served attractively in dishes.

(2) Meals for the residents shall be of adequate quantity, well planned, well balanced and sufficiently varied. Weekly diet menus shall be maintained.

(3) Special diets must be prepared and served, when prescribed. These menus shall be posted conspicuously.

(4) Breakfast shall not be served before 7:00 a.m. Supper shall not be served before 5:00 p.m. Night nourishment shall be provided as indicated.

f. Kitchen Waste and Garbage

Kitchen waste and garbage shall be emptied after each meal, and the containers and covers shall be washed, dried and aired before being returned to the kitchen.

7. *Dining Room (Optional)*

a. Location and Equipment

(1) Dining room facilities when provided shall be:

(a) Suitably located in a well lighted, ventilated and heated area, and attractive.

(b) Equipped with tables of sturdy construction with a hard-surface, washable top.

(c) Equipped with comfortable chairs of sturdy construction and of a sanitary type.

8. *General Maintenance and Housekeeping*

a. The home shall be kept in good repair, clean and sanitary at all times, and in a manner so as to prevent the entrance and harborage of rats, other rodents, vermin and insects.

b. There shall be facilities and equipment provided for housekeeping of the following:

(1) Basement

(2) Laundry

(3) Kitchen

(4) Each floor

c. Equipment shall include an adequate supply of:
   (1 Wet and dry mops (improvised mops shall be prohibited)
   (2) Mop pails
   (3) Radiator brushes
   (4) Cleaning supplies
d. Non-skid floor wax shall be used.
e. A vacuum cleaner shall be provided for each home, and kept in good repair.
f. All housekeeping equipment and cleaning supplies shall be kept in good condition, maintained in a sanitary manner and stored in suitable storage areas. Such equipment shall not be stored in lavatories, bathrooms or halls or on stairs.
g. Wet mops shall be laundered daily.
h. Dry mops, if washable, shall be laundered twice a week.
i. Dusters and cleaning cloths shall be laundered daily.

B. ACCOMMODATIONS AND EQUIPMENT FOR RESIDENTS

1. *Floor Area*

For licenses in existence on the effective date of these regulations,

a. Single rooms shall have a minimum of 60 square feet of floor area.
b. Multi-bed rooms shall have a minimum of 60 square feet of floor area per adult bed, with at least 3 feet between beds.

2. *Floor area*

For all new licenses issued after the effective date of these regulations,

a. Single rooms shall have a minimum of 100 square feet of floor area.
b. Multi-bed rooms shall have a minimum of 70 square feet of floor area per adult bed, with a least 3 feet between beds.

3. *Quota Increase*

Any increase in quota granted after the effective date of these regulations must provide in the room or rooms under consideration:

a. 100 square feet of floor area in single rooms.
b. 70 square feet of floor area per adult bed, with at least 3 feet between beds in multi-bed rooms.

4. *Window Area*

For new licenses issued after the effective date of these regulations, the minimum window area shall be at least one-eighth of the floor area.

5. *Rooms for Residents*

a. All rooms used for residents shall be outside rooms.
b. No room or ward off a kitchen shall be used for resident care unless another acceptable means of entrance is provided.
c. A well lighted and ventilated sitting room shall be provided for residents. A reception hall or any facility cannot be used if it blocks an egress.
d. Each home with eighteen or more residents in which residents do not have a private room shall have a suitable room which can be used for serious illness pending the transfer of the resident.
e. Provision shall be made for the immediate removal of a body from a multi-bed room in the event of death.

6. *Equipment*

a. Beds of household height shall be used and spaced three feet apart Beds shall be arranged so as to avoid drafts, heat from radiators and other discomforts. Cots and folding beds are not permitted.
b. Each resident shall be provided with:
   (1) A comfortable bed, bed spring and mattress, which shall be maintained in a sanitary condition and kept in good repair. The mattress shall be protected by a cover and pad.
   (2) An adequate number of bed pillows of good quality for each resident, maintained in a sanitary condition and in good repair.
   (3) An adequate supply of bed linen, bed blankets, bedspreads, towels and washcloths of good quality for each resident, maintained in a sanitary manner and kept in good condition.
   (4) A bedside table adequate for individual needs, maintained in a sanitary condition and kept in good repair.
   (5) A comfortable chair suited to individual needs, maintained in a sanitary manner and kept in good repair.

(6) Footstools according to residents' needs, maintained in a sanitary manner and kept in good repair.
(7) Adequate artificial lighting in each room to meet individual resident needs, kept in good repair.
(8) A bureau or other adequate provision for the storage of residents' clothing, maintained in a sanitary manner and kept in good repair.
(9) Washable window curtains or draperies for all resident bedrooms, kept clean and in good condition.
(10) An individual mouthwash cup, a toothbrush and dentifrice, and containers for the care of residents' dentures, maintained in a sanitary manner.
(11) An individual soap dish and bar of soap.
(12) Individual sputum receptacles of a sanitary type shall be provided when needed and maintained in a sanitary manner.
(13) Sufficient bedpans, urinals, hand wash basins, bath basins and emesis basins for emergency use when residents are ill with short-term illnesses, such as colds or grippe. This equipment shall be maintained in a sanitary manner and kept in good condition. It shall be stored in such a manner that it cannot be interchanged between residents.
(14) A portable screen or other suitable facility when needed to insure resident privacy.
(15) A signal system or a hand bell shall be provided for each resident at the bedside. Bathrooms and sitting rooms shall have a signal system or hand bell for emergency use by residents.

c. A standard scale for weighing residents shall be provided.
d. All stairways used by boarders shall be well lighted, and provided with hand rails on both sides.
e. Grip bars properly placed shall be in all bathrooms used by residents.
f. An adequate number of wastebaskets of a sanitary type shall be provided in each resident's room and sitting room and maintained in a sanitary manner.

7. Adequate facilities and equipment shall be provided for the proper disinfection of:
   a. Beds
   b. Bedsprings
   c. Bed pillows
   d. Mattresses
8. Adequate storage space shall be provided for the following:
   a. Residents' towels and washcloths, when not in use.
   b. Beds, bedsprings, mattresses, bed pillows and blankets.
   c. Residents' clothing during all seasons of the year, personal effects and valuables.

C. MEDICAL SUPERVISION

1. Each resident or his guardian or the agency responsible for his care shall on admission designate the name and address of a physician registered to practice medicine in Massachusetts to be responsible for his medical supervision, including periodic checkups.
2. Each resident on admission shall have a physical examination, including blood pressure, and these findings, with the routine to be carried out, shall be recorded and signed by a physician registered to practice medicine in Massachusetts.
3. No person requiring nursing care shall be admitted to a rest home.
4. No person who develops a need for nursing care shall be cared for in a rest home. Arrangements shall be made for the transfer of such individuals to a suitable facility. (Exception: Care for temporary short-term illness, such as cold or grippe.)
5. No resident shall be transferred or discharged from the home without a dated, recorded, signed statement of his or her physical condition made by the attending physician at the time of transfer or discharge.
6. All medical and psychiatric consultations shall be dated, recorded and signed by the examining physician at the time of examination.
7. No medication or therapeutic diet shall be given to a resident except on the written order of a physician registered to practice medicine in Massachusetts.

D. SUPERVISION AND CARE OF MEDICATIONS

1. A medicine cabinet or closet of a type approved by the Department shall be provided for the proper storage of all residents' drugs.
2. The medicine cabinet or closet shall be located in an area that is inaccessible to residents or visitors.
3. The medicine cabinet shall be well lighted, shall have running water easily accessible, and shall be provided with a suitable lock and kept locked at all times.

4. There shall be a separate locked compartment within the locked medicine closet for the proper storage of prescribed narcotics and sedatives.
5. Poisons and medications for external use only shall be kept separate and apart from internal medications in a locked compartment.
6. A responsible person shall be in charge of and administer all medications to residents.
7. Custody of the key to the medicine closet shall be assigned to a responsible person at all times.
8. All medications shall be accurately recorded and accounted for at all times.
9. No medication for a specific resident shall be administered to another resident.
10. Medications shall not be stored in residents' rooms.
11. Medicines shall not be removed from their original containers.
12. Prescription labels shall not be defaced.
13. Medications having a specific expiration date shall not be used after date of expiration.
14. Medicines shall be properly refrigerated when required.
15. Following a resident's transfer or discharge, all drugs prescribed for said resident, if not transferred with the resident, shall be disposed of as follows:
    a. Narcotics and sedatives shall be destroyed in the home in the presence of the hospital inspector and the fact duly recorded, dated, timed, signed and witnessed in the Narcotic and Sedative Book (Sec. I - 2c)
    b. All other drugs shall be disposed of as directed by the hospital inspector.
16. Upon the death of a resident, all drugs prescribed for said resident shall be disposed of as follows:
    a. Narcotics and sedatives shall be destroyed in the home in the presence of the hospital inspector, and the fact duly recorded, dated, timed, signed and witnessed in the Narcotic and Sedative Book.
    b. All other drugs shall be disposed of immediately as directed by the hospital inspector.
17. The medicine cabinet or closet shall be used exclusively for the storage of medications and equipment required for their administration. This cabinet or closet shall be maintained in a sanitary manner.
18. Rubbing alcohol, when not in use, shall be stored in a locked closet.

E. PERSONNEL

1. There shall be at least one person physically and temperamentally qualified who is responsible for the supervision and care of the residents at all times.
2. There shall be sufficient and adequate personnel maintained to provide adequate supervision and care of the residents, and for the satisfactory maintenance of the home at all times.
3. No male individual shall care for female residents.
4. There shall be sufficient personnel maintained for relief and vacation periods.
5. Homes with 18 or more residents shall provide a person for night duty to supervise residents' needs at night.

F. SUPERVISION OF CARE INCIDENT TO OLD AGE

1. *Health Supervision*
    a. In the event of illness or accident the resident's physician shall be notified immediately.
    b. Each resident shall have a complete physical examination at least once a year. Special examinations, when indicated, shall be arranged for the care of the residents' eyes, ears and teeth. Ey- glasses, hearing aids and dentures shall be provided when indicated by the responsible individuals or agencies.
    c. Proper arrangements shall be provided for residents reporting to clinics or to a doctor's office.
2. *Personal Hygiene*

    The functions to be supervised by the licensee shall include:
    a. A bath at least twice a week
    b. A shampoo at least twice a month
    c. A shave at least twice a week
    d. A haircut as needed
    e. The care of feet, hands and nails
3. *Clothing*

    Supervision of residents shall insure the following:
    a. That proper seasonal clothing and footwear are provided and maintained in good condition.
    b. That proper seasonal clothing and footwear are worn.
    c. The care of personal laundry, mending and dry cleaning.
    d. Provision of adequate night attire.

4. *Occupational Therapy and Rehabilitation*
   These shall be supervised as prescribed (see Section III). Arrangements shall be made with the Division of the Blind of the Massachusetts Department of Education for provision for occupational therapy and recreational facilities for residents who are blind or have impaired vision.
5. *Care During Temporary Illness*
   In the event a resident is temporarily ill, the following shall be provided:
   a. Adequate equipment for care during temporary short-term illness, kept in good repair and maintained in a sanitary manner. This equipment, when not in use, shall be stored in a manner approved by the Department.
   b. Tray service if a resident is temporarily ill and unable to go to the dining-room.

G. ADMISSIONS

1. Admissions to rest homes are restricted to persons who are ambulatory and who are not in need of nursing care.
2. No rest home shall admit a person suffering from a contagious disease, or a person requiring prenatal or maternity care.
3. No rest home shall admit or care for persons who are suffering from insanity or abnormal mental conditions, or persons who are addicted to the use of narcotics or stimulants.
4. Persons released by and under the supervision of the Department of Mental Health are eligible for admission provided prior approval has been received from the Department of Public Health.
5. No person receiving shock therapy shall be admitted to a rest home.
6. No person shall receive shock therapy in the home.

H. RESIDENT TRANSFER OR DISCHARGE

1. No licensee shall arrange for the transfer of a resident from one home to another or for his or her discharge without the written permission of the resident, a responsible individual or relative, or a responsible public or private agency.
2. The resident shall be examined by a physician prior to transfer or discharge. The physical findings of this examination shall be recorded and signed and dated on the resident's record by the examining physician.
3. A record shall be kept of all drugs transferred with a resident at the time of discharge or transfer. This record shall include:
   a. Date, name and new address of resident
   b. Name of resident's physician
   c. List and amount of medications
   d. Prescription numbers
   e. Name of pharmacy that dispensed medications
   f. Signature of person taking medication from the home
   g. Witnessed signature of the responsible individual on duty in the home at the time of transfer

I. RECORDS

1. Each home shall provide a suitable area, conveniently located, for the recording and storage of resident records.
   The following equipment shall be provided:
   a. Desk or table and chair
   b. Adequate lighting
   c. File cabinets for active and inactive records
2. Required record material for each home shall include:
   a. A standard type bound Resident Register Book for the recording of admissions, transfers, discharges, deaths and other required data
   b. A bound Doctor's Order Book with a stiff cover and numbered pages
   c. A bound Narcotic and Sedative Book with a stiff cover and numbered pages
   d. Heavy cardboard folders and/or file cabinet for filing of individual resident records
   e. Record forms for all pertinent medical and other data, as required by the Department
   f. Record form for listing residents' clothing, personal effects and valuables at time of admission
3. All records shall be permanent, either typewritten or legibly written with pen and ink (no record shall be written with pencil). No erasures or ink eradicator shall be used. No pages shall be removed from bound books.
4. A complete and accurate record shall be maintained for each resident from the time of admission to the time of discharge. This record shall be kept in an individual folder or file and shall include all pertinent medical

and other data in chronological order. This record shall be filed in a safe manner and kept in the home for not less than five years following the resident's discharge or death.

5. Resident's record shall include:
   a. Identification data
      Date and time of admission; resident's name, previous address, age, sex, color, race, marital status (married, single, divorced or widowed) and religion; name and address of referring physician or hospital; name and address of attending physician; name, address and telephone number of person or agency responsible for resident.
   b. Medical records
      (1) A statement of the resident's physical condition and diagnosis at the time of admission, transfer or discharge, dated and signed by the attending physician, shall be incorporated in the resident's record within twenty-four hours after admission and prior to transfer or discharge.
      (2) All doctors' visits and orders for treatments and diet during period of temporary illness shall be dated, recorded and signed in the Doctor's Order Book by the attending physician.
      (3) Residents shall be examined at least annually and said physical examination shall be dated, recorded and signed by the attending physician and incorporated in the resident's record.
      (4) All medical and psychiatric consultations shall be dated, recorded and signed by the examining physician and incorporated in the resident's record.
      (5) A record shall be kept of all accidents occurring to residents in the home including the date and time of accident, physical findings and treatment prescribed. This record shall be signed by the attending physician and incorporated in the resident's record.
   c. Residents' individual records
      (1) Admission data
         How admitted -- referred by whom and accompanied by whom, date and time
      (2) Description of resident's condition upon admission, including weight, recorded and signed by admitting personnel.
      (3) Date, time, dosage and method of administration of any medications administered during period of temporary illness.
      (4) The person administering medications shall record and sign them on the residents' record.
      (5) All pertinent data relating to residents shall be recorded on the weekly resident's record and signed by the individual responsible for resident supervision. Weight shall be recorded monthly.
      (6) A list of the resident's clothing, personal effects and valuables shall be entered at time of admission on a form, dated and signed by the resident or responsible person and witnessed. A copy of this list shall be given to the resident or other responsible person.
      (7) Discharge or transfer data
         (a) Date and time of discharge or transfer
         (b) Reason for discharge or transfer
         (c) Condition of resident at time of discharge or transfer
         (d) Address to which discharged or transferred
         (e) Accompanied by whom
      (8) An individual narcotic and sedative record shall be maintained for each narcotic or sedative prescribed for each resident during period of temporary illness. This record shall be kept in the Narcotic and and Sedative Book in a manner approved by the Department and shall include:
         (a) Resident's name
         (b) Name of physician prescribing the medication
         (c) Name of medication, strength of dosage prescribed
         (d) Amount of medication received
         (e) Date medication received, prescription number, name of pharmacy dispensing medication
         (f) Date, time, dosage and method of administration of medication
         (g) Signature of person administering medication
         (f) There shall be a recorded, dated narcotic and sedative count checked daily and signed by the responsible person in charge.

J. RESPONSIBILITIES OF THE LICENSEE

1. To insure humane understanding care of the residents. Their personal and spiritual rights and privileges shall be respected at all times by all employees.

2. Pertinent information regarding employees shall be on file in the home and available for inspection and shall include name in full, maiden name if any, address, Social Security number and previous experience, if any.
3. A complete and accurate report of all accidents occurring to residents shall be submitted by the licensee to the Department. This report shall include:
   a. Date, time and circumstances involved in the accident
   b. Attending physician's name
   c. Attending physician's report and treatment prescribed
   d. Condition of resident
   e. Name of person in charge at time of accident, and names of witnesses, if any.
4. Arrangements shall be made with responsible persons or agencies when indicated for the provision and maintenance of the following resident necessities:
   a. Proper clothing, night attire and footwear, legibly marked and for seasonal wear.
   b. Eye examinations and eyeglasses
   c. Ear examinations and hearing aids
   d. Dental care and dentures
   e. Prosthetic devices and braces
5. Arrangements shall be made with the Division of the Blind of the Massachusetts Department of Education for the provision of recreational and occupational therapy for blind residents and for residents with impaired vision.
6. All personnel shall be strictly supervised as to cleanliness of person and clothing. Food handlers shall wear caps or hair nets, and shall be suitably clothed. Facilities shall be provided for the storage of street clothing for non-resident personnel when employed.
7. To report immediately by telephone giving complete and accurate details to the Department the occurrence of epidemic disease and poisoning, including food poisoning. On weekends or holidays call State House, Capitol Police. This verbal report is to be confirmed in writing within 24 hours.
8. To report as soon as possible in writing all fires involving residents, personnel or property.
9. Instruct all personnel as to their duties in case of fire or other emergencies. A first-aid kit shall be provided.
10. To encourage residents' punctual attendance at clinics when such appointments have been made.
11. To submit an annual report. This form, which shall be furnished by the Department, is to be filled out for the calendar year, January 1 through December 31, and returned in duplicate not later than January 15 of each year.
12. To provide adequate facilities for storage of the following.
   a. Towels and washcloths.
   b. Clothing during all seasons of the year, personal effects and valuables.
   c. Beds, bed springs, mattresses, bed pillows and blankets when not in use.
13. Beds, bedsprings, mattresses, bed pillows and bed rubbers shall be properly disinfected as indicated and following the discharge, transfer or death of a resident. Adequate equipment shall be provided for said disinfection.
14. All equipment used for the administration of medications and treatments shall be properly cleaned and sterilized after each usage.
15. To arrange for the religious benefits for residents of all denominations, if desired.
16. To check and identify residents' medications and personal belongings at time of transfer of ownership of the home.
17. A complete narcotic and sedative count shall be made by the licensee and the new owner at time of transfer of ownership. This count shall be recorded in the Narcotic and Sedative Book, and shall be signed by the licensee and the new owner.
18. Pets
   a. Pets shall not be allowed in any of the following areas:
      (1) Kitchens and areas used for preparation, serving or storing of food
      (2) Laundries
   b. No commercial breeding of pets shall be allowed in the home.

SECTION III — REHABILITATION

A. OCCUPATIONAL THERAPY

1. Homes contemplating the establishment of an occupational therapy unit shall submit to the Director, Division of Hospital Facilities, Massachusetts Department of Public Health, in duplicate, the following information:

a. Name and address of the home
b. Date license was issued and number of beds
c. Name address and qualifications of the registered occupational therapist to be employed
d. A floor plan of the home identifying the proposed location of the unit to be used for occupational therapy

2. The unit, when provided, shall be well lighted, ventilated and heated, and shall be separate and apart from rooms used for resident facilities. There shall be a bell or signal system to summon aid in an emergency.
3. A prescription for resident participation in occupational therapy shall be recorded, dated and signed in the Doctor's Order Book by the attending physician. This prescription shall state specifically all details regarding the type of occupational therapy prescribed.
4. A record shall be kept of the physical progress made by the resident and his reactions to the occupational therapy prescribed. This shall be incorporated in the resident's individual record.
5. The occupational therapy program shall be supervised by a registered occupational therapist.
6. All storage and unit facilities shall be maintained in a sanitary manner and kept in good repair.

B. RECREATIONAL THERAPY

1. Homes contemplating an organized recreational therapy unit shall submit to the Department a floor plan of the home, identifying the specific area to be used. The Department reserves the right to disapprove the location of the unit when indicated.
2. This unit shall be well lighted, ventilated, heated and equipped with a bell or signal system to summon aid in an emergency.

C. PHYSICAL THERAPY

1. No home shall be permitted to establish a physical therapy unit for treating residents without the approval of the Director of the Division of Hospital Facilities, Department of Public Health.
2. The request for such approval shall be written in duplicate, signed by the licensee, and shall include.
   a. Name and address of home
   b. Date license was issued, and number of beds
   c. Name and address of licensee
   d. Name, address and qualifications of the registered physical therapist who will administer physical therapy.
   e. A floor plan of the home, identifying the specific areas to be used for administering physical therapy and/or for the storage of the equipment. The Department reserves the right to disapprove the location.
3. This unit shall be well lighted, ventilated and heated, and hand washing facilities shall be separate and apart from rooms used for resident occupancy or other resident facilities.
4. This unit shall be used exclusively for the administration of physical therapy treatments to residents.
5. Equipment used for physical therapy shall be approved by the American Medical Association.
6. All physical therapy equipment shall be serviced at least annually by a qualified person. No repairs shall be made except by a qualified person.
7. The following basic equipment shall be provided for the physical therapy unit.
   a. Treatment table and footstool; chairs
   b. Adequate linen supply
   c. Supply closets
   d. Sanitary waste containers
   e. Hamper for soiled linen
   f. Disposable towels
   g. Curtains or cubicles to assure privacy
   h. Desk or table and chair for clerical use
   i. Hand bell or signal system to summon aid in an emergency
8. A prescription for the administration of physical therapy shall be recorded, dated and signed by the prescribing physician in the Doctor's Order Book. This prescription shall state specifically the type of treatment to be given, frequency, duration and all details regarding the treatment.
9. The physical therapist shall record, date and sign all pertinent data pertaining to the treatment. This shall be incorporated in the resident's record.
10. No resident shall be unattended while receiving physical therapy treatments.
11. Physical therapy shall be administered by qualified persons:
    a. A physician registered to practice medicine in Massachusetts, or
    b. A physical therapist currently registered in Massachusetts.
12. All equipment and facilities shall be maintained in a sanitary, safe condition and kept in good repair.
13. All plumbing and electrical installations required for the administration of physical therapy shall be inspected and approved by the appropriate local or state authorities.

Senator SMITH. How many new nursing homes would you say have been licensed in Massachusetts this year?

Dr. RUBENSTEIN. I do not have that figure, but I would imagine that it is somewhere between ten or a dozen new ones. The reason for the increase in new nursing homes is that the regulations have been changed so that now it is no longer possible to convert a two-story frame dwelling, residence type of building, into a nursing home. Now, in Massachusetts we will only license new facilities built for the purpose of nursing home operation. That has been in existence since January.

Senator SMITH. That was January this year?

Dr. RUBENSTEIN. January 1961. We just completed our first year of experience with that new law.

Senator SMITH. During the last several months, Doctor, I have had occasion to visit some of these new nursing homes in the Commonwealth and I have been greatly impressed by the great improvement and the wonderful strides that have been taken in this field.

Dr. RUBENSTEIN. Thank you, Senator.

Senator SMITH. What would you say, Doctor, was the need for new additional nursing homes right now in Massachusetts?

Dr. RUBENSTEIN. As a matter of fact, I am just in the process of evaluating our experience this year with respect to the number of new beds being added in new homes and to compare that figure with the number of nursing home beds which have been added in previous years to see just what the difference is. My impression is that we are perhaps adding newer and more beds under the new program than we did under the old for the simple reason that many of the nursing homes in the past were smaller; 6, 7, 8, 10, 12, 15 beds. The new ones tend to be in the vicinity of 50 to 60 beds. So one new nursing home would represent perhaps three, four, or five old ones in number of beds.

Senator SMITH. Of course, here in Massachusetts, I am sure you are all aware of it, the number of people 65 years of age or over has increased a great deal in the last 10 years.

Dr. RUBENSTEIN. Yes.

Senator SMITH. Since 1950 I think our regular population figures show an increase of slightly under 10 percent while those over 65 years of age in Massachusetts has increased 22 percent. I am sure that this will point up a greater need for additional nursing homes here in Massachusetts.

Dr. RUBENSTEIN. Yes; we are all growing older fast.

Senator SMITH. That seems to be the case. It is interesting to note right now Massachusetts has more people in this category than the State of Florida, and we here are inclined to think of Florida as the great retirement State.

Dr. RUBENSTEIN. 21,000 people in nursing homes.

Senator SMITH. What was that figure?

Dr. RUBENSTEIN. 21,000 nursing home beds in Massachusetts at the present time. I believe one of the reasons for this is the fact that our welfare department has been aware of this and has set a regular quota which tends to be a little higher than in most other States.

Senator SMITH. Doctor, last week we had hearings in the State of Connecticut, and I was wondering: Do we have different standards for acceptable beds? Does that vary from State to State?

Dr. RUBENSTEIN. Yes; I believe that there are differences. We have simply taken the definition set by the Public Health Service for unacceptability. In other words, if it is a frame structure, we consider this unacceptable because this is the definition set by the Public Health Service. We might have done this, but we could have done it another way. We might have said that any nursing home which complied with our local and State regulation would be acceptable, but this would be just fooling ourselves, and we have taken the realistic approach that we will call them as we see them.

Senator SMITH. You certainly are to be congratulated in taking just this approach, Doctor. Let me just say at this time that I appreciate the wonderful work that you have done in your department and we look forward here in Massachusetts to continued advances in this field and hope that we will always be leaders throughout the Nation.

Thank you very much, Dr. Rubenstein.

Dr. RUBENSTEIN. Thank you, Senator.

Senator SMITH. Once more I find it necessary to deviate from our scheduled list of appearances of witnesses. I would like to call Dr. Neville Booth who is representing the Massachusetts Dental Society.

STATEMENT OF DR. NEVILLE BOOTH, MASSACHUSETTS DENTAL SOCIETY

Dr. BOOTH. Mr. Chairman and members of the committee, I am Dr. Neville Booth. I represent Dr. Francis C. Bates, president of the Massachusetts Dental Society.

As a practicing dentist specializing in oral surgery with teaching appointments in Massachusetts and as a consultant to a number of hospitals, I have many occasions to come in contact with nursing homes and their patients. My remarks reflect personal observations and the activities of the State dental society.

The problem: The dental care for the homebound and aged is a neglected area in public health. There is no formal program within the dental society at the present time to aid these unfortunate citizens.

The residents of nursing homes present the following types of dental problems:

(1) Poor oral hygiene. This is due to either a lack of adequate nursing care or self-cleanliness. It is doubtful whether the personnel employed in nursing homes are adequately trained in methods of accepted oral hygiene.

(2) The geriatric patient shows degenerative changes in the teeth, the gums, and other oral structures which require care and treatment. These changes superimposed along with poor oral hygiene lead to infections which can be more serious than bed sores.

(3) Most persons in the category under consideration are partially edentate. In many instances they have inadequate and/or ill-fitting dentures or lack entirely the replacement for missing dental structures.

(4) Few nursing homes adapt their dietary program to the needs of patients with the above-mentioned conditions. The nutritional requirement of these people is of paramount importance, both from maintenance of reasonably good health and the correction of deficiencies and disease.

Members of the dental profession render services to patients either at the nursing home or at the office. It is, however, primarily an emergency service consisting of the extraction of diseased teeth and the repair of dentures. Treatment in nursing homes can be very difficult due to inadequate equipment and other local factors.

In most instances the services are rendered by a local dentist on the request of the home. Few, if any, nursing homes have dentists or dental consultants on their staff.

I would like to digress, Senator, to compliment the program which has recently been introduced in the city of Brookline which is almost a pilot study.

Remedial programs: Massachusetts has long been a pioneer in matters of dental education and dental health. The Massachusetts Dental Society is vitally concerned with the dental health of the citizens of the Commonwealth. The problem of the dental needs of the chronically ill and aged was given particular attention last year following the attendance by the president, Dr. Philip H. White, at the White House Conference on Aging. His programs have been continued and expanded under the direction of the present administration.

The Council on Dental Health under the chairmanship of Dr. James H. Dunning, former dean of the Harvard School of Dental Medicine and a recognized authority in public health dentistry, has initiated action. A committee to study the dental care for the chronically ill and aged has been actively working with the Director of the Massachusetts Federation of Nursing Homes to conduct the survey of the more than 700 nursing homes recognized by the federation. This survey will seek to obtain definite information on the dental health, the dental needs and the availability of professional assistance as they now relate to the patients involved.

The cooperation of the Massachusetts Dental Hygienist Association has been solicited for the development of a training program which would provide instruction in dental health and prophylactic therapy for the patients in the nursing homes. Such a program would require closer cooperation between directors of nursing homes and the dental society than now exists.

The State department of public health through its division of hospitals established about 1 year ago a commission for a study of accreditation for nursing homes. Consultants were invited from all related fields. It is my privilege to represent the Massachusetts Dental Society on this commission. At the present time the School of Nursing at Boston College is developing a program to study the various phases of this broad program. It is evident to me that the contribution of the dental profession to this commission will be of vital importance in the final analysis.

I would assure this committee that the Massachusetts Dental Society is not only very much aware of the problems of dental health and nursing homes but is taking active steps to survey the situation.

Remedial measures will be formulated and presented to the responsible bodies for their implementation within developing programs. Undoubtedly the findings of this committee will be of great value to us in the dental society.

On behalf of the Massachusetts Dental Society, I thank you for the opportunity of appearing before you.

Senator SMITH. Thank you very much, Dr. Booth. I should like to say at the outset that it is encouraging to hear of these steps that are being taken, and the Massachusetts Dental Society is certainly to be congratulated on its participation. I was glad to hear you bring out the relationship of dental health to nutrition which we all recognize as one of the most important points in the health and welfare of these elderly citizens. I am sure that in your work with the State health department's study commission that you can make a great contribution.

Dr. Booth, would the dental society favor any requirement for a dental consultant to the nursing home in the same way that many States require a medical consultant?

Dr. BOOTH. I think that the personnel of nursing homes could be greatly helped and so would the patients, which is after all your primary concern; the patients. The patients could be greatly assisted if perhaps a dentist on a consulting basis were affiliated with nursing homes. I am sure that there are many problems in nursing homes at the present time which could be checked as a minor problem before they become acute and which undoubtedly add to the discomforts and the troubles of the unfortunate residents of the nursing home. I think that something could be done in that line, Senator.

Senator SMITH. Thank you. I had occasion last week in the hearings in Hartford to visit the Hebrew Home for the Aged in Hartford. They have a very fine dental setup there, and I assume that the Hebrew home that is now under construction here in this area will have the same facilities. Of course this is a larger scale facility certainly, and I recognize the problem of the small units.

Thank you very much, Dr. Booth. Your testimony will certainly be a great contribution to the study of this committee.

Senator SMITH. Our next witness this morning will be Mr. Theodore Fabisak, director, Hospital Costs and Finances, Commission on Administration and Finance, Commonwealth of Massachusetts.

Mr. Fabisak.

STATEMENT OF THEODORE FABISAK, DIRECTOR OF THE DIVISION OF HOSPITAL COSTS AND FINANCES, COMMISSION ON ADMINISTRATION AND FINANCE, COMMONWEALTH OF MASSACHUSETTS

Mr. FABISAK. Mr. Chairman and members of the committee, I am very pleased to have been invited to speak before this body this morning in connection with your continuing study of the problems of the aged. You have asked that I limit my remarks to 6 or 8 minutes of oral testimony, and I think I will be able to contain all of my comments within 5 minutes of your time.

Let me say at the beginning that the division of hospital costs and finances, of which I am the director, is concerned with only a very

small facet of the overall problem dealing with nursing homes. The limited area in which I am concerned deals with the rate-setting mechanism for payment of these nursing homes by various agencies of the government of Massachusetts.

Prior to the establishment of the authority under the law under which we operate, there appears to have been at least three different rates established by the department of public welfare which range from $5 per diem for ambulatory patients to a different amount for a bedridden patient, and still another rate for extracare patients. This old procedure was changed by the passage of a law in 1958 which placed within the authority of our division the rate-setting mechanism which I have just mentioned.

Briefly, let me say in order to establish any kind of rates for nursing homes it was necessary for our division to establish as simple an audit procedure as possible whereby auditors from our division would visit on as frequent a basis as possible more than 700 nursing homes scattered throughout the Commonwealth of Massachusetts. It will interest the committee to know that back in 1956 we were then dealing with about 575 nursing homes. Today we are dealing with over 700 nursing homes. This represents an increase in the number of nursing homes of about 29 percent during the past 4 years.

I am sure your committee is not interested in the mechanism of our audit. Time does not permit me to detail this information. Therefore, I shall simply say that our staff audits various financial reports sent to our division in compliance with the rules for such reporting. We have not encountered any difficulty in dealing with nursing homes in this regard. They have been more than cooperative in making available to our State agency their financial data and information which they know forms the basis for the payment of public funds on behalf of public-aided patients.

It is, of course, well understood by all that nursing homes are not heavily endowed groups which contain the most up-to-date electronic accounting equipment. Nursing homes are run more as private institutions and the State respects this status and does not intend in any way to dictate the actual operation of the nursing homes. This is left to the initiative and genius of our private citizens who dedicate themselves to such service. It is therefore not unusual to find the proprietor of the home acting as business manager, bookkeeper, purchasing agent, and actually rendering some nursing care to the patients themselves.

We find that here in Massachusetts most of the nursing homes are located in and about our Greater Boston area. On the average, the size of the nursing home accommodates about 31 beds. In such accommodations, the occupancy approximates about 91 percent. There are approximately 23,000 licensed "beds" with an average of 60 percent occupancy by public-aided patients. Since 1956 over 75 percent of all licensed nursing and convalescent homes have been visited by auditors of our division. The other 25 percent have not as yet been visited because many of them have not accommodated so-called public-aided patients, they deal primarily in private patients.

It is interesting to know that since this rate-setting mechanism was established in 1958, there have been a series of rate increases authorized by this division. The first rate which was established by this division called for a payment of $5.75 per day. In 1959, 1 year

later, the rate was increased to $6.50 per day. In 1960, the division, on the basis of available data, maintained the same rate of $6.50. However, in 1961 the rate was increased to $6.60.

All such rate changes are changed only after a public hearing with adequate notice being furnished to all parties concerned. As a matter of fact, on Monday of this week this division conducted a public hearing in order to determine the rate which should be established for the calendar year 1962. That rate, of course, has not as yet been set.

It is our contention, of course, that the Legislature of Massachusetts has taken forward steps by the establishment of such a rate-setting mechanism, the proof of which is borne out by the fact that the rate for 1960 yielded only three appeals; two of these were granted, one was rejected. Last year, that is 1961, 12 appeals were filed; 2 were granted, and 10 were rejected. This certainly points out that the public has every reason to have confidence in the care which is being exercised in the dispensation of public funds for such a worthy and necessary cause.

The liaison which the division of hospital costs and finances maintains with the department of public health is such that upon the licensing of any nursing or convalescent home, such information is immediately forwarded by the department of public health to our office. We are also aware, of course, of any action taken to withdraw a license that had already been granted.

In a personal way, Mr. Chairman, may I say that I have enjoyed working with the members of the nursing-home profession. I have found them cooperative. I have found them extremely desirous of giving of their best in the help of our citizens who are in need of this type of medical care.

I would say, Mr. Chairman and members of the committee, one of the most important topics to be considered in the matter of nursing homes deals with the standards of care. I, for one, working in this field for quite some time, strongly believe that the standards of care cannot be determined exclusively by the simple device of increasing rates. This is not the answer.

The standards of care may best be determined and thereby increased to their maximum only within the jurisdiction of the licensing authority. This authority should either grant or not grant a license, depending on whether the nursing home meets certain specified and clearly defined standards.

I hope I have been able to contribute some small part in this massive study in which you are engaged. If I may be of assistance, Mr. Chairman, and members of the committee, I shall be happy to be of service.

Senator SMITH. Thank you, Mr. Fabisak. You mentioned a rate. Is this an annual review or revision, certainly a review, every year?

Mr. FABISAK. It is an annual review as required by law, Mr. Chairman.

Senator SMITH. Has there been developed any set formula or a firm policy on the fair rate of return on investment in these establishments?

Mr. FABISAK. Yes, we do take into account a fair return on invested capital and this is resolved through the mechanism of a formula which we apply and is reflected in the overall per diem as it is set.

Senator SMITH. Does this involve an audit on the figures?

Mr. FABISAK. Yes, it does, Mr. Chairman. We audit as many homes as it is possible so to do. I might say, believe it or not, that with the responsibility we have of setting rates for over 700 nursing homes that I have at my disposal at the present time one semisenior field accountant to do the job.

Senator SMITH. I see. Thank you very much. We appreciate the excellent work your department is doing and hope you continue with this fine work.

Mr. FABISAK. Thank you, Mr. Chairman.

Senator SMITH. Our next witness this morning will be Mr. Edward F. Connelly who is executive director and general counsel of the Massachusetts Federation of Nursing Homes.

Mr. Connelly.

STATEMENT OF EDWARD F. CONNELLY, EXECUTIVE DIRECTOR AND GENERAL COUNSEL, MASSACHUSETTS FEDERATION OF NURSING HOMES

Mr. CONNELLY. Thank you, Senator.

For the record my name is Edward F. Connelly. I speak for the Massachusetts Federation of Nursing Homes, Inc., having a membership of about 300 proprietary nursing homes. We are grateful for this opportunity to appear before this Special Committee on Aging.

I have been asked by the Federation of Licensed Nursing Homes of Rhode Island, Inc., to leave with the committee a short statement on their behalf which I shall do.

Senator SMITH. That will be received as part of the testimony. Thank you very much.

(The statement referred to above follows:)

PREPARED STATEMENT BY MRS. ANNE THEINERT, PRESIDENT, FEDERATION OF LICENSED NURSING HOMES OF RHODE ISLAND, INC.

Nursing homes were first licensed in the State of Rhode Island in 1929. The bed capacity at the present time, for proprietary homes, is approximately 2,350. The census of nursing home patients shows that approximately 1,500 are welfare cases and 850 are private patients. Of the 1,500 welfare patients, 900 are in nursing homes, 300 in convalescent homes, and 300 in rest homes. At the present time, a home of 48 beds, an entirely new facility, has just been completed and opened in East Providence. Another is under construction in East Providence, with a minimum of 50 beds. Several homes have modernized and enlarged their facilities; also, several new homes are under construction in various parts of the State. It is anticipated by the licensing agency for nursing homes that the overall potential may reach 100 to 150 more beds within a year.

Educational programs, aiming to improve standards and to provide better patient care through education, are now being planned by the department of health, and it is anticipated that before long we will have the cooperation of the University of Rhode Island. These programs will be made available to nursing home administrators and personnel. It is now compulsory in Rhode Island that all new nursing home administrators must take a course in nursing home administration given by the department of social welfare, which is the licensing agency for nursing homes. Courses for nurses' aids are also given periodically by the departments of health and welfare.

Mr. CONNELLY. I have also been asked to leave a report from the New Hampshire Licensed Nursing Homes.

Senator SMITH. That, too, will be made a part of the record.

(The report referred to follows:)

REPORT FROM THE NEW HAMPSHIRE ASSOCIATION OF LICENSED NURSING HOMES

The New Hampshire nursing homes were first licensed in 1948. Licensing was completed in 1949. Today there are 174 licensed nursing homes in New Hampshire.

Out of 3,206 beds available in the State, some 1,282 are occupied by welfare patients. The maximum allowance for these patients from the welfare department is $165 per patient per month.

Our association has worked both with the welfare department and the health department to effect the following changes:

(1) In 1952, we were successful in getting an increase of $0.54 per day per welfare patient.

(2) In 1959, this was again increased to $1.50 per day per welfare patient.

As a result of constant meetings with the health department, we succeeded in getting:

(1) A cut in home classifications from 5 to 2 (e.g., nursing homes and rest homes).

(2) The responsibility of fire safety shifted from the health department to the fire commissioner.

(3) A change in the requirements of the charge nurse from licensed practical nurse to graduate registered nurse.

(4) Increased numbers of periodic inspections for all homes which resulted in the closing of unlicensed homes by the health department.

The New Hampshire Association of Licensed Nursing Homes maintains a committee throughout the year to work with the health department to effect necessary changes.

Mr. CONNELLY. The last request is to leave a report prepared for this committee by the Maine Association of Nursing Homes which I shall do with the permission of the chairman.

Senator SMITH. Thank you. That will be made a part of the record.

(The report referred to follows:)

REPORT FROM THE MAINE ASSOCIATION OF NURSING HOMES

This committee will be making a thorough survey of all facets in nursing home operations. Thus, I wish to limit my remarks to that phase relating to the emphasis upon patient care as opposed to emphasis upon building construction.

The Maine Association of Nursing Homes was organized in 1954 and since its inception has consistently disagreed with State officials who advocate improvement of standards of care by concentrating on the physical plant. In many instances these officials are expressing sentiment which emanates from Washington.

In 1960 an attempt was made in the State of Maine to create an atmosphere of "crisis in nursing home care" through the press. This attempt fell flat when the true facts were presented. At times we cannot help but feel that the Federal Government unduly upsets the everyday living of its citizens by creating an atmosphere of crisis. This approach has long been utilized by the reformers and theorists who are constantly debunking the values of private enterprise and seek to establish greater governmental controls.

Our association recognizes that the standards of care must be improved in many areas but we are convinced that the private administrators with their everyday practical experience can perform the job much more economically than can the Government. We are even more convinced that private enterprise can furnish better bedside care than can any governmental agency, whether the control be direct or through nonprofit ventures.

There is, of course, a relationship between standards of care and monetary rates. However, a high rate is not the hallmark of success in operating a nursing home. The success of nursing home operation can be measured only by the comfort, contentment, and happiness of the patient. Our association has consistently pressed this point with State officials and gradually the merit

of our aims is being recognized and accepted. A high salaried professional in the nursing home cannot compete with the private administrator who unstintingly dedicates himself to providing around-the-clock bed comfort.

Our association has done much to strengthen and implement State licensing in Maine and strongly advocates stringent enforcement of the laws, rules, and regulations for the purpose of raising standards of care. However, enforcement of licensing should be accomplished in an atmosphere of cooperation as opposed to an atmosphere of Government mandate.

In conclusion, we submit that the payment of realistic rates for the State aid and general relief patient will gear the nursing home economy to a level where the problem of private patient care will be self-solving.

Respectfully submitted.

KENNETH D. ROBINSON, *President.*

Mr. CONNELLY. Realistically, this State and Nation must look to proprietary nursing homes as the main avenue, now and in the future, for the nursing home care of the elderly infirm. Charitably supported homes could not possibly expand enough to do the job. Government institutions would be impractical and costly. Now what does that mean? It means that each proprietary nursing home has a responsibility not alone to itself, but to the general public, and to society as a whole. The Federation of Nursing Homes also has a large responsibility.

I want to make it clearly understood that when I speak of nursing homes as counsel for proprietary nursing homes, I am not trying to insist that every nursing home in the Commonwealth is perfect, or even that they are doing as good a job as they could under the circumstances. But I do insist, and I think reasonable men will agree, that by and large the nursing homes in Massachusetts are doing an excellent job and their quality of performance is to be applauded. This, may I say, is due in no small measure to the leadership and understanding provided by many departments of State government. We are indeed fortunate in this respect.

Now, though we believe this, and though we insist that the public good will be served by such proprietors receiving a decent return for their investment and services, in our estimation the important thing is that the operation of the proprietary nursing home is akin to a profession and must have as its primary motivation the performance of the service. As we look at it only those people who have this motivation for service should be the proprietors of nursing homes. We have and we will support all laws and all regulations directed toward the maintenance of this concept.

Now, Mr. Chairman, before turning to some of the realities involved in this field I should like to try and answer a question, although I know it has been answered before here today, which the newspapers and the radio have said is in the minds of this committee. The question is, Why does Massachusetts have 14,544 nonacceptable beds?

The fact of the matter is that a Federal agency had been granted money by Congress to distribute throughout the States for the purpose of constructing hospitals and nursing homes. One of the conditions was that need for such nursing homes must be established. Therefore a questionnaire was drawn up. One of the questions in that questionnaire was, "How many beds are in homes that are constructed entirely of fire-resistant materials?"

Well, our State literally answered that question. We sent to Washington the simple fact that 14,544 beds were not in homes constructed entirely of fire-resistant materials and only 405 were in such homes.

The fact is that the literal answer required this State to exclude all beds in every frame nursing home in the Commonwealth. It excluded all of the beds in every brick nursing home in the Commonwealth that had a wooden floor or wooden steps. All of those nursing homes are regulated rigidly by the State Department of Public Safety, by local city and town departments of safety, by building departments, by fire departments. Many of these homes have sprinkler systems and every manner of fire protection.

Now I should like to turn to some of the realities and I would like to skip over them very, very quickly.

(1) Though great progress has been made in the nursing home care of the elderly infirm, much remains to be done.

(2) About 60 percent of patients in our State are public aided and the percentage is rising and will continue to rise. One of the reasons is the enactment here in this State of the medical aid to the aged law which broadens the area of participation of people in public funds for nursing home care.

(3) Standards of care and safety cannot rise much above what the public-aided rate can provide. Now let's be realistic. Whatever talk we may have about standards of nursing homes, the simple fact is that now and in the future such standards cannot be any better than what the public aided rate will allow.

(4) States must establish systems whereby standard setting is matched by cost studies so that patients can get the care that is being purchased and the home can have income to give the care.

(5) All of us struggle to move forward toward a greater acceptance of our responsibilities toward the elderly. But most of the time we are not entirely sure of where we want to go or of how we are going to get there or of how much it will cost or of whether it is practical. All of us want to do everything that we can to improve the standard of care but how many times do we know what we are talking about? Do we know what the standard of achievement is that we want to find?

It is fine to talk in generalities but you have to ask yourself some very practical questions. When we talk about rehabilitation of patients in nursing homes are we thinking about recreational therapy, or occupational therapy, or physical therapy? Or are we thinking about plain tender care that spurs on people to enjoy their faculties to their fullest extent?

Now when we have this desire for achievement do we know what it would cost? If we do, are we willing to incur this cost? Is provision for giving such a service included in the rate?

(6) Now the next reality is the taxpayer. Very understandably the taxpayer wants everybody to have everything but he does not want to pay any more for it, and that is a very understandable reaction. The taxpayer is certainly entitled to be assured that the goals we set are not beyond his capacity to pay.

(7) The next reality is this: Though those who operate nursing homes are not in any sense singularly gifted as compared with others, nevertheless because of their preoccupation for many years with the elderly infirm, there are probably more people among them who know more about the total picture of nursing home care than in any other group in our society. I am now talking about those who operate the

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proprietary nursing homes as well as those who operate the charitable homes.

These are a few of the realities. What do they add up to? In my own mind the first is that there is a lot of working together that needs to be done on the part of the governmental agencies and the interested parties who have a responsibility and have a knowledgeable interest. The second general conclusion is that the primary level of working together is the State level.

Now I am going to skip through this. I am going to say that the working together on the Massachusetts level has been been exceptional and that is primarily due to the unusual qualifications of the people in the Massachusetts Department of Public Health, the Massachusetts Department of Public Welfare, the division of hospital costs and finances, and others.

I am going to skip on to one example of working together. Recently in Congress there was enacted, last year in fact, the Kerr-Mills bill. With the passage of the Kerr-Mills bill the Massachusetts Commissioner of Public Welfare, with great foresight and expedition, introduced a medical care for the aged bill in the Massachusetts Legislature to implement congressional action. Now in addition to opening up the areas of coverage not previously existing, the commissioner's bill shifted all nursing home patients and other patients over to the medical aid to the aged category and it brought in about $12 million more in Federal money to reduce cost burdens on the State, cities, and towns.

Now such legislation has its problems, both in language and in the detailed application to specific circumstances, and in many other ways. The Massachusetts Commissioner of Public Welfare brought together a representative of the Massachusetts Federation of Nursing Homes, a representative of the Massachusetts Taxpayers Association, and a representative of the Senior Citizens of Massachusetts, Mr. Charles C. O'Donnell. This group cooperated with one another, they differed with one another in detail but they were united in objectives. They worked together with a subcommittee of the legislature on the legislation, they journeyed to Washington together to iron out problems with the Federal agencies, they considered the problems of all other groups with respect to details on which the subcommittee was bound to advise the legislature, and ultimately the law was enacted last year. This State was among the first, if not the first, to implement the Kerr-Mills bill.

This is an example of working together that is taking place here in Massachusetts between the nursing homes and the various departments of government, and it is the reason why Massachusetts stands today near the top in the Nation in the standard of care for patients in nursing homes.

Under the Kerr-Mills bill as implemented by the Massachusetts medical aid to the aged bill, all low-income elderly over 65, in Massachusetts, have assurance that their medical needs will be met without exhausting their capital, their equity in their homes, or their income.

When we mention the Kerr-Mills bill we can't avoid some mention about the King-Anderson bill of last year in the Federal Congress insofar as it relates to the area of nursing home care. So far as it relates to this area of nursing homes and nursing home care, the Massachusetts Federation of Nursing Homes does not like it. We

don't like it because (*a*) it is unrealistc and is of little help to those needing nursing home care and (*b*) it is vague, cumbersome, and pregnant with a multitude of practical problems for nursing homes.

Let us see how far it would help elderly people needing nursing home care. Remember that the average age of persons in nursing homes in Massachusetts is 81 or 82. Remember that they do not come into nursing homes unless they have physical disabilities, and the combination of age, disabilities, and family circumstances generally make it pretty farfetched that many can return to home or family.

As we read the King-Anderson bill the maximum number of days of nursing home care covered would be 180 days in a benefit period. The number of days would be less where the person spent time in a hospital. The benefit period, during which this limitation of compensable days of care would apply, would begin with the first day in a hospital or nursing home and last for the rest of that person's life unless for some period of 90 days such person was not confined to either a nursing home or a hospital.

Thus when we think of the benefits which would come from such a law, so far as nursing home services are concerned, we come up with these realistic facts:

(1) Such a law would not benefit a very high percentage of elderly people at all because they would not have contributed under the system.

(2) Even for those who would be under the system, 90 to 95 percent of them would be entitled to only up to a maximum of 180 days of nursing home care during their lives.

Thus the nursing care help they would receive from such a law would be minor and they would still have to look for their main source of assistance to State programs implementing the Kerr-Mills bill or otherwise.

Now I am not going to detail the degree to which Federal agency control or domination of the nursing homes under such a bill would be extended. In the main it covers the field of what is a skilled nursing home, excluded services, medical policies of such homes, general conditions which the Secretary "may find necessary," usage of a nursing home facility utilization plan, conditions and limitations attached to becoming an eligible provider of nursing home services, determination of costs of services, execution of contracts, and innumerable other relationships.

Now we insist that for the good of the people who need nursing home care, there should not be more than one system covering them. If they are included under the King-Anderson bill, or any similar bill, it will merely mean that most will get only 180 days of coverage and the remainder will have to be picked up by another system. It is better they have one system rather than two.

Now I would like to conclude with these observations.

A democratic society can meet its problems only through cooperative action on the part of its members. Here it is cooperative action by nursing homes and their organizations with others in and out of government. By encouraging and aiding such cooperation we strengthen democracy as well as follow the most practical course to a speedy attainment of the highest objectives. Massachusetts offers many examples of the fruits of this cooperative spirit.

The area for strong cooperative action is the State. Trying to mastermind and regulate from the national level can be disasterous

in this field. Strong Federal interest and aid to the States in evolving this cooperative approach is greatly to be desired.

All authority over standards of care ought to be centered in one State department; namely, the department of public health. All authority with respect to safety should be coordinated in one State department. Standards of care desired should be genuinely studied and fair costs determined.

Cooperation and united action in common objectives at the State level should give the guidance to local community cooperative action.

We deal here with a human problem, and the solution to human problems ultimately comes down to the relationship of the nursing home staff, and its administration, with patients. The closer we get to seeing the picture through their eyes; namely, the eyes of the patient and the eyes of the people who have got to give the care to the patient, then the quicker we will accomplish some great things.

Thank you, Senator.

Senator SMITH. Thank you very much, Mr. Connelly, for this testimony. Let me say that I realize that the Massachusetts Federation of Nursing Homes has a great responsibility, we all realize that. I feel that they are trying to meet these responsibilities at the present time, but I think there is a great deal more that we can do in the future and a great deal more that must be done.

Mr. CONNELLY. I agree with you, Senator.

Senator SMITH. Would you state again how many homes are members of your federation?

Mr. CONNELLY. There are 300 nursing homes who are members of the Massachusetts Federation.

Senator SMITH. What proportion of the 21,000 beds?

Mr. CONNELLY. As far as beds are concerned, in the vicinity of 50 to 55 percent of the beds in the Commonwealth, but in terms of number of nursing homes it would be a ratio of 300 to about 700.

Senator SMITH. In other words, these are generally the larger nursing homes?

Mr. CONNELLY. No, they are not generally the larger nursing homes. A greater percentage of the larger nursing homes are members, but most of our members are small homes. The average number of beds in a home is 30 and I suppose the average number of beds in the Federation homes are about 30 to 32.

Senator SMITH. Mr. Connelly, you mentioned decent return. What is a decent return on a nursing home investment? Are there any figures on that?

Mr. CONNELLY. I have not seen any figures. We have never attempted to set it down categorically because in our present experience of 3 or 4 years in the setting of the rate by the division of hospital costs and finances the method of setting such rate has never gotten down to such a percentage detail. I think we have to start from this concept, that the cost of money today, for instance under an insured Federal—what is it, the Federal home mortgage?

Senator SMITH. FHA.

Mr. CONNELLY. Even under FHA, where repayment is guaranteed by the Federal Government, you must pay 5½ to 6 percent interest. Therefore a return to nursing home proprietors for all of the risks they take in the operation of the nursing home, obviously that has got to be well in excess of any 5½ or 6 percent. I am not so sure that most

of the nursing home proprietors would not be satisfied, under present operations, with 5 or 6 percent return but theoretically it should be much greater than that.

Senator SMITH. Mr. Connelly, do you think that the nursing home field has developed reliable information on the actual costs of their services?

Mr. CONNELLY. I think that the nursing home field has developed very reliable cost on the actual cost of their services. That is true today because every nursing home in Massachusetts must make such a reporting to the division of hospital costs and finances. What has not been done, however, is a cost analysis of what the public would consider to be the minimum adequate standard of care that ought to be provided for patients.

If this were done two things would follow. First, the nursing home could not be accused of failing to give proper care if rates paid were inadequate to permit it; and secondly the public, knowing through a State agency what the standard of care it is buying, would be able to exact adherance to such standard. There has not been enough work and study in this direction.

On this score may I say that in the hearing before the division of hospital costs and finances this year with respect to the nursing home rate, which was held in this room Monday of this week, an addition to a general presentation the Massachusetts Federation of Nursing Homes asked two other things. We asked that, through the division of hospital costs and finances, the appropriate State departments, which would include the department of public health and others, study a recreational therapy program for nursing homes and the cost of putting such a program in effect in a nursing home. Knowing the program desired and what it would cost, the necessary moneys could be provided to nursing homes having an approved plan. Thus, we would know what we wanted, we would know what it would take in money to do it, and we could have programs where people who did put it into effect would receive the compensation for it.

Senator SMITH. Mr. Connelly, you speak of the realities of standards of care and the costs. In your opinion what standards would you recommend for the future?

Mr. CONNELLY. I cannot answer that question. I do not know in detail what the standard should be in the future, whether it should be a standard which would cost $7, $8, $9, $10 or $15 a day. I do not know because we have not had the facilities for such a study.

Senator SMITH. That might be something that your association could look into and make recommendations.

Mr. CONNELLY. We would love to do it but of course we would need a great deal of money to do it. Secondly, we would prefer that it would be done by a disinterested group, maybe composed of members of the Federation of Nursing Homes but involving a lot of people in other professions in order that such a recommendation would have wider public acceptance.

Senator SMITH. Just one last question. Do you have any specific suggestions for Federal action to support the efforts at the State level, Mr. Connelly?

Mr. CONNELLY. Generally I would say that any aid and comfort, whether it be sympathetic words or grants or appropriations to the State, that would promote cooperative action at the State level would

be a great step forward in the solution of problems. In my mind, working together at a level where people have got to be interested in practical performance is the best means of moving forward fast.

Senator SMITH. Thank you very much, Mr. Connelly, for this testimony.

Our next witness this morning will be Mrs. Eleanor Baird, accreditation chairman of the New England region and vice chairman of the National Accreditation Committee, American Nursing Home Association.

STATEMENT OF ELEANOR B. BAIRD, CHAIRMAN OF REGION I, ACCREDITATION COMMITTEE OF AMERICAN NURSING HOME ASSOCIATION

Mrs. BAIRD. Mr. Chairman and members of the committee, I am Eleanor B. Baird. I am a chairman for the New England region of the American Nursing Home Association accreditation program.

In 1948 the Second World War had been ended almost 3 years. The American political scene was geared to the high tension of a presidential election year. Many problems confronted the whole of mankind: Peaceful reconstruction, prosperity, poverty, starvation, disease, the problem of the aging. So it was then when the American Nursing Home Association was established in order to improve the kinds and quality of care rendered by nursing homes.

To those of us closely connected with this area of the aging problem it was an essential beginning, to others it went largely unnoticed—the attention of the public was not yet focused on the great increase in our older population and the problems arising, but this attention would come. It did, culminating in the well-publicized White House Conference on Aging last January.

In the 13 years since its formation the American Nursing Home Association, as it should have done, fully aware of its responsibilities, fought for recognition of, acceptance of, and improvement of the spiraling problem of the aging by the public, other social and medical groups, and State, Federal, county, and municipal government. Much has been accomplished. Much more remains to be done.

What then is the American Nursing Home Association doing? The following remarks taken from the context of a report made by the U.S. Senate Subcommittee on Problems of the Aged and Aging from hearings held in 1959 are pertinent here:

> Most proprietary nursing home operators do the best they can within the limits of their income. Some have done outstanding work. And in association with one another they attempt to improve conditions to meet better standards.
>
> Much of the basic reasons for the present generally inadequate level of medical care and restorative services in nursing homes lies in the traditional attitude toward them.

These remarks are merely echoes of similar ones printed in newspapers, magazines, and other literature concerning nursing homes and related facilities all through the years.

The general impression of nursing homes is most often based on very little actual knowledge of fact, observation, or direct experience, but rather, on conjecture of "what everyone knows to be so." Such conjective opinion is too often based on prejudice carried on, in a few instances, from long past experience, but most often from vague ru-

mor or hearsay. Attitudes of this nature are both inaccurate and unfounded.

The performance and purpose of the American Nursing Home Association has been and will be progressive. Good standards in institutional practice cannot be brought about solely by means of legislation, nor good patient care assured through inspection and licensure. By the same token, a good public image cannot be secured by knowing and saying most nursing homes are doing a good job. More must be done, and by the nursing home profession itself, not only to improve, secure, and maintain high standards in nursing home practices and good patient care, but also to establish recognition by the public of the existence of that improved care, and a proper public attitude.

To this end, in 1959, the American Nursing Home Association adopted a national accreditation program. Copies of this projected program were to be attached to this report but unfortunately they are not. They will be mailed to you.

(The program referred to follows:)

PROGRAM OF THE NATIONAL ACCREDITATION COMMITTEE, AMERICAN NURSING HOME ASSOCIATION

I. ANHA NATIONAL ACCREDITATION COMMITTEE

To be composed of—

A. 1. A chairman to be appointed by president of ANHA upon recommendation of ANHA National Accreditation Committee for a term of 1 year, who shall be an ANHA member in good standing and shall have a vote only in the event of a tie vote.

2. One representative from each of the eight regions of ANHA with one vote each, who shall be selected by the regional vice president with the approval of the ANHA Accreditation Committee. The original representative appointed from the first, fourth, and seventh regions shall be appointed for 1 year each, and the representative of the second, fifth, and eighth regions for 2 years each. Thereafter, the successive terms of the representative of the aforesaid regions and the original and successive terms of the third and sixth regions, shall be for 3 years each. These regional representatives shall be the regional chairmen and shall be in overall charge of development, implementing, and supervising the accreditation program within the States in their regions in accordance with the policy of the national accreditation committee.

3. One representative each from the American Medical Association, American Dental Association, American Hospital Association, and American Nurses Association with one vote each.

4. The president, coordinator, and general counsel of ANHA shall be ex officio members and shall have no vote.

B. The duties of the national accreditation committee shall be—

1. The responsibility for the criteria, planning, and implementation of the national accreditation program.

2. To hear and determine appeals from denials of accreditation by the State accreditation board.

3. To issue certificates of full accreditation granted by it, the State board, or the executive committee of the board.

4. To adopt uniform survey report forms and to establish a reporting system for use of surveyors.

C. The duties of the chairman of the national accreditation committee shall be—

1. To preside at all meetings of the committee.

2. To execute, develop, and implement the policy of the national committee.

3. To prepare an annual budget for consideration and approval by the committee and presentation to ANHA.

D. National coordinator.

1. A national coordinator shall be appointed by the national accreditation committee which coordinator shall receive and process all applications for

accreditation by licensed nursing homes and related facilities (which have been in operation for 12 months or more). The coordinator shall establish a code system and such other procedure as is necessary with the approval of the national accreditation committee to be used in connection with all processing, surveys, accreditation, and appeals. After the survey team has completed its survey of an applicant, it shall forward its recommendations to the national coordinator who shall process the same in all successive appeals until a final determination is made by the national accreditation committee.

II. THE STATE ACCREDITATION BOARD

To be composed of—

A. One representative each appointed by the following organizations (insofar as practicable) who shall have one vote each:

1. State medical society.
2. State hospital association.
3. State dental association.
4. State nurse association.
5. State league for nursing.
6. State practical nurses association.
7. State licensing agency.
8. State reimbursing agency.
9. Blue Cross-Blue Shield and/or Health Insurance Council.
10. Three active members of the State Nursing Home Association (insofar as possible there shall be one representative of each type of facility recognized by the applicable State law appointed).
11. A chairman (who shall also be chairman of the executive accreditation committee) shall be appointed by the president of the State Nursing Home Association for a term of 1 year. The chairman shall be a nursing home administrator and shall have one vote.

B. The duties of the State accreditation board shall be—

1. To implement, develop, and execute the policy of the national accreditation committee on a State level.
2. To review the findings and orders of the executive accreditation committee on appeal from the grant, denial, or revocation of accreditation and to affirm, set aside, or modify such order.

III

A. There shall be an executive accreditation committee of the State board composed of the chairman, one other nursing home administrator, and three other members selected by and from the State accreditation board, no one of whom shall be a nursing home administrator.

B. The duties of the executive accreditation committee shall be—

1. To consider applications for accreditation of nursing homes and related facilities in operation 12 or more months on the basis of a code system and as received from the national coordinator.
2. To use the basic accreditation program as established by the national accreditation committee. Any addition to the evaluating criteria made by the States must be approved by the national committee before it is implemented.
3. To review and consider the established standards of nursing home performance, including, but not limited to all administrative, professional, operational, and organizational aspects.
4. To establish survey teams and authorize surveys as requested by the national coordinator.
5. To review all survey reports and determine the status of the nursing home and transmit their findings and order to the State accreditation appeals board.
6. To recommend revocations of accreditation at any time for cause.
7. To grant or deny the transfer of accreditation from one licensee to another.

IV. PROCEDURE

A. Accreditation shall be made in the name of the facility which shall be resurveyed within 3 years from the date of issuance of the certificate.

B. All records shall remain the property of ANHA National Committee and shall be considered classified unless released by the committee.

C. Accreditation shall be made only to a nursing home fully licensed in accordance with State and local statutes where the home is located.

D. The survey team may be composed of a nursing home administrator, one nurse, a registered professional or a licensed practical nurse who has had at least 2 years' nursing home experience, and one other qualified person such as a physician, dentist, public health officer, sanitarian, or social worker. The exact number shall be left to the discretion of the State, but no more than three shall survey a facility. However, in the event the survey team is composed of only one individual who is either an official of a public agency or a hired surveyor, his qualifications shall be cleared with the National Committee.

V. FACILITIES

There shall be sufficient nursing personnel (or in the case of a supervised living care facility, a competent qualified individual) on duty at all times to assure safe nursing care.

A. *Supervised living care facility.*—Personal care and service shall be provided by a competent, qualified individual.

B. *Intermediate care facility.*—Nursing service shall be under the supervision of a registered professional nurse or a licensed practical nurse.

C. *Skilled nursing care facility.*—Nursing service shall be under the supervision of a registered professional nurse. At least one licensed practical nurse shall be on duty at all times.

D. *Intensive care facility.*—Nursing service shall be under the supervision of a registered professional nurse and a registered professional nurse shall be on duty at all times. The equipment available for use shall be consistent with the standards in the profession for the condition of the patient under treatment or care.

OCTOBER 1961.

EVALUATION FORM FOR NURSING HOMES

ADMINISTRATION

	Yes	*No*
A. Physical plant:		
1. Compliance with individual State laws governing nursing homes for licensing	( )	( )
2. Compliance with State rules and regulation for fire safety	( )	( )
B. Administrator:		
1. Qualifications and education:		
(*a*) 4 years of high school or its equivalent?	( )	( )
(*b*) Is this training sufficient for proper discharge of his duties?	( )	( )
(*c*) Is his experience sufficient for proper discharge of his duties?	( )	( )
2. Professional advancement:		
(*a*) Does the administrator/owner belong to local, State, National organization representing this profession?	( )	( )
(*b*) Does the administrator/owner regularly attend organized institutes, workshops, association meetings, etc.?	( )	( )
C. Personnel policies:		
1. Does the nursing home have written personnel policies?	( )	( )
2. Are the personnel policies explained to employees when they are hired? Are written copies readily available?	( )	( )
3. Are schedules, plans, and duties posted in writing?	( )	( )
4. Is an evacuation and distaster plan posted conspicuously? Are employees trained in the execution of the evacuation and disaster plan?	( )	( )
5. Is a preemployment and annual health examination, including chest X-ray required for all personnel?	( )	( )
6. Is there any formal inservice training program (including staff meetings) for personnel?	( )	( )
7. Are reference materials readily available to staff?	( )	( )
8. Is a written employment application required for all personnel?	( )	( )

	Yes	No
D. Office management:		
1. Does the administrator use commonly accepted/approved forms?	( )	( )
(a) Does the administrator have a brochure explaining the policies of the home regarding admission, discharge, refunds, handling of personal possessions, etc.?	( )	( )
(b) Does the administrator make inventory of patient's possessions, on admission?	( )	( )
(c) Does the administrator have permission from the patient or responsible person on admission to summon a doctor other than patient's own private physician in case of emergency?	( )	( )
(d) Does the administrator use an acceptable bookkeeping and record system (census, menu, etc.)	( )	( )
2. Administrator relationships:		
(a) Is the family or some responsible person kept informed of the patient's condition?	( )	( )
(b) Is the relationship among administrator, patient/guest and family a good one?	( )	( )
(c) Is there good administrator-personnel relationship?	( )	( )
3. Insurance:		
(a) Does the administrator/owner carry professional liability insurance?	( )	( )
(b) Does the administrator/owner carry premise liability insurance?	( )	( )

II. MEDICAL CARE

A. Does the record show that each patient admitted to the nursing home has a personal physician of his choice?	( )	( )
1. Does the physician make periodic visits, at least once every 3 months or more often as indicated by the patient's condition?	( )	( )
2. Does the physician enter progress notes on record at time of visit?	( )	( )
B. Does the nursing home have a principal staff physician or or physicians, or a medical liaison committee for consultation pertaining to patient care?	( )	( )
C. In case of emergency, has the personal physician indicated an alternate to be called when he is not available?	( )	( )

III. MEDICAL RECORDS

A. Does individual record for each patient include:		
1. Admission record and diagnosis?	( )	( )
2. Identification, such as social security number, color, race, nationality, religion, name of person or agency responsible for payment of services, and marital status?	( )	( )
3. Physicians' progress notes	( )	( )
4. Physicians' orders?	( )	( )
5. Reports and medication records?	( )	( )
6. Are nursing notes kept daily and signed by the nurses?	( )	( )
B. Is patient roster complete and adequate for statistical and legal requirements?	( )	( )

IV. NURSING CARE

A. Is there a registered nurse in charge of patient care (minimum 5 days, 40 hours per week)?	( )	( )
B. Is there a licensed practical nurse in charge of patient care (minimum 5 days, 40 hours per week)?	( )	( )
C. Is there a practical nurse in charge of patient care (minimum 5 days, 40 hours per week)?	( )	( )
D. Is there a consulting registered nurse (minimum 8 hours in 1 week)? (Where consulting registered nurse is employed, dated record must be kept of all recommendations.)	( )	( )
E. Is there a night nurse on duty, awake and fully dressed?	( )	( )
F. Are there written policies, procedures, and guides available to the nursing staff?	( )	( )

V. RESTORATIVE MEASURES

	Yes	No
A. Are restorative procedures maintained in accordance with the determination of the attending physician?	( )	( )
B. Are there special restorative programs under the supervision of a professional therapist?	( )	( )
C. Has the nursing staff been given special instruction in such a program?	( )	( )
D. Are there provisions for this service from the appropriate community facilities and agencies when such services are not available at the nursing home?	( )	( )
E. Have the nurses received special instruction or training in procedures leading to maximum self-care, and do they practice them?	( )	( )

VI. DIVERSIONAL ACTIVITIES

A. Are facilities/equipment available for—		
(1) Reading material?	( )	( )
(2) Letter writing?	( )	( )
(3) Religious services?	( )	( )
(4) Games	( )	( )
(5) Radio?	( )	( )
(6) Television?	( )	( )
(7) Other? (specify)	( )	( )
B. Are recreational activities encouraged and supervised?	( )	( )
C. Are volunteer services utilized?	( )	( )
D. Are there adequate visiting hours?	( )	( )

VII. ESSENTIAL SERVICES

A. Medication:		
1. Are there provisions for the safe sorting and proper recording of narcotics and dangerous drugs?	( )	( )
2. Are other drugs properly safeguarded and records?	( )	( )
3. Are any medications or drugs allowed at bedside tables?	( )	( )
B. Dietary:		
1. Is there a variety of good quality foods served at each meal?	( )	( )
2. Is the food prepared and served in a form to suit the individual needs?	( )	( )
3. Food supplies:		
(*a*) Is there a 1-week supply of staple foods?	( )	( )
(*b*) Is there a 1-day supply of perishable foods?	( )	( )
4. Is the kitchen clean and equipment (dishwasher, garbage-handling facilities, pots, pans, and dishes) adequate?	( )	( )
5. Are refrigeration and storage adequate?	( )	( )
6. Menus:		
(*a*) Are menus planned and on file?	( )	( )
(*b*) Is the menu varied sufficiently?	( )	( )
7. If required, are food handler's permits current?	( )	( )
8. Are problem patients being aided satisfactorily with their eating?	( )	( )
9. Are there provisions for serving special diets?	( )	( )
10. Is there a maximum of 14 hours between the evening meal and the morning meal?	( )	( )
11. Are 3 meals served per day with supplementary feedings in evenings?	( )	( )
12. Are patients weighed monthly, with weight recorded and dietary changes made if ordered by the attending physician?	( )	( )

	Yes	No
C. Housekeeping:		
1. Is the general housekeeping of nursing home good?	( )	( )
(a) Are there any objectionable odors present?	( )	( )
(b) Is the general atmosphere suggestive of homeness and comfort?	( )	( )
(c) Is there—		
(1) A dining room?	( )	( )
(2) Recreation room, patio, sunroom, or porch	( )	( )
D. Sanitation:		
1. Are rodents and insects present?	( )	( )
2. Are sanitary food handling procedures practiced?	( )	( )
E. Safety measures:		
1. Are there written evacuation plans in home?	( )	( )
2. Are there first aid supplies for emergency care?	( )	( )
3. Are all personnel instructed in household accident prevention?	( )	( )

VIII. SUMMARY AND RECOMMENDATIONS

Include an objective listing of the deficiencies found. This should make mention of those points in which the facility excels.

There is also room here for the subjective appraisal by the surveyors of the facility. The utility of this summary and recommendations will depend in part on the skill and perspicacity of the surveyors.

Recommendations where a specific deficiency exists should be clearly made, offering the administrator/owner a chance for self-improvement.

It is recognized that collateral information may be obtained by the surveyors which might be helpful in the overall evaluation of the facility.

Surveyor's Manual for Evaluation of Nursing Homes

I. ADMINISTRATION

A. Physical plant: As State licensing requirements and fire safety regulations change from time to time, it is anticipated that this will be answered on the basis of the requirements in effect at the time of the survey.

B. Administrator:

1. Qualifications:

(a) A factual chronological recitation of the administrator/owner's formal education, training, and experience is to be included here.

(b) Attention also should be given to the degree of integrity, devotion, and dedication of the administrator/owner.

(c) Evidence that the administrator/owner, if not qualified, purchase the necessary services for the discharge of administrative duties?

2. Professional advancement:

(a) It is felt that the progressive administrator/owner, the one who is truly interested in the advancement of his facility, will want to avail himself of the opportunity of allying with people who have a similar interest.

(b) The attendance at meetings that advance the training and skill of the administrator is important. More and more emphasis is placed on restorative procedures and knowledge concerning these is available at various workshops and training courses. Current attendance at these indicates again that the administrator/owner is interested in increasing his knowledge and skill.

C. Personnel policies:

1. Personnel policies should be written, kept up to date, and readily available for references.

2. The explanation of personnel policies should not be static; it should come from two sources—counseling at the time of employment, and amplifying throughout employment. For the clear understanding of all concerned, it is felt advisable that personnel policies be readily available.

3. Each employee will function most efficiently when he understands completely the extent of his duties.

4. It is felt advisable that each facility have a clearly understood and smoothly practiced evacuation and disaster plan commensurate with the size of the facility. Naturally, a paperwork evacuation plan is of little or no value at a time of emergency unless it is periodically reviewed by all personnel. Personnel and the administrator/owner must function efficiently and effectively in maintaining the safety of the patient and guests.

5. Preemployment and annual health examinations protect both the personnel and the patients. It is felt that whenever possible, the 14- by 17-inch chest film is desirable. In those areas where it is impractical or impossible to obtain a large X-ray, the minifilms as taken by the mobile chest units, such as those of the National Tuberculosis Association, will be acceptable. This section includes the administrator/owner under the general terms of "personnel."

6. All facilities should have on-the-job training in an attempt to raise the level of service performed by the employees. Outlines of lectures and demonstrations given should be kept on file, together with signed attendance records of employees present.

7. Reference material, such as medical dictionary, practical nursing textbook, PDR (physicians' desk reference) manual for diabetic food interchange, etc., should be available at all times for staff.

8. References of all applicants should be checked.

D. Office management:

1. Does the administrator/owner use commonly accepted/approved forms?

(*a*) All policies regarding admission, discharge, and refund policy should not only be in writing, but the person or patient himself should clearly understand same before admission.

(*b*) Those possessions or valuables left in care of the administrator/owner should be receipted and a copy furnished the family/responsible person.

(*c*) It is recognized that there may be those, who, for religious reasons prefer not to summon a physician in time of need. Arranging for this permission before admission, as well as calling another doctor if patient's own physician is not available in case of an emergency, will greatly expedite the situation.

(*d*) The bookeeping and record systems will reflect, generally speaking, the efficiency and attention to details of the organization.

2. (*a*) Most of the families show a genuine interest in the welfare of their relatives, so that, for the most part, elaborate systems of contact are unnecessary. In those instances where, by virtue of indifference, apathy, inaccessibility, or for a variety of other reasons, the relatives do not visit regularly, it is felt that the relatives (nearest of kin) should be informed at not less than monthly intervals. When a considerable change takes place, particularly a sudden deterioration, communications should be as frequent as necessary.

(*b*) This, again, is rather subjective and is perhaps most easily ascertained by the general interpersonal relationship which pervades the establishment. It might be well to make part of the evaluation during the normal visiting hours so that the visitors can be observed.

II. MEDICAL CARE

A. In concurrence with the American Medical Association Council of the American Nursing Home Association, and the American Medical Association and American Nursing Home Association Liaison Committee, each patient should be given the privilege of choosing his own physician.

B, C. The staff physician or medical liaison committee of the county medical society could be utilized for consultation of medical care of patient. Also, they would be available for emergency calls when the patient's regular physician is unavailable.

III. MEDICAL RECORDS

A. Individual record folders for each patient includes:

1. Admission record and diagnosis.
2. Proper identification.
3. Orders.
4. Progress notes.
5. Reports and medication records.
6. All daily nursing notes on each patient.

B. A roster should be maintained of all patients admitted and discharged in the nursing home.

IV. NURSING

A, B, C, D, E. The minimum nursing personnel and supervision are delineated by each individual State standard.

V. RESTORATIVE MEASURES

A. Written orders from the attending physician should be obtained for all restorative procedures performed in nursing home.

B. Larger facilities may employ a professional physical and occupational therapist to manage this department. Smaller facilities may have a visiting physical and occupational therapist.

C. Provision should be made by the administrator/owner for instruction of the nursing staff in restorative procedures. Examples of how this might be accomplished are: visiting physical and occupational therapists, workshops, county medical society liaison committees, and personal example.

D. Larger communities will undoubtedly offer a restorative program. Adequate use of these should be made wherever possible.

E. Relates to B.

VI. DIVERSIONAL ACTIVITIES

A. Diversional activities may vary from the simplest (reading material and letter writing) to organized group activities. This will depend upon the size of the facility, as well as on the interest and skill of the supervisor and nursing staff. It is not anticipated that a chapel for religious services will be considered a part of a nursing home. Services may be held or transportation arrangements with local churches and synagogues.

B. The older patients, particularly those who are senile, will require considerable encouragement and supervision. There is a tendency of many older people to insulate themselves from the activities which surround them. A skillful nurse or aid can sometimes motivate the older patient to join in group activities.

C. Volunteers include the American Red Cross Gray Ladies and Transportation Service, the women's auxiliary to the medical societies, the Friendy Visitors' Service, women's organizations of the various churches and clubs, etc.

D. There are many services given for the patients which cannot be performed during visiting hours and for this reason unrestricted visiting may pose problems. However, visiting hours should be adequate. Visiting by friends and relatives should be encouraged.

VII. ESSENTIAL SERVICES

It will be noted that this entire section has received an asterisk because herein lies the heart of all problems—that is, the provision of service to the elderly, where a qualitative difference separates the truly superior home from the average or substandard home. It is recognized that excellent service can be provided in an average physical plant, and certainly the reverse thereof is also true.

A. Medication:

1. Self-explanatory.

2. Self-explanatory.

3. Here, the type of facility must be given prime consideration. In the facility rendering nursing care, no medications are permitted at the bedside table. In the home for the aged, certain innocuous medications may be left at the bedside table.

B. Dietary:

1. Each patient should be provided daily with the kind and amount of food according to dietary allowances currently recommended by the Food and Nutrition Board, National Research Council, Washington, D.C.

(*a*) One pint or more of milk, including fresh milk or its equivalent in evaporated or dry milk solids.

(*b*) Orange, grapefruit, tomato, or other vitamin C foods (fresh, frozen, or canned): one or more servings (approximately one-half cup) daily.

(*c*) Green or yellow vegetables (fresh, frozen, or canned): one or more servings.

(*d*) Potatoes, other vegetable, and fruit (fresh, frozen, canned, or dried): two or more servings.

(*e*) Lean meat, poultry, fish, or eggs: two or more servings. (Dried peas, beans, or peanut butter may be used as an additional serving.)

(*f*) Whole grain or enriched breads and cereals: two or more servings.
(*g*) Butter and other fats with each meal.
(*h*) Additional foods in amounts to meet the patient's caloric needs and to make meals appetizing and satisfying.
(*i*) Iodized salt as a seasoning.

It is not sufficient merely to prepare a variety of good foods at each meal if no consideration is given to individual food preferences and individual abilities to consume the food. Many elderly people, particularly those who are somewhat senile, will prefer to make a meal from one type of food. Personnel who understand the situation can see to it that dietetic correction can be made at the next meal.

2. Food should be prepared by accepted methods to conserve maximum food value and to produce maximum palatable and attractive meals.
3. Self-explanatory.
4. Self-explanatory.
5. Self-explanatory.
6. Cyclic menu planning is acceptable, taking into consideration the season of the year and also the length of the cycle. It is felt that cycling should not be of less than 3 weeks, preferably 5 to 6 weeks. Monotony is to be avoided.
7. Self-explanatory.
8. This question has many ramifications, including physical ineptness at eating (e.g., the arthritic patient, the patient with a stroke, etc.), the patient who prefers certain types of food to the exclusion of a well balanced diet, etc.
9. Facilities should be equipped to serve a low salt (low sodium) diet and also uncomplicated diabetic exchange diets.
10, 11. It is felt that nursing home patients should have a minimum of three meals per day. Should it be the policy of the homes in certain areas to have more than 14 hours maximum between evening and morning meal, then supplemental feedings should be served in the evening when requested.
12. Patients should be weighed monthly wherever possible, weight recorded with significant changes reported to the attending physician. When unable to weigh a patient, measurements of bust, waist, hip, ankle and calf may provide a criteria of weight change.

C. Housekeeping:
1. Self-explanatory.
2. This will require a subjective answer and will depend in part upon the perspicacity of the surveyor.
3. Again, this is primarily subjective in character. The smaller homes will attempt to duplicate the atmosphere of the well-organized and well-run private homes. The larger facilities, particularly those that offer skilled nursing care will, in many instances, more closely resemble a clean and sanitary small hospital. The general atmosphere should reflect those services which the facility is offering.
4. It is anticipated that not all facilities should or will have a communal eating room. The situation will depend upon the type of facility. Recreation rooms and other communal rooms are desirable so that the elderly patients and guests may have an adequate area in which they may fraternize and enjoy each others' company.

D. Sanitation:
1. Rodenticides and insecticides: Harmless compounds should be used whenever and wherever possible in the extermination of rodents or insects.
2. Sanitary food handling: Employees should be adequately instructed in acceptable and sanitary food handling practices.

E. Safety measures:
1. All evacuation plans should include the following information:
(*a*) What to do in case of an emergency.
(*b*) When the evacuation plan is to be placed in operation during a specific emergency.
(*c*) Where evacuation equipment is located and what routes are to be taken.
(*d*) How evacuation plan operates and who is responsible for each phase.
(*e*) Why each employee is required to know his task in relation to entire plan.
2. First aid supplies for emergency care should be maintained in a place known and readily available to all personnel responsible for the health and well-being of patients.

3. It is felt that all personnel should be aware of ordinary household accident prevention measures (examples: vacuum cleaner cords, mop handles, etc., being left in pathway of patients and other personnel).

VIII

Self-explanatory.

IX

The fee schedule may be adjusted to meet the needs of the individual State nursing home associations.

Mrs. BAIRD. The idea was not new. Dr. Ernest P. Boas suggested such action in his book "Chronic Disease, the Unseen Plague," published in 1940, 21 years ago. The Nursing Home Associations of California, Colorado, Connecticut, Illinois, New York, and Wisconsin had developed individual State accreditation programs. Connecticut and Milwaukee County, Wis., had progressed to inspection of facilities and certification of accreditated homes. However, the ineffectiveness of many totally unrelated and unrecognized accreditation programs was evident to leaders in the nursing home field. This led to a study of the problem by the American Nursing Home Association and subsequent adoption by that organization of a national program.

I might deviate briefly and explain that we are in the process of forming a wholly owned, nonprofit subsidiary of the American Nursing Home Association to be called the Joint Council for Accreditation of Nursing Homes and Related Facilities. It will be composed of the American Medical Association, American Hospital Association, American Dental Association, American Nurses Association, and our own organization. On the State level we have provided for representation from the reimbursing agencies and the licensing agencies as well as third party payment on independent insurance companies.

I will not take the time of the committee to explain the workings of the program, as time is limited.

By adopting a national accreditation program the American Nursing Home Association has proved to the public and others in the health field that they recognize the need for some evaluation of quality, some guide to those who are in need of and must select specialized services. In the coming years one will be able to use the phrase "intensive nursing home care" and its meaning will be exact, in the New England States of Massachusetts, New Hampshire, and Connecticut, in Michigan, in Oregon, indeed in all the States.

In the formation of its accreditation program the American Nursing Home Association was gratified by the encouragement and interest shown by other groups in the paramedical field. The assistance of the Joint Council To Improve Health Care of the Aged was of particular value.

This is what the American Nursing Home Association is doing to improve standards in nursing homes, accreditation as well as many of the other projects related by previous speakers. Accreditation is a great step forward for all nursing homes and it deserves the cooperation and support and welcome of all.

Senator SMITH. Thank you very much, Mrs. Baird. Let me just ask one question on your standards. Does your program call for written standards?

Mr. BAIRD. The American Nursing Home Association has a standards committee which met with the U.S. Public Health Service and helped formulate the standards which are supposedly used by all States as a basis for their licensing program.

These standards have also been used in our accreditation program. They have been raised in some States because some States require 24-hour licensed nursing staff and others only require supervision by a registered nurse. We have tried to adapt our accreditation program to the licensing requirements of all the States.

Senator SMITH. In what percentage of the States do you find that program going forward at the present time?

Mrs. BAIRD. At the present time we are waiting until all of the other groups are in and the new national program is functioning. We had 110 homes surveyed prior to that strictly on a State level. Of those approximately 43 homes had been accredited but certificates were not awarded since the program was just revised this past October.

Senator SMITH. Let me say at this time, I think that as your program progresses if you could make reports available to this committee I think it would be a great help to us.

Thank you very much, Mrs. Baird.

Our next witness will be Mr. Miroslav Kerner, Director of Services to the Aged, Jewish Family and Children's Service of Boston.

STATEMENT OF MIROSLAV KERNER, DIRECTOR, SERVICES TO THE AGED, JEWISH FAMILY AND CHILDREN'S SERVICE, BOSTON

Mr. KERNER. Mr. Chairman and members of the committee, I am Miroslav Kerner and I am head of the Services to the Aged, Jewish Family and Children's Service, here in Boston.

I thought it my duty as a practicing social worker to voice a warning against singling out too much only one single problem such as the nursing care for the aged of the entire complex of the care for the aging. I want to give an example of what happened in Massachusetts in the last, let's say 7 years.

In 1954 the basic public assistance nursing home rate in Massachusetts was $28 a week, and in 1961 this rate is $46.20 a week, which represents an increase of 65 percent.

Senator SMITH. Would you repeat those figures again.

Mr. KERNER. Yes. The basic rate in 1954 was $28 a week and in 1961 the rate is $46.20. That represents an increase of 65 percent.

The basic public assistance rate in rest homes, which are also licensed in Massachusetts, was in 1954, $25 a week and is now in 1961, $29.75; in other words, an increase of approximately only 12 percent.

Now this had some very unfortunate results. I would like only to interject here that although the Nursing Home Association claims that the nursing home operations are quite expensive, on the other hand apparently during the past 10 months, they were quite profitable business because their number increased in the period between 1948 and 1957 twice. In the last 2 years, for instance, there were in the city of Boston only 13 new nursing homes opened as against only 1 rest home.

In the town of Newton, for instance, we had in 1959 9 rest homes and 14 nursing homes. In 1961 we have in the town of Newton 1 rest

home and 17 nursing homes. We do not have in the entire Greater Boston area a single Jewish rest home.

I think that this is the result of our effort when we focus on only one single type of care for the aging. We push too many older people into nursing homes. The aging need all kinds of facilities of arrangements for living such as their own apartments, rooms, rooms with kitchen privileges, room and board, rest homes, convalescent homes, homes for the aged, and then finally nursing homes and private hospitals for custodial care.

I thought that it may be important, that we should not forget that the care for the aged should be balanced and that all these programs should get the necessary attention, both financially and licensewise.

Senator SMITH. Thank you very much, Mr. Kerner, for your testimony. It has been most interesting and I know that it will be helpful to us.

Mr. KERNER. Thank you.

(The prepared statement of Mr. Kerner follows:)

PREPARED STATEMENT OF MIROSLAV KERNER, HEAD OF THE SPECIAL SERVICES TO THE AGED OF THE JEWISH FAMILY AND CHILDREN'S SERVICE IN BOSTON

My name is Miroslav Kerner and I am the head of the Special Services to the Aged of the Jewish Family and Children's Service in Boston. I am testifying in my capacity as a social work practitioner.

It is very encouraging to see that the Special Committee on Aging is spending so much time on the problems of the aging and on the specific problem of nursing home care, which is one of the most pressing and difficult in the entire area of care for those aged persons who cannot any more continue their independent way of life. Nevertheless, I thought it important to raise the voice of a social work practitioner in calling the attention of the committee to the fact that such problems as the nursing care should and have to be considered within the scope of the integrated care for the aged. If only one problem is singled out and improved without necessary regard to the other needs of the aged, the planning for the care of many other aged persons who do not need nursing care is becoming more difficult.

In order to illustrate what can happen I would like to point out our present situation in Massachusetts, particularly in the Greater Boston area. We have in our State one of the best public assistance programs for the care of the aging which is reflected both in the high allowances in the public assistance budget and also in the excellent medical care which is being provided for the aged population of Massachusetts on public assistance. Being aware of this situation our public welfare department increased several times the rates for the nursing home care since 1954. The basic rate in that year was $28 a week. After several raises it is now at the level of $46.20 a week which represents an increase of 65 percent.

During the same period of time the basic rent in the rest home which provides care for ambulatory residents has been increased from $25 a week in 1954 to $29.75 in 1961, and that only very recently. The increase amounts to approximately 12 percent and, in my opinion, is very belated and also very inadequate.

The inadequacy and poor correlation in the increases of the fees in these different types of care for the aged is proved by the development of nursing homes and rest homes in many communities in Massachusetts. In the city of Boston proper there was only one rest home opened since 1959 as against 13 nursing homes, out of which some have quite a large number of beds. In the town of Newton, for instance, there were nine rest homes and 14 nursing homes in 1959. Two years later, in 1961, there is only one rest home in Newton, but 17 nursing homes. Although the proprietors of privately owned nursing homes claim that the fees paid for their residents on public assistance are low, it seems that ownership of a nursing home is quite a lucrative business, or at least was, according to the standards required in the past, because the number of nursing homes in Massachusetts in the period between 1948 to 1957 doubled and since that time still continued to increase. Probably this increase will slow down as higher standards are being required by the licensing authority and this is all to the better.

The results of the substantially increased rates for the nursing home care without a simultaneous improvement of the rates in the rest homes made the operation of a nursing home commercially much more attractive. Not only did the number of rest homes diminish but the quality of their care suffered. Most of them serve meals on trays as they do in nursing homes. There is inadequate space for social activities of the residents so that lay persons cannot very well differentiate a rest home from a nursing home. The low rate for rest home care makes it also much more difficult for nonprofit organizations to operate rest homes as they have to bear a burden of a large subsidization.

As social workers we would like to provide for every aging person the kind of living arrangements which are best suitable for him, or her, or for the aged couple. There is an entire scale of living arrangements which should be all available in every community, especially in a metropolitan area. At the present time, unfortunately, there is not a single Jewish rest home in the Greater Boston area.

Many of the elderly persons, Jewish and non-Jewish, are forced into entering nursing homes where they are fast deteriorating both physically and emotionally to the level of the majority of the bed-ridden patients living in these nursing homes. This is very unfortunate and we would like to see that some of them should be enabled to live in their own apartments, either in private houses or in publicly supported housing developments. Other adult persons can continue to live in individual rooms either in lodging houses or with families, if they are still capable of eating outside and do not require special diet. The next group of elderly may be satisfactorily placed in rooms with kitchen privileges or in room and board arrangements in cases where eating in restaurants would be too difficult or is not recommendable by their medical needs. When neither of these arrangements can be used, but the old person is ambulatory, a foster home can be a very highly recommendable solution and if even this could not be provided such persons should be offered an opportunity to live in a rest home where they would be served meals in a dining room and would have adequate space for socializing in a lounge or similar room where they could congregate. Such homes can be located close to the downtown areas and do encourage their residents in participation in the community life as their residents are not confined to their premises. A small rest home for 15 up to 30 residents is a much healthier living arrangement than a large home for the aged with a population of several hundred persons which constitutes a tremendous need for readjustment on the part of persons who were used to independent living and are now forced into a group accommodation with many restrictions on their liberties. Homes for the aged should be a matter of last choice when all other placements are unsuitable.

I would like to emphasize again that the nursing home care is very essential for the needs of the elderly citizen, but providing nursing home care which would be much superior to the other possible placements would only aggravate the entire situation in the field of the care for the aging and probably would again force many people into nursing homes who should not be there and should be encouraged to continue an independent way of life.

Senator SMITH. Ladies and gentlemen, I am very happy now to welcome back to the statehouse a man who has spent a great deal of time right here in this very statehouse, a man who you all know has spent a great deal of his life serving all of the people of Massachusetts, and a man who is sincerely interested in the great problems of the aging that face us today. I am very happy to present to you my distinguished colleague, Senator Leverett Saltonstall, whom you all know so well.

Senator SALTONSTALL. Senator Smith and ladies and gentlemen, first may I say I appreciate very much Senator Smith asking me to join him here for a few minutes today. As he says, I have sat in this room a good many times, at this desk all the way up and down the line here, and occasionally in front over the years. I cannot see that the room has changed very much in appearance but I am glad to have a distinguished colleague sitting as the chairman. I am sure that he will give very interested and pertinent attention to the facts that you ladies and gentlemen bring out on this very important subject.

Now, Senator Smith, you are on this committee and you are very familiar with the problems as they face the Federal Government. I just say this: As I see it there are three points that we who are in the Federal service need to know and want the facts as best we can get them on this subject of retirement income.

First, whether nursing homes are being well run or not. Now all who are here know that in the old days hospitals and hospital care were very much less expensive than they are today so that people could stay longer in the hospitals if they had to and then go to their homes in relatively better physical condition. Now today hospitals are so expensive that people cannot afford to stay in them for a very long period of time so that they want to go or may have to go to these homes where they can get care and yet not have as an expensive overall daily cost as they do at the hospitals. So what we want is a greater number of these nursing homes rising. We want them well run, we want them safely run. We know that there have been several bad accidents in this State, one I think in this State and several elsewhere, and we want them to have as little, if you want to call it that, as little overall regulation that will hurt their services rather than help them. That is one point.

Now the second point is that, as we all know, there are more people becoming older and staying reasonably healthy but needing care in their old age. So there are a greater number of people who desire this care in homes. Perhaps they cannot afford their own home or they have children with a large number of grandchildren, so that they want to go somewhere else in their older age. That is another point that involves us in the Federal Government.

Then the third point of course, as Senator Smith and I know from our experience in the last session and the session before, is the question of aid to the elderly, whether that should be on the social security basis or whether it should be on a volunteer basis. That brings up a very important problem that we will face in this session of the Congress.

So we have these three points that really come down to the basic fact that there are more elderly people today in our State and in our Nation than there were 15, 20, and 25 years ago. How are we going to look after and help those elderly citizens to a healthy and happy old age and at the same time not burden them, burden our administration—either State, local or national—with too much regulation.

Now I know that my colleague, Senator Smith, has studied this subject in Washington. I am confident that you ladies and gentlemen who are here today will help him to reach a thoughtful conclusion that he will bring to his colleagues in Washington as to what we are doing here in Massachusetts, what we can get Federal assistance to do more properly and helpfully and at the same time keep our elderly people in a contented and happy and healthy basis.

Senator Smith, I thank you very much for this opportunity to be here with you today. I am sure that this hearing will bring fruitful results to you and to all of us in the Federal service.

Senator SMITH. Thank you very much, Senator Saltonstall, for your very fine remarks. We certainly appreciate your taking the time to join us today.

Our next witness this morning will be Mr. Richard Steinman, Committee on Aging, Community Services of Greater Worcester.

It is a pleasure to have you with us, Mr. Steinman.

STATEMENT OF RICHARD STEINMAN, PROJECT DIRECTOR, COMMITTEE ON AGING, COMMUNITY SERVICES OF GREATER WORCESTER

Mr. STEINMAN. Thank you, Senator.

Mr. Chairman and members of the committee, I am Richard Steinman, project director, Greater Worcester Project on Aging, Community Services of Greater Worcester, Mass., Inc.

In August 1960, in competition with 120 other American communities, Community Services of Greater Worcester was honored by the Ford Foundation with a grant to demonstrate, over a 3-year period, sound methods of organizing community services for older people. Among the seven communities to receive these grants Worcester was the only one east of the Mississippi River.

I came to Worcester in 1960 to direct this project, and it will interest you Senators from Massachusetts to know that the whole nationwide project is being conducted under the leadership of the Florence Heller Graduate School for Advanced Studies in Social Welfare at Brandeis University.

My remarks will be divided into two parts: First, reflecting the work of those I represent; and secondly, stating positions which are not necessarily those of Worcester citizens but which I judge would be helpful to the Senate Special Committee on Aging.

PART I

Citizen leaders of Worcester are working to increase the well-being of nursing home patients by promoting closer working relationships between nursing home operators on the one hand and the medical and welfare community on the other. By reducing mutual suspicion and enhancing cooperation between nursing homes and services their patients need, it is believed that patients can be more individually selected for nursing home care, more vigorously restored—once in a nursing home—to maximum functioning, and more actively helped to return to community life as a result of therapy prescribed and received. There is documented experience that approximately 25 percent of the patients in a chronic illness facility can be rehabilitated significantly.

Very simply, we recommend—and are striving to demonstrate in Greater Worcester—that the nursing home become a part of a network of health and welfare services enabling older citizens to remain in or return to their own homes or comparable private homes. This network would consist of the physician and social worker (reviving the time-honored but now all too little practiced home visiting of their respective professions); the dentist whose testimony was very rewarding this morning; the visiting public health nurse and the licensed practical nurse whose services are ever-increasingly devoted to the aging and chronically ill; the physical and occupational therapists whose value to the patient in his own home the community has

hardly begun to grasp; the homemaker whose availability in the United States lags shamefully behind that in our sister countries of Western Europe; the nutritionist who, when permitted to, sees and alleviates the half starvation (which frequently opens the gates to disabling illnesses) of many older people living in lonely isolation, whether in the centers of our crowded cities or on far-removed farms; and the therapeutic recreationist, librarian, and friendly visitor who bring meaningful diversions and companionship into the patient's home.

I would like to mention here how pleased I was to hear Mr. Connelly testify about the recent work conducted under State auspices and with his federation's cooperation, concerning attempts to provide therapy and recreation to nursing home patients. There was some question about what this might cost, and it might interest this committee as well as those working on it here in Boston to know that Connecticut has started a program whereby the State provides 60 cents per day per patient in nursing homes for the sole purpose of serving those patients with therapeutic recreation. This demonstrates the importance that the Legislature of Connecticut attaches to the therapeutic recreation for these patients.

A significant number of patients could be saved by such a network of services from ever having to enter nursing homes or hospitals.

In the opinion of Dr. Samuel Bachrach, chairman, Committee on Aging, Worcester Community Services, the nursing home can become an important steppingstone back to some degree of independence for from 25 to 50 percent of older people entering nursing homes. There would be certain patients who could return from hospital to community by way of nursing homes if the latter would serve as halfway houses offering the network of active therapy described above. Thus the patient could again be on his way toward being on his own: in a rest home, a foster home, a group residence, a hotel, an apartment, or a relative's home.

In other instances Dr. Bachrach suggests doctors might refer their patients directly to nursing homes for treatment and convalescence. The Senate committee can readily see the concomitant effects this would be likely to have on the availability of hospital beds, thus helping to lessen the need for hospital expansion.

PART II

The following are comments which, in part, are my individual judgments, and not necessarily those of Worcester Community Services.

This work of Worcester's Committee on Aging suggests exciting opportunities to nursing homes: opportunities and challenges. A question of key importance—and I hope it is eventually answered in the affirmative—will be: Can the proprietary nursing home, operating as it does as a profit-making business in the great American tradition of free enterprise, overcome the pitfalls encountered some decades ago by the proprietary hospital which, except for a few isolated instances, had to evolve into the nonprofit hospital we know today in order to be able to offer the network of expensive medical and related services which medical progress made necessary?

If the American nursing home will strive to change its status from a point-of-no-return facility to that of a vital partner in rehabilitation and long-term care, serving younger chronically ill patients as well, it can become, so to speak, a revolving door through which patients return to the community rather than an end-of-the-line terminus which it is for so many today. Many of us in related professions would be glad to assist in bringing this about.

I referred earlier to care by relatives. When mutually satisfactory to all generations involved, this can be ideal. You have, however, been offered considerable testimony that it often does not work.

Recent anthropological evidence indicates that, contrary to commonly held assumptions, acceptance of responsibility for the care of parents is not necessarily a natural consequence to family life. Whereas parental love for the child, and desire to protect and rear him, is clearly an instinctual drive, the reverse—love for the parent, and the desire to contribute to his well-being—is something children must learn, and are not born with. An extension of this finding suggests that the middle generation, striving to nurture its offspring fully, is caught in a cruel vise when society expects it to care for parents with equal zeal.

Prof. Alvin L. Schorr points out that—

> It was only when an economy that separated wages from ownership meant that the old person was no longer in control, that many adult children had reason to examine their willingness to help their parents * * *. It is in the 20th century that the idea has achieved wide currency and effect that an adult should voluntarily sacrifice his own, his wife's, and his children's resources to assist his parents before the community will assume responsibility.

There is not time for me to present today the brilliant development of this idea recently published by my distinguished colleague, Dr. Esther Lazarus, director of the Baltimore Department of Public Welfare, but it is listed in the footnote and I recommend it very highly to a dedicated group of public servants such as this Senate committee and would be happy to provide it as an appendix to my testimony.

In closing, however, you might find rewarding, as I did, the following tale with which Dr. Lazarus opens her paper:

> A pious, 17th-century Jewess relates the tale of an eagle that set out to cross a windy sea with his fledgling. The sea was so wide and the wind so strong that the father bird was forced to carry his young one in his claws. When he was halfway across, the wind turned to a gale and he said, "My child, look how I am struggling and risking my life in your behalf. When you are grown up, will you do as much for me, and provide for me in my old age?"
>
> "My dear father," the eaglet replied, "it is true that you are struggling mightily and risking your life in my behalf, and I shall be wrong not to repay you when you are grown old, but at this critical time I cannot bind myself. This, though, I can promise: When I am grown up and have children of my own, I shall do as much for them as you have done for me."

Thank you, sir.

Senator SMITH. Thank you very much for this very fine testimony, Mr. Steinman.

Earlier in your remarks you mentioned what foreign countries are doing in this field. I should like to mention at this point that Senator Clark, who is a distinguished member of this committee, was in Stockholm during October, and has made a very fine report on the services for the aged in Sweden which will be published soon. I think you will find it extremely interesting.

Senator Saltonstall, do you have any remarks or questions?

Senator SALTONSTALL. No. I thought that was a very impressive paper, particularly the last part.

Mr. STEINMAN. Thank you, sir.

Senator SMITH. Thank you.

Now before declaring the session in recess I would like to remind you that we will resume at 2 p.m. when we will have our town meeting aspect of the conference and allow speakers to state their views on the various problems of the aged.

Thank you very much.

(Whereupon, at 12:20 p.m., the hearing was recessed, to reconvene at 2 p.m. of the same day.)

AFTERNOON SESSION

Senator SMITH. The second session of the hearing on problems of the aged conducted by the Special Senate Committee on Aging will please come to order.

This afternoon we have a meeting here based on the town forum plan where members from the audience will be allowed to speak. We request that you limit your remarks to 5 minutes. There are many people here and I welcome you all. I must say that this is probably one of the finest gatherings, the greatest group of people that we have had during our hearing. It certainly shows the keen interest that you people have in the problem facing us today and the very human problem. I am very glad to see you and look forward to hearing your testimony.

If you will, step forward and give us your name for the record so that we can have this permanently. If you care to state your age, that would be of interest to the committee, too, I am sure.

STATEMENT OF PROF. FRANCIS L. HURWITZ, DIRECTOR OF SPECIAL PROGRAMS, CENTER FOR CONTINUING EDUCATION, NORTHEASTERN UNIVERSITY, BOSTON, MASS.

Mr. HURWITZ. My name is Francis L. Hurwitz. I live in Brookline, Mass. I am director of special programs and associate professor of adult education in the Center for Continuing Education at Northeastern University. I trust what I have to say is in order for this afternoon's session. I do not have prepared notes but I have an outline so that I will be able to keep within the 5-minute limit.

Senator SMITH. That can be made a permanent part of the record if you wish after you are through.

Mr. HURWITZ. All right, sir.

I thought it incumbent upon me to submit for your consideration some of the aspects of the educational program of my department as it has been involved with nursing home administration. I do so because I was in attendance in the morning session and heard the presentations that were made, several of them having had reference to the university. I refer to Commissioner Tompkins, Dr. Rubenstein, and Mr. Connelly.

I feel that the mere reference to the educational pursuits of nursing home administrators, while no doubt are considered important to you for what they may import, I believe it needs no interpretation but

some amplification for it will reveal to you one aspect of the problem that concerns you and that is the kind of people who are administrators of nursing homes in Massachusetts and in New England. At least those with whom we have come in contact, which may now run to some 125, we wish to indicate to you their desire to establish higher standards and to become a profession.

Now the important thing to bear in mind is that they came to the university, and they came to the university as other fields of endeavor have come to us, for their continuing education. I have reference to schoolteachers, superintendents of schools, engineers, pharmacists, and the like. As I said, not just a mere handful are involved nor is it merely a gesture on their part intended as a public relations gimmick, and in a moment it will become clear why I so say.

These folks in this first year of the program have spent of their own money as much as $500 each by way of tuition fees and the like. They have invested a considerable amount of their time. As they come to the initial undertaking it means spending 4 days in our conference center. In other words, they have to be away from their place of business from 4 to 5 days. In addition, when they then attend the subsequent seminars, some of them travel as much as 200 miles in 1 day. It would mean leaving their home as early as 6 o'clock in the morning to come to the conference center and spend an entire day, not leaving until 5 and then traveling back to their place of residence. The nearest that anybody is to the conference center is about 40 miles.

Now what is the program? I am not going to take the time except to say that we require them to undertake this workshop and then the seminars. They are not merely concerned with skills and techniques but understandings because we endeavor to understand who is the elderly citizen, how can we cooperate with them, and the like. I wish time permitted me to go into detail as to the content; it just does not permit it.

I would like to say at this time that among those who are on our staff are Dr. Rubenstein and Mr. Connelly whom you heard this morning.

Now the major effort is in cooperation with the Massachusetts nursing homes and with the American Nursing Home Association. Initially we started on the State level. We are now working with the entire New England area. As Dr. Rubenstein told you this morning, we concluded the third workshop just yesterday afternoon which began Monday morning.

Now let me give to you one indication among others that I think will be important to you. We endeavor to evaluate everything we do. When we undertook the seminars that were conducted this past spring—and if I have not stated before I would like to say so now, we began the program just a year ago. It was in November of 1960 when we held our first workshop at the Endover Inn but which we now hold at our own conference center. We made a stipulation that we would like to undertake to evaluate what we are doing.

Senator SMITH. Could you finish up in one moment?

Mr. HURWITZ. Yes, sir. They gave us the grant of $500 for that evaluation which we have just received.

I will conclude with this and then I will be able to submit, if you desire, the report we made of our first year's activity. I would like you to know that the Special Committee on Aging was most coopera-

tive and has been furnishing us with the material for all of our training programs.

Thank you very much.

Senator SMITH. Thank you, Mr. Hurwitz. We will be glad to have your full statement and the reports you mention to be included in the record.

(The prepared statement of Mr. Hurwitz follows:)

PREPARED STATEMENT OF FRANCIS L. HURWITZ

Mr. Smith and members of the subcommittee, my name is Francis L. Hurwitz, residing at 14 Egmont Street, Brookline, Mass. I am associate professor of adult education, and director of special programs in the Center for Continuing Education of Northeastern University, Boston, Mass.

I felt it incumbent upon myself to submit for your consideration some aspects of the continuing education program the Department of Special Programs of Northeastern University has been developing for nursing home administrators in the New England area. I believe the committee should be aware of this educational activity on the part of a growing number of nursing home administrators. It seems to me that it imparts a trend that should be taken into cognizance, the development of more effective administrators that I feel will improve the quality of nursing home care. Also, I was in attendance in this morning's session and heard the presentations that were made, several having included reference to the educational activity in nursing home administration being conducted by Northeastern University. I have reference to the statements of Dr. A. Daniel Rubenstein, director of hospital facilities of the Massachusetts Department of Public Health; Mr. Patrick A. Tompkins, commissioner of the Massachusetts Department of Public Welfare; and Mr. Edward F. Connelly, executive director and general counsel of the Massachusetts Federation of Nursing Homes.

These references to the educational pursuits of nursing home administrators are undoubtedly considered by you important activities for what they indicate. However, it seems to me there should be amplification of what is involved in the Northeastern program. By so doing, I believe it will reveal the kind of people who have the administrative roles; also, to indicate the desire on the part of the administrators who are participating in the program to overcome their inadequacies in order to meet more effectively the demands of a changing role, as well as an attempt to establish high professional standards.

I should like to emphasize that not just a mere handful of administrators have been involved. I should like also to emphasize that their involvement in the educational program has not been just a mere gesture, nor is it intended by them as a public relations gimmick. As of this date, 137 nursing home administrators have participated in 11 training offerings; 3 having been workshops in nursing administration, each of which was a 4-day-living-in experience, the most recent of which concluded yesterday afternoon; and 8 were seminars in management principles, each having been 10 weekly 3-hour sessions, concerned with such areas as organization and administration, interpersonnel relations, financial operations of the nursing home, and mental health of the aged.

Further, I should like to have the committee have an awareness that these administrators have been obliged to spend a considerable amount of time and money in this educational effort. Quite a few have spent up to $500, and a number have traveled as much as 100 to 200 miles each day of their attendance at the seminars.

Initially, the offerings were undertaken in cooperation with the Massachusetts Federation of Nursing Homes, and involved administrators of Massachusetts facilities. However, as the program developed, our offerings were made on a regional basis in cooperation with the American Nursing Home Association, involving the six New England States.

As I have already stated, we designed the educational program to have the participants approach their studies through workshops and seminars. While the focus is on the administrator's role in the nursing home, we do know that the way in which a nursing home organization functions has a direct impact on the care of the patients.

I thought it would make my statement more meaningful if I appended a reprint of a report of our first year's activity, authorized by my colleague, Dr.

Reuben J. Margolin, and myself, which originally appeared in the September 1961 issue of Nursing Homes, the publication of the American Nursing Home Association. I also thought it might be helpful to you if I made available the program of the workshop in nursing home administration which was held this week, November 27 through 30, at the University's conference center, Henderson House.

I would like to take this opportunity to express our appreciation for the cooperation we have received from the Special Committee on Aging of the U.S. Senate in furnishing us materials, especially for the workshops.

Finally, I wish to inform the committee that indicative of the seriousness with which these administrators approach their desire for continuing education, the Massachusetts Federation of Nursing Homes, at our request, gave us a modest grant of $500, though of great significance in its intent, to evaluate the seminars. The study has just been completed and will be published soon, and I shall be pleased to furnish copies of the findings as soon as they are available. It is our desire to test and evaluate at all times our offerings, in order that we may fulfill most effectivley our responsibilty in the educational program we are developing for the administrator of the nursing home. The continuing educational opportunities for nursing home administrators should be encouraged. One of the best ways, I submit, is by aiding and supporting the educational institutions, making available educational opportunities for nursing home administrators.

[Reprinted from Nursing Homes, September 1961 issue]

A University Report on Administrator Program by Francis L. Hurwitz,[1] B.B.A., LL.B. and Reuben J. Margolin,[1] Ed. D.

Northeastern University has been engaged, through its department of special programs of the center for continuing education, in developing a training program for nursing home administrators since the late summer of 1960. It is the first institution of higher learning to engage in such a pioneering venture. This, of course, makes for the excitation that comes from frontiersmanship; and which simultaneously engenders the sense of grave responsibility whenever the educator dares to venture forth into uncharted territory.

The initial request for a training program came from a courageous nursing home administrator who had been attending, along with three other nursing home administrators, workshop for nurses at a local hospital just south of Boston, Mass. The four administrators felt that similar training programs specifically geared toward the problems of the nursing home would be of great value. Shortly after Labor Day, 1960, the Education Committee of the Massachusetts Federation of Nursing Homes met with Northeastern University's Department of Special Programs. During several meetings in September there was an intensive exploration of needs as seen on three levels: those of the administrators, those of the nursing homes, and those of the community; together with the setting of objectives to be gained. The approach was one of programing in adult education.

WHAT IS ADULT EDUCATION?

What then should be our conception of adult education? Our society is dominated by a tremendous amount of change. The important fact, however, is the rapid acceleration of change. For the first time in the long history of man the knowledge and personal equipment we acquired in youth will not function adequately in our mature years. Until this present older generation, an individual could live his entire life and be able to have the formal education of his youth still valid and serve him. The only change needed was that of youthhood. The time span of social revolution now is a generation; whereas, formerly, several generations were required. We are the first generation doomed to obsolescence unless we accept and adapt to change throughout life. From the professions and industry comes loudly the cry "study or perish."

Adults demand education that serves their recognized needs. They desire a learning experience that helps them solve their immediate life's problems. Since they are in a position to demand suitable learning experience, adults usually insist on the following conditions: Adults desire to set their own prognoses, and so want to take out of each learning situation that knowledge and those skills and attitudes which fit their recognized needs. To the extent to which

[1] Director, special programs, Northeastern University, Boston; and associate professor of social science, Department of Special Programs.

adults have the opportunity to share in defining their problems, is the degree to which they are freemen, and the direct relationship will be behavioral change. Adults want educational experience that will help them master life, not merely subject matter. They want to draw upon organized knowledge as a resource that gives more meaning to their experience. Adults want their learning to be useful in the immediate or foreseeable future. Adults want to be actively involved in the learning process. Finally, adults demand competent leaders who have a thorough knowledge of a special field and the ability to relate that field to the purposes of the learner.

ADULT BRINGS LEARNING

The adult brings to learning situations a tremendous range of stored learnings. The teacher should capitalize on the possibilities of transfer from the stored knowledge and skills of the adult. Some are negative attitudes, including the memories of childhood which make the adult learner bring to the school old feelings of insecurity. So the adult educator has the responsibility of trying to give the learner a sense of security and mastery without any feeling of shame or inadequacy.

There should be the understanding, by the adult educator, of differences in environment, culturally and technologically; the differences in behavior patterns because of subgroup affiliations. Further, an awareness that adults by their education and their experiences, may have ideas, tendencies, attitudes, and interests which interfere with their modification of older learnings and acquisition of new adjustments.

Our explorations with the education committee were carried out in the light of these basic principles of adult education. We saw that the nursing home was occupying a position of ever-increasing importance in our medical and social communities. The rapid growth of the nursing home requires a careful analysis of its current status and the formulation of effective management methods. Therefore, we felt that we should focus on the administrator's role, and not patient care. However, it is important to recognize that the efficient administrator does affect patient care, and not just peripherally.

As the initial project in our training program, we undertook to conduct a residential workshop in nursing home administration in cooperation with the Massachusetts Federation of Nursing Homes. We had two basic objectives: (1) Analytical discussion of the community image of the nursing home, with recommended procedures for future action; and (2) the development of sound management policies and practices for effective care of patients and for profitable operation. The workshop was designed to serve the needs of top-level administrative personnel responsible for policy and operation; primarily, the owner-manager.

WORKSHOP HELD

The workshop was held at the Andover Inn, on the campus of Phillips Andover Academy, Andover, Mass., from Monday evening, November 28, through Thursday afternoon, December 1, 1960, and involved 31 nursing home administrators. Concentration on the initial sessions through Tuesday night was on management principles in the organizational setting, with a concern for recruitment, training, and supervision of personnel. There was then a consideration of the interaction and behavior patterns in a social system; the relationship of staff to outsiders; and how patient care is affected. The nursing home was then related to the general community as well as to the medical community and how the community could be improved.

We endeavored to involve maximally the participants, and we did this by maximizing the opportunity for audience participation. Each participant was given a take-home notebook which included prepared outlines of all staff presentations, supplementary selected materials, bibliographies, and relevant articles. The staff numbered 11, involving, in addition to the writers, 5 members of the Northeastern faculty, as well as the director of hospital facilities, Massachusetts Department of Public Health,[2] superintendent, Boston City Hospital,[3] the director, Medical Care Studies Unit, Beth Israel Hospital, Boston,[4] and the executive director, Massachusetts Federation of Nursing Homes.[5]

[2] Dr. A. Daniel Rubenstein.
[3] Dr. John F. Conlin.
[4] Mr. Jerry Solon.
[5] Edward F. Connelly, Esq.

Through daily evaluation followed up with a postworkshop evaluation, we learned that additional training was desired. Also, we obtained clues for a more effective design for subsequent workshops.

Immediately following the workshop two steps were taken. We met with the director of hospital facilities, Massachusetts Department of Public Health, to explore the broad areas and the limitations of our training program from the perspective of the department of public health. Since the initial venture last November, we felt it important to consult constantly with the director of hospital facilities in all of our planning and programing.

ANOTHER MEETING

After this meeting we met again with the education committee of the federation and went through the same process of exploring how we might best further the continuing education of the nursing home administrators. From these deliberations it was determined to go into depth in some of the areas explored at the Andover workshop namely, administration and interpersonal relations. We also discussed with the education committee a more comprehensive evaluation of the seminars. On our proposal the Massachusetts Federation of Nursing Homes made a grant to the university in the amount of $500 for the evaluation of the seminars. A modest sum, but it was important as an expression of purpose. A competent social scientist from Boston Univerity was engaged to conduct the evaluation. The purpose, as we saw it was twofold: to determine the impact of the seminars upon those nursing home administrators who enrolled, and secondly to obtain some idea of the administrator's self-image of an ideal nursing home administrator's role. A report on this evaluation will be the subject of another paper.

The design of the seminars contemplated a maximum of 25 participants, to run 3 hours each session for a period of 10 weeks, beginning March 15, 1961. While the offering was in cooperation with the Massachusetts Federation of Nursing Homes, at the request of the director of hospital facilities, the seminars were opened to administrators of nursing homes not affiliated with the federation. The response was phenomenal. We were required to hold second sections of each seminar on the following day, permitting 27 in each of the seminars in administration, and admitting 26 to the seminars in interpersonal relations.

Some 85 percent of those who participated enrolled for the two seminars. In each instance those who took a single seminar did so solely because of time pressure. Almost one-third were unaffiliated with the federation. However, a number of these have since become members of the federation. Almost all of the administrators were from nursing homes located in the eastern part of the State. Because a number of administrators were unable to attend the seminars, due to lack of space, the request was made of us to undertake a program in the western part of the State, especially for nursing homes there. In our meetings with the education committee, our recommendations for a residential experience as the initiating experience was accepted. The design developed contained modification of the Andover experience, principally on the basis of the postworkshop valuation by those participants. For the second workshop in nursing home administration, the Lord Jeffrey Inn on the campus of Amherst College in Amherst, Mass., was selected. The workshop was held June 5 through 8, 1961, with 21 in attendance.

SOME MODIFICATIONS

The Amherst workshop design had these modifications. Sessions were held in the mornings and afternoons. In the evenings the workshop population was divided into two small discussion groups, each led by one of the authors. Though intended for the exploration of pertinent problems revealed in the day's presentations, the participants had the opportunity to build their own agenda. We found this modification a valuable contribution to the learning experience of the participants.

A new area was included: that of financial control and budgeting. And in addition to community relations, the areas covered included organization and administration, interpersonal and human relations, as well as the relation of the nursing home to the medical community. At some of the sessions we used the devices of the reaction panel and the buzz groups. At the conclusion of the evening small group session, the participants were given evaluation sheets to fill out. Again, the participants were given a take-home notebook with

materials covering the various sessions, and reading and bibliographical materials as well.

In the week following the workshop the participants received a postworkshop evaluation sheet. Returns have already been received. We have valuable suggestions for further redesigning of the future workshops which should enhance the learnings of participants. Two things especially were noted, we shall have to add a day to any future workshop, and there is an almost unanimous desire to have further training opportunities, especially seminars, such as were offered this past spring.

An innovation at the Amherst workshop was having the members of the instructional staff join the group for dinner the evening before their appearance and sit in on the evening small group sessions. There was mutual benefit through this procedure; the staff persons were able to know the group better; the participants found they could relate better to these leaders. We shall continue this practice in future workshops. Also, we were the beneficiaries of the presence of the health education consultant, nursing home services section, Division of Chronic Diseases, Public Health Service, Department of Health, Education, and Welfare,[6] who came on from Washington to observe the workshop.

In the evaluation of both the seminars and the workshops, there was unanimous agreement that further training opportunities were needed. Advanced seminars will be offered to those who have completed the basic seminars. Four areas were selected including mental health of the aged, rehabilitation in a nursing home setting, financial operations, and social gerontology. It is interesting to note in regards to the first two areas that the Chief, Division of Chronic Diseases, Public Health Service, Department of Health, Education, and Welfare,[7] in his address at the Massachusetts federation's 12th annual convention, urged his audience to be concerned with mental health and rehabilitation as they are extremely important to the welfare of their patients. In regards to the offering in social gerontology we envisage an interdisciplinary staff to possibly include a psychiatrist, a physician, a social worker, a nurse, a psychologist, a sociologist, and an anthropologist.

DEFINITE INTEREST SHOWN

We thus find definite expressions of interest by nursing home administrators for their continuing education. We contemplate undertaking during the coming academic year, in the fall, the two basic seminars in organization and administration and in interpersonal relations; and two advanced seminars in finance and mental health plus a third workshop. In the spring of 1962 we would again conduct the basic seminars. The advanced seminars would be in rehabilitation and social gerontology.

During these months of program development, the education committee of the federation also explored with us the possibility of developing a professional certification program for nursing home administrators. We see this as reflecting a commendable desire to upgrade the professional status as well as the training background and qualifications of administrators. This is no longer the dream of a few visionaries. It is a reflection of a constantly growing number of owners and administrators who have taken considerable time out to participate in the training offerings at Northeastern, some 100 since the program started less than 7 months ago. More than half of this number have attended both a workshop and the seminars.

As to our goals for the future we see our operation on three levels. (1) Further development of our current training program, through residential workshops and weekly seminars. (2) A special gerontology program involving an interdisciplinary staff of 5 or 6, working with a small number of nursing home administrators, preferably no more than 20, who may have to be specially chosen, at least for the initial undertaking. Our explorations in social gerontology we consider as vitally significant because it will provide us, we hope, with the theoretical underpinning necessary to the practitioner's operations. (3) Investigation of a professional certification program. In order to develop a meaningful certification program, we intend to invite outstanding leaders from the fields of medicine, geriatrics, nursing homes, human relations, executive development, and rehabilitation to sit down and explore with us the basic essentials necessary for a nursing home administrator to be considered properly trained and qualified.

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[6] Miss Alice Frazer.
[7] Dr. Leslie W. Knott

EXPERIMENTATION NEEDED

To realize our goals means breaking into new frontiers of training, considerable experimentation will be involved; responsible evaluation will be required. Nevertheless we are challenged by the nursing home administrator's desire to become efficient and professional in his role, mindful of his responsibility of effective leadership both within his instituton and in the community. Such training, we believe, will have direct effect on the welfare of the patient in the nursing home. We already have evidence of this from the administrators who have participated in our training programs.

We feel constrained to add that for the fullest development of our program considerable funds will be necessary. We trust that we shall be able to obtain funds from the Department of Health, Education, and Welfare; from the American Nursing Home Association; and from foundations interested in the welfare of our senior citizens, in order to validate and enhance Northeastern's continuing education program for nursing home administrators.

The future looks optimistic. A trained nursing home administrator with the ability to initiate programs soundly based in human relations and good patient care will be performing a valuable community service; and incidentally help to dispel the current negative community image. He can join with dignity and on an equal status level the ever widening circle of acceptable administrators in the medical profession.

WORKSHOP IN NURSING HOME ADMINISTRATION

Conducted by Northeastern University in cooperation with Region I, American Nursing Home Association, Henderson House, Weston, Mass., November 27–30, 1961

PURPOSE

The nursing home is occupying a position of increasing importance in our medical and social communities. Its rapid growth demands of the administrator knowledge and understanding of its current status and comprehension of sound and effective management methods. The workshop is designed to serve the needs of top-level administrative personnel responsible for policy and operation, with two basic objectives:

(1) The development of sound management policies and practices for profitable operation;

(2) an analytical discussion of the community image of the nursing home—with recommended procedures for future actions.

FACULTY

An outstanding faculty, each a specialist in his respective area:

Dean Albert E. Everett, Center for Continuing Education, Northeastern University

Prof. Francis L. Hurwitz, director of special programs, Northeastern University

Mr. William D. Brohn, Department of Drama, Speech, and Music, Northeastern University

Prof. Stephen G. Burke, Bureau of Business and Industrial Training, Northeastern University

Prof. Herman V. LaMark, director, Bureau of Business and Industrial Training, Northeastern University

Dr. Reuben J. Margolin, associate professor of social science, Department of Special Programs, Northeastern University

Mr. Theodore H. Needle, instructor in accounting, Northeastern University; partner, Penn and Needle, CPA's Boston

Dr. A. Daniel Rubenstein, M.D., director, Division of Hospital Facilities, Massachusetts Department of Public Health

Mr. Jerry Solon, director, Medical Care Studies Unit, Beth Israel Hospital, Boston

Prof. Robert L. Wells, Fine Arts Department, Northeastern University

PROGRAM

Monday, November 27, 1961:
4 p.m.: Registration
6–7:30 p.m.: Dinner
7:30–8 p.m.: Greetings and overview. Dean Albert E. Everett, Northeastern University; Mr. Theodore E. Hawkins, vice president, region I, American Nursing Home Association; Prof. Francis L. Hurwitz, Northeastern University.
8 p.m.: Problem census.

Tuesday, November 28, 1961:
7:30 a.m.: Breakfast.
9 a.m.: "Managing a Nursing Home." Organization for Effective Operation—Planning as a Basis for Action—How To Manage Your Organization—Elements of Control—Job Analysis and Evaluation. Reaction panel and audience participation.
12–1 p.m.: Lunch.
1:30 p.m.: "Getting Things Done Through People." Recruitment and Selection—Indoctrination for Orientation—Induction for Job Knowledge—Training for Improved Skills—Supervision for Effective Performance—Climate To Develop Morale—Nurture for Continued Growth. Reaction panel and audience participation.
6–7:30 p.m.: Dinner.
7:45 p.m.: Small group session. An opportunity to explore in the small group setting through discussion pertinent problems revealed in the day's presentations.

Wednesday, November 29, 1961:
7:30 a.m.: Breakfast.
9 a.m.: "Financial Control and Budgeting." Profitable Nursing Home Management and Operation—Cost Control—Record Keeping—Tax Planning. Reaction panel and audience participation.
12–1 p.m.: Lunch.
1:30 p.m.: "Social and Psychological Forces Confronting Nursing Home Administrators." Significance of various interpersonal patterns among staff and between staff and visitors—Leadership role of Administrator in these relationships. Reaction panel and audience participation.
6–7:30 p.m.: Dinner.
7:45 p.m.: An evening of entertainment.

Thursday, November 30, 1961:
7:30 a.m.: Breakfast.
9 a.m.: "Improving the Image of the Nursing Home in the Community." Misconceptions of Nursing Homes—Competitive Aspects of Nursing Homes—Community Relations—Public Relations.
11:20 a.m.: Small group session.
12:30 p.m.: Lunch. Address: "The Relation of the Nursing Home to the Medical Community." Discussants, summary remarks, presentation of certificates.

Senator SMITH. This committee is extremely interested in hearing especially from the elderly people today at this afternoon forum, so we would be glad to hear from them. I think we covered pretty well the problems of the nursing home this morning and we would like to hear from you people this afternoon.

STATEMENT OF MARY KELLEY, BROOKLINE GOLDEN AGE CLUB, BROOKLINE, MASS.

Mrs. KELLEY. My name is Mary Kelley and I am from the Brookline Golden Age Club. Sometime ago about a hundred Golden Agers met at a meeting and formed six different study groups, and out of that came 25 important things that these Golden Age people would like.

First, more service needed to be taken to those older people who are not able to travel to existing facilities such as hospital out-patient departments. I know of a case where two people have to help one person to get down the stairs and over to the Peter Bent Brigham Hospital and has to go in a taxi each time. That person is on old age, too.

Then study should be made for the needs of homemaking service. Senior citizens who are able to perform homemaking services might supplement their income and be of service to others, senior citizens who are willing and anxious to perform volunteer service and community progress. However, material and transportation should be provided by the agencies involved. They need the transportation because old people like us, we cannot stand on the street and wait for buses to take us there. People have to change probably once or twice to get there. Transportation for elderly volunteers and of older people to and from the recreational, educational and health facilities is the problem that should be studied. Some suggested solutions include volunteer drivers or taxi pools.

Local nursing homes should receive more inspections and closer supervision from the State Department of Public Health. I know they probably claim they have taken care of us all right but what about the mental health there?

There should be greater flexibility in compulsory retirement ages with more individual evaluation after 60.

Social security payments should be more flexible and tied in with the cost of living.

I think that that is all I have to say. Thank you.

STATEMENT OF CHARLES J. FLYNN, BOSTON, MASS.

Mr. FLYNN. My name is Charles J. Flynn. I am a World War I veteran and also a member of the VFW. My remarks are concerning the disability provisions of the Social Security Act. I notice that the finding of disability introduced into the Congress by the administration was defeated. I also note that in the final vote of the Senate you abstained from voting. The provisions of the Social Security Act provide that disability must be of long standing or resulting death, also that a person must be so disabled as to prevent him from following a substantially gainful activity—they use the word activity.

The regulations are very drastic. I have legal opinion that they are not in accord with the provisions of the Social Security Act. The prior session of the Congress, subcommittee of the House Ways and Means Committee, studied the disability situation but failed to establish any criteria. The courts have been more liberal. I hope you will favor a legislation which will establish a criteria in accordance with the Social Security Act. Thank you.

Senator SMITH. Thank you very much.

STATEMENT OF WILLIAM H. McMASTERS, NATIONAL OLD AGE PENSIONS, INC., CAMBRIDGE, MASS.

Mr. MCMASTERS. My name is William H. McMasters and I am the president of the National Old Age Pensions, Inc., and have been so for about 25 years.

Mr. Chairman and gentlemen of the committee, first I wish to thank the committee for allowing me a few minutes to speak in behalf of the aged of my State whose economic condition compels them to be confined in a nursing home at public expense. I am sure that the committee will agree with me that living in a nursing home at public expense, no matter how well the home is conducted, is not the best approach to the "life, liberty, and pursuit of happiness" that the founders of the Republic assured us are the God-given, unalienable rights of all men.

Practically every resident in these homes is in what we refer to as the middle or lower income bracket. Those living in the homes at public expense are in the lowest income group. In order, therefore, to find the right answer to the problem of nursing homes, that I understand to be the reason for this hearing, it should be the first objective of the committee to learn whether the amounts paid for public patients in the various homes engaged in this highly specialized activity, is sufficient to make things mentally and physically adequate for these special guests. I do not use the word "inmates" because it savors too much of penal or mental institutions.

In this very practical age, I can only suggest that the answer to your problem is "more money per guest," just the way that hotels, motels, and even highly endowed colleges meet their mounting operation costs, if they expect to stay in business. It is important that you make every effort to see that any inadequacy of public help is not passed on to other guests who pay their own expenses or have them paid for them by relatives. Regulations and constant inspections will not solve your problem, but merely increase the difficulties of the solution. What these homes need is more dough, and I don't mean in their apple pies.

In the few minutes remaining to me, I will endeavor to demonstrate my theorem, and one good way to do that is by using the analogy of our national public administration.

On Wednesday, February 8, 1939, nearly 23 years ago, I was the first witness called by Chairman Doughton of the House Ways and Means Committee on bill H.R. 2, introduced on behalf of Dr. Townsend. It was in the largest hearing room at the Capitol and the room was filled to capacity, with hundreds unable to gain admittance. Dr. Townsend had told me, the day before, that I would not be allowed to speak on his bill. That wasn't the only thing the good doctor didn't know about our national Congress. He evidently didn't know that John W. McCormack was on the committee. Not only was I the first witness but I was the only witness for the opening session, due to the fact that every member of the 25-member committee wanted to get something into the record. I can assure the committee that I did not once invoke the fifth amendment during my 2½ hours of testimony.

At that time we had a national debt limit set by the Congress at $55 billion. A member of the committee who may have thought my proposals, if put into effect, might wreck the country, asked me how far I thought the country could go further into debt and be safe. I told him I wasn't the least worried about the financial solvency of the Republic. What concerned me was its moral solvency and that was why I was speaking for a national pension.

Since then, Congress has increased the debt limit, step by step, until it is now $300 billion. We should modernize the process and put it on

an escalator and let it ride into outer space. We now are far beyond the legal debt limit set by the Congress, but fancy bookkeeping and IBM machines take care of it. It is sure to jump again before any of you gentlemen run for reelection.

My point is that the only practical answer to every governmental problem is more money. I assume, of course, that it will be expended judiciously and not wasted. But you have congressional committees to look into that phase, so we can forget it. As for today's hearing, I contend that if more money is spent on the aged, whether inside or outside nursing homes, that money is well spent. The more we spend on the aged, the less they will need nursing home care. Far too many of the elderly who are now confined in nursing homes are there because of ill health brought on by financial worries and lack of proper medical attention. With psychiatric visits running as high as $25 a shot, these people are not likely to spend much time on a couch, only to be told that all of their worries are in their imaginations. With sufficient income, scores of thousands of present-day patients in nursing homes throughout the country would be living in health and dignified security outside these homes. I trust that I have left the thought with the committee that the overall answer to your problem is a national pension, based on what is necessary in order to live in comfort, as befits every good American citizen on reaching the age at which he, alone, feels that he should retire.

I do not concur with the widely held idea of compulsory retirement at any arbitrary age. Some men are practically senile at 40. Others are young at 90. Your former tennis-playing colleague, the distinguished Senator from Rhode Island, is a good example. The wealthiest man in Massachusetts has an active and vigorous mind at 100. Years ago, I told him he was sure to reach par. He doesn't even worry over his income tax. You can imagine what would happen if Congress passed a law forcing him to retire because he was over the century mark. Compulsion of any kind is abhorrent to every American. It is not consistent with a freedom-loving people. A national pension might do more for our world prestige than a hundred Geneva conferences. Thank you.

Senator SMITH. Thank you, Mr. McMasters.

STATEMENT OF HAROLD L. NILES, PRESIDENT, COMMONWEALTH HOUSING FOUNDATION, BOSTON, MASS.

Mr. NILES. Gentlemen, my name is Harold L. Niles, real estate. I am now interested in developing more housing for the elderly in Roxbury. We have completed a project like that with private charitable funds and it is completely occupied by elderly colored people.

For the sake of time, I would be perfectly willing to leave this to be recorded.

Senator SMITH. Thank you very much, Mr. Niles. Your statement will be made part of the record.

(The prepared statement of Mr. Niles follows):

PREPARED STATEMENT OF HAROLD L. NILES

My name is Harold L. Niles and I am a realtor. I am president of the board of trustees of the Commonwealth Housing Foundation, a member of the board of directors of Senior Living, Inc., and director of many private and charitable organizations. The Commonwealth Housing Foundation is the sponsoring

agent of the Ada Hinton Apartments, 85 Dale Street, Roxbury, a nonprofit, nonsectarian, nonracial, nonpublic project to house elderly of limited income. A grant from the Home for Aged Colored Women through the Commonwealth Housing Foundation made it possible to make 24 apartments of 1½ to 2½ rooms available to senior citizens of low income. The apartments were named for the late Ada Hinton, widow of Dr. William Hinton, Harvard professor and creator of the famed Hinton tests, who was long active as a board member of the Home for Aged Colored Women.

I would like to stress the importance of the role of nonprofit charitable agencies desiring to construct housing for the elderly. Unless the authorizing agencies within the States are lenient in granting characters to such organizations to carry out this purpose, there will be considerable delay in securing the tax status and necessary funds from donors to construct such low-rent housing and this will work a hardship on the elderly of low income. These nonprofit charitable organizations have a great impact in assisting minority families at the lowest rung of the economic ladder and who are in need of this type of housing as well as public housing.

May I quote the administrator of the Ada Hinton Apartments, Frank W. Morris, who is also a trustee of the Commonwealth Housing Foundation. According to Mr. Morris the development has operated successfully for 1 year at rents ranging from $50 to $65 per month including heat, hot water, and cooking, janitor and elevator service. The cost of electricity is borne by the tenant. This development has been commended by Commissioner Weaver and many local planning and rehabilitation experts. It is the single example of private rehabilitation at this time in the Washington Park Renewal Area.

It is my recommendation that the establishment of private, nonprofit charitable corporations, to deal specifically with the problem of housing for elderly of low income, will go far toward easing the economic and social problems of our senior citizens. There is a need for public and private housing of this nature.

STATEMENT OF DR. EDWARD L. YOUNG, BROOKLINE, MASS., VICE CHAIRMAN, PHYSICIANS FORUM, NEW YORK, N.Y.

Dr. YOUNG. Mr. Chairman, I am Dr. Edward L. Young, a practicing surgeon of Brookline and vicinity and also one of the officials of the national organization headed in New York which is attempting to improve medical care.

I particularly want to speak in relation to the attempts that I have made over the years to get patients into nursing homes, my studies of the nursing homes, and what I think could be done to improve the situation. I did not know of this until too late to prepare a statement. I would be glad to send it in later if you wish.

First, I think the nursing homes should all be rated in regard to what they can give to patients in regard to health, nursing care, medical care, and rehabilitation. That is not done at the present time; we have to choose too blindly unless we have previous knowledge of the nursing home.

I think, too, because a large number of the inmates of these homes are on old-age assistance or some form of charitable help, that there should be a rating of those homes in regard to this, particularly because in a certain number of them, as you know, the patients are so close they have hardly room to breathe. There are other homes where there is an attempt to do a good job, make less profit, but are paid the same sum. I think there should be a rating for that.

I think the most important part of the whole subject of nursing homes is the fact that we have to have established sooner or later nursing homes for nonprofit. That is one of the most important things, I believe, that is necessary and must come.

A great help to us also would be to establish the ownership of these homes just as the ownership of periodicals has to be by law and just as hospitals have to put down their costs and make that public, so I think nursing homes should have the same obligation to do the same thing. There are good nursing homes but I think the vast majority of nursing homes with which I have come in contact in this State—I will not say the State because it is only around Boston that I have had personal contact—are not nursing homes that I would want to live in and many of them are not nursing homes that I would even send a patient to even if they cannot pay for a good nursing home. Thank you very much.

(The prepared statement of Dr. Young follows:)

PREPARED STATEMENT OF DR. EDWARD L. YOUNG

I am Dr. Edward L. Young, a physician practicing in the Boston area, who often has occasion to put patients in nursing homes. I want to report on the difficulties that I have met, and I think all my colleagues meet, in finding a suitable home. I also wish to make suggestions for changes that will help.

I also represent the Physicians Forum, a national organization of physicians whose objective is the improvement of medical care.

The advances in medical knowledge have made it possible for more of our citizens to reach 65, and on the other hand, the economic changes have made it much more difficult for these old people to be cared for at home. If an individual has plenty of money, and most of them do not, the difficulties can be overcome relatively easily. I am concerned about, and speaking here of those with limited income, particularly of those whose expenses are paid for in whole or in part by public funds.

It is difficult to know the important facts that we wish to know about a nursing home in order to place the patient where he or she can be best cared for. The following facts should be matters of public record:

(1) How many patients are accommodated in what size homes.

(2) See that there is nursing supervision all of the time by a registered or practical nurse.

(3) How easily are medical facilities obtained when necessary.

(4) Is there a good liaison with the physician who referred the patient or the institution from which that patient came.

(5) What, if any, means of rehabilitation are there for those cases where it is indicated.

If these things were a matter of public record it would help very much in placing a patient.

Of those nursing homes that do accept patients being paid for by public funds there are certain ones, the percentage of which I do not know, but I think very large, where there is no attempt to do anything for the patient. They are crowded in as closely as possible and where actually there is nothing for them to do but sit and wait to die. These are a disgrace and there should be some way in which they could be eliminated or at least their actions publicized. There are other nursing homes where there is an honest attempt to help the patient. Both of these types of homes are paid the same sum by public funds. I think there should be some way in which a differential in payment could be made. As a taxpayer I hate to see my money go in part to the first type of nursing home.

I believe there should be a public record of the ownership of nursing homes. They are almost all proprietary and exist for the purpose of making money for the owners, and where they are as much of a disgrace as many of them certainly are I think we should know where to put the blame in every instance.

The cost of the nursing home should be a matter of public record. I mean by that, the statement of expenses involved in running the home, so that anyone who wished could compare it with the cost to the patient.

But, above all things what is most needed is the establishment of nonprofit nursing homes, either connected with hospitals and run by the same board of trustees or developed in the same way and run by competent oversight. Until we get these I believe that we will always have the problem of poor nursing

homes and because they are becoming more and more necessary I believe that sooner or later, nonprofit homes will have to be established and, if eventually why not now.

Senator SMITH. Thank you.

STATEMENT OF LOIS TOWNSEND, SUPERVISOR, SAVIN STREET UNIT, BOSTON HEALTH DEPARTMENT, BOSTON, MASS.

Miss TOWNSEND. I am Lois Townsend, supervisor from the Boston City Hospital in the Savin Street area. We are concerned with the quality of the nursing homes and the quality of any service that is for the benefit of our citizens. We are handicapped by the lack of personnel and by the lack of those who are specifically trained in this particular field. We are doing our very best to study these conditions, we are doing our very best to remedy some of the conditions that the doctor speaks about. We do know that they exist but it is not because we are not aware of it and it is not because we are not willing to work and not willing to try. My nurses have a great field which they must cover and this is a generalized program.

To get down to practical facts in this matter, it is almost impossible for us to make an inspection of nursing homes any more often than once a year, and usually it is once every 2 years at the time that the license is up for renewal. We do make investigations on complaint of anything going wrong but again we say that we realize this is not adequate and that we do need more personnel if we are to do our part of it. We are glad to go on record as being interested in the quality of the care that these people are getting within the nursing homes. Thank you very much.

Senator SMITH. Thank you very much, Miss Townsend.

At this time I would like to call on Mr. Paul G. O'Friel who is a member of the Massachusetts Council for the Aging. We had requested his presence here this morning and he was unable to be here. He has just recently served as moderator at Boston College on "The Problems of the Mature Worker."

STATEMENT OF PAUL G. O'FRIEL, MEMBER, MASSACHUSETTS COUNCIL FOR THE AGING

Mr. O'FRIEL. Thank you, Senator Smith.

Discrimination against older workers is becoming an ever more serious problem in our economy today. Many thousands of business firms have either written or unwritten policies against hiring older workers. In some cases the age limit is set as high as 55 but in others it is far below that.

A few years ago the U.S. Bureau of Employment Security made a survey of job openings in seven labor markets across the country. Forty-one percent of these jobs had age barriers set at 45. For 25 percent of them these jobs actually were down as low as 35. In Massachusetts there is a law on the books that prohibits discrimination in employment because of age but that is not easy to enforce.

The major accomplishment to date has been the elimination of age specifications in help wanted ads and employments. There is no doubt that a worker over 40 still has a big strike on him when he goes to look

for a new job. Some jobs do require great physical stamina and these cannot be filled by older workmen, but mechanization has continually tripled the volume of this type of work.

Unfortunately, there remains a tendency toward the Charles Atlas type man for jobs that can be adequately filled by mature but less muscular men. It is doubtful how long we can afford this without serious economic trouble. According to the U.S. Labor Department, America's labor market will increase by 13½ million persons between 1960 and 1970. During the decade 16 million people now working will be lost due to death, retirement, and other causes. Entering the job field will be an estimated 29 million new workers, 26 million of whom have had no previous experience. Because of the low birth rate of the 1930's there is going to be an actual decrease in the number of workers in the prime age bracket 35 to 44.

Now, what we are going to have to do then is have an uneven spread of our workers. There will be a large group of untrained workers at the bottom and roughly 40 percent of the work force will be in the upper age bracket, 45 and over. All these figures add up double to that. We will have to stop our present practice of age discrimination in employment.

The most tragic part of this shortage is that it will be strictly artificial. The job future of our growing number of older workers is important to the economy in another way, too. If these people have jobs and continue to draw paychecks, they will remain consumers of our national product, steady users of our services. If they cannot find work, they will become dependent upon savings, the earnings of their children, and very likely on public welfare funds. Even today there are a large number of older workers among the hard core of unemployed who live on general relief funds. All they can look forward to at age 65 is moving on to old-age assistance. Instead of contributing to the economy, these older workers without jobs reluctantly become drains upon it.

The U.S. Department of Labor, the National Association of Manufacturers, and some labor groups have done important research in the field. This shows that hiring qualified older workers for many jobs is a sound and profitable management policy. This fact must be stressed over and over again.

We have been doing this in our current editorial, highlight it more in some of the programing that we plan. The reaction to this has been tremendous. Just this morning this came across my desk, which is typical of the letters that we have received:

Regarding your program on the senior citizen which we heard last week, since that time this senior citizen has made application for employment at more than 20 establishments advertising for help in various newspapers. I am 60 years of age and in good physical condition with fair education and good character, sober and industrious, with the responsibility of a wife. I am a veteran of World War I, discharged honorably as a sergeant major. I have never applied to anybody for aid in my life. I have always been self-confident and self-reliant, but I am becoming so frustrated, always being shunted away with "We will call you" that I am almost desperate.

So, sir, I am making this appeal to you to see if you can find or help me find a job, a job of any kind that will help me keep my small home together. If you will grant me the time out of what must be a busy schedule to grant me an interview, I am sure I would be able to show you the undeniable fact that age is the only thing keeping me from securing employment.

My undying thanks and prayers for any courtesy you may be able to extend.

Now I recently was moderator and took part in the Conference on the Problems of the Older Worker which was sponsored by the Massachusetts Department of Labor at Boston College. There experts in various fields were able to point out to employers the facts and figures about older workers' costs and productivity. I know I found that session most informative and I think others like it should be held on a regional basis across the country.

The State law banning discrimination and hiring because of age is sound, and I feel efforts should be made to enforce it even more stringently. Perhaps there is a need for national legislation along the same line for those who are put out of work by collapse of a particular company or some other industrial change. There should be better facilities for retraining, job counseling, and placement. This, I think, is a joint responsibility of Government, labor, and management.

We in America are proud of our standard of living, the fact the average life expectancy has climbed to an all-time high of 70 years, but these extra years of life can mean nothing but prolonged tragedy if we do not allow people to work and remain active.

Senator SMITH. Thank you, Mr. O'Friel.

STATEMENT OF MABEL STEVENS, BOSTON, MASS.

Mrs. STEVENS. I have one or two problems that perhaps you men might be able to help on with regard to the older people. I am Mabel Stevens. I live at 9 Alexander Street, Dorchester. I am going to be 77 in January. I have worked very, very hard all my life.

Now, the point is, that I went down to the social security office because some of my friends were getting much more money than I was getting. They sat down and were very nice to me and went into it very deeply and showed me that when they made up the income of my husband they took the lean years and the fat years—this was before 1952—and then they rated what I was to get on this by the lean and the fat.

Now since 1952, if I understand rightly, they take only the good years; the lean years are thrown out. Now that does not give me the benefit of the work that I have done, see. I went in at the beginning of 1937 when it went in and I worked very much. I really worked until I was going on 69 so that I should have much more money.

I would like to ask the committee if you have anything to do with that, change that law, that the people who went into it in 1937, we had to wait a long time to get it and we had to work up to it. See that we get it and get as much as the people that come in and just need so many quarters and then they get much more money than we get.

Now could I ask one more question, please? Thank you.

We have not too many projects in Dorchester. Now we have one going up and it only contains 62 units and it has 1,200 applicants if I am right. Mr. McCormick was there when the post office was dedicated and he would do something for that party, not me, if he could but he could not do it. They have enough applicants right now.

There is another one out near Peabody Street, out in that direction. Now whether that is a little larger, whether it is the same, I do not know. Now we have one on the boulevard, City Point, corner of H and 8th Streets. I understand that there is a lot of quarreling, pros

and cons and whys and wherefores, and that will be 900 units, so I understand. There are many of the landlords around there who are opposing it and there may be many more reasons why, because we will take some of the people from the houses that live in these homes around there and anywhere in Dorchester. So if it is possible for anybody in this room to find out what is holding up that project there and to see if it cannot be built as soon as possible.

That is all I have to say. Thank you very much.

Senator SMITH. Thank you very much, Mrs. Stevens.

Your remarks about everyone being treated equally under the social security program, I think this certainly should be reviewed and I certainly recommend that.

STATEMENT OF HYMAN COHEN, PRESIDENT, GOLDEN AGE CLUB, GREATER BOSTON COUNCIL

Mr. COHEN. My name is Hyman Cohen and I am the President of Greater Boston Jewish Centers comprising 17 groups of about 2,500 members. I am also a member of the Jewish Community Center of the City of Quincy.

I was here at the morning session and I heard the speakers, all their griefs and reference to the nursing homes. Each one expressed that the nursing homes can be a lot improved provided they get financial aid. Some of them expressed the opinion that if financial aid would be from the Federal Government it would be limited, if the Social Security Act would be amended as recommended by our President. Others expressed the opinion that the medical aid bill should be passed and that will help the members, those that are over the age of 65 that are in need of nursing homes; that will help the nursing homes and it will help them a lot.

I wish that Senator Saltonstall would have been here now on the platform and I would ask him to face all these elderly people and state why he is against the medical aid bill. He has given several times several excuses why this and that, and that private enterprise will deal with a whole lot better. We have private enterprise insurance companies that are supplying aid, but those of us that are over 65 and have worked under social security are not asking for any charity. By the time we have worked, we have paid.

The millions of dollars that are accumulated in that particular fund are part of our income that we have contributed into that fund. The administrators, our Senators and our Congressmen, when the law is passed for the people there is someone that has to administer it and they are given the power to administer it. Now the Senators and some of the Congressmen are denying us, the elderly people, the right to which we are entitled. Even those that are working today that are not 65 yet, I don't think that any of them will deny that he is willing to pay one-tenth of a percent in order that this social security fund today should not be even touched for the benefit of the medical aid that the elderly will receive.

I would ask Senator Saltonstall that, let him answer that. He talks on television where people don't see him. Let him out to a mass meeting like we have today and face it and then I do not think he will be able to say that he is the real representative of the people of Massachusetts.

STATEMENT OF JOHN S. MURPHY, NATIONAL AND LOCAL PRESIDENT, RETIRED WORKERS OF AMERICA, LOCAL 201, IUE, AFL–CIO

Mr. MURPHY. Senator Smith and members of the committee, my name is John S. Murphy. I am the national and local president of the Retired Workers of America, IUE, AFL–CIO, West Lynn, Mass.

I wish to record my organization as being in favor of the King-Anderson bill which would provide medical care for the aged through the social security mechanism.

I have just a short resolution here that I will read. I had quite a speech made but I do not have time. I know, Senator, we can send in the rest of the material later.

Senator SMITH. It will be made a part of the permanent record if you will submit it.

Mr. MURPHY. Thank you very much.

At a regular monthly membership meeting of the Retired Workers of America, local 201, IUE, AFL–CIO, held at West Lynn, Mass., the following resolution was unanimously adopted:

Whereas there is certain legislation now pending in Congress known as the King-Anderson bill providing medical care for the aged to be administered through the social security system; and

Whereas social security is an insurance system which is paid for in a large part by the premium deductions from the worker's pay. It is a businesslike system that pays its own way, it is soundly financed to pay all benefits, it provides working people and their families disability protection, retirement protection, and survivor's protection in case of the worker's death, and there is no honest reason why it cannot now provide medical care protection; and

Whereas our organization represents thousands of retired workers throughout the Commonwealth of Massachusetts and the country who desire this dignified plan and who are opposed to charity medicine in any form, and

Whereas our organization has the unanimous support with New England district AFL–CIO and the 92 locals it represents, the aforesaid medical plan has the backing of all organized labor throughout the country: Therefore be it

Resolved, That we respectfully ask you to do all in your power to further the enactment of the aforesaid legislation for a medical plan for the aged based on social security.

Thank you.

Senator SMITH. Thank you very much.

STATEMENT OF ANNIE BUTLER, PRESIDENT, SENIOR CITIZENS CLUB, PAWTUCKET, R.I.

Mrs. BUTLER. My name is Mrs. Annie Butler. I am president of the Senior Citizens Club of Pawtucket, R.I. The reason I am here today is to ask you gentlemen here on this bench, Will you get behind the President and do for him like we would want to do for you when we put you in these positions? What I want you to do, and I ask you simply, is get behind him on this medical aid on the social security because we have just got to the part where those people—me as well, I am 73 years old, and I have over 20 members in my club that are over 80, and I want you to try to do your best to get this medical aid for them.

I have some bills here that I can prove to you that it is a shame that this should happen in the richest country in the world. We talk about sending this and that to other countries, but I think myself that charity begins at home.

I have one bill here for 10 days: Doctor, $10; prescriptions, $2.70; insulin every week, $1.49; digitalis, $1; urine test, $1; blood test, $1; X-rays, $13, making a total of $32.19 out of $60 a month. Do you think that is fair?

I have another bill here, she is sick—she is very, very sick, this person, with sugar, and in 10 days she paid $32. Do you think that is fair?

I have a Mr. Henderson, $22 a day for the hospital. He has just died, and the wife is 84 years old and does not know how to pay this bill.

I have another one, she pays over $30 a month. She has had to give her home up because she could not meet the expenses of the home.

Now, gentlemen, would you like that on your mothers? No, you could not say that. So I am asking you, please, please, from all my heart, don't make her sign that pauper's bill because we will die on the street first.

Thank you.

Senator SMITH. Thank you, Mrs. Butler.

STATEMENT OF JACK E. MOLESWORTH, REGIONAL CHAIRMAN, YOUNG AMERICANS FOR FREEDOM, INC., BOSTON, MASS.

Mr. MOLESWORTH. Senator and members of the committee, I appear before you as chairman of the Massachusetts chapter of Young Americans for Freedom, Inc., representing the position of that chapter.

Young Americans for Freedom, Inc., is a nonpartisan, conservative political organization similar in organization and objectives to our counterpart on the left, the ADA. You are doubtlessly aware of the nationwide conservative political revival which is reflected in Massachusetts by our recent formation. Nationwide we now have over 200 affiliated chapters with in excess of 20,000 members. In Massachusetts there are 12 active chapters, 10 college ones, with over 500 members.

I wish to present a strong stand against the administration's proposals to provide Federal medical care for the aged through the social security system, specifically the King bill (H.R. 4222), which will be a matter for consideration by Congress in its 1962 session.

Our current social security system rests on such an unsound financial base that it is in severe danger of complete collapse within the next 10 years. The anticipated income at present and scheduled future payroll tax increases to a maximum of 9½ percent are insufficient to pay the current level of benefits, with the rapidly increasing number that are yearly becoming eligible to receive them, let alone higher benefits that Congress seems prone to vote almost every year. The inclusion of a very expensive medical aid benefit into the social security program would only serve to further undermine it and assure its ultimate collapse. The suggested increase in payroll taxes designed to finance this medical aid would fall way short of providing anything like the probable cost. The socialized medical program of Great Britain now costs that country 10 times the original estimate.

We feel that the further undermining of the social security system would serve to perpetrate a cruel hoax on our senior citizens, especially those of very modest means, by severely endangering the source upon

which many depend for the majority of their income. We further reject the plan where a poor working man making $5,000 or less per year would pay taxes for such medical benefits as those proposed, only to have a portion of the benefits go to millionaires who are well able to take care of themselves.

If this bill is passed, it will practically assure that those now in the age brackets of 20 to 50 will not receive the benefits they have been led to expect, as the money they have paid into the fund will by the time they are eligible have been completely dissipated with an increasingly large deficit being incurred every year. The social security system is now funding on a deficit basis with benefit payments exceeding contributions by an increasing proportion.

Finally, it is those in the age brackets under 39 years of age, which the membership of Young Americans for Freedom comprises, who will end up paying the bulk of the taxes, yet have no assurance of receiving any benefits in return. We emphatically reject this proposed financial suicide on the part of the Federal Government. We are sick and tired of the National Congress repeatedly running up Federal deficits which increase the Federal debt, the burdens of which we the younger members of society will have to bear long after most of those responsible for the debt have passed on.

We insist that at the present time adequate medical care is available for any senior citizen in need of it, regardless of his financial condition which makes the proposed program completely unnecessary. If Congress wishes to aid the senior citizens of the United States, the most important step it could take would be to cease its wild spending in excess of income, balance the Federal budget, and pass legislation to curb the monopoly power of labor unions which has allowed them to push wages repeatedly in many industries well in excess of increases in productivity.

The inflation resulting from these two major sources has done more to undermine the financial stability of our senior citizens than anything else in the past 20 years. We urge Congress to show the courage to help our senior citizens as well as all other citizens in the area where aid is so vitally needed; namely, the cessation of Federal policies that promote inflation.

STATEMENT OF MILDRED DEAN, PRESIDENT, THREESCORE CLUB. AND PRESIDENT, FOREVER YOUNG, PROVIDENCE, R.I.

Mrs. Dean. I am Mildred Dean, president of the Threescore Club and Forever Young, member of two golden age clubs, and a member of three other clubs besides.

I am for help for our aged. I have been trying to work on it for a long time. We have wonderful people in Providence trying to do their best, but without your help they can do nothing. We are asking very little, just medical care through social security. I myself am a member of Blue Cross. Three years ago I went into the hospital and was operated on. I understood that with my pension of $64.80 a month that the Blue Cross took care of the expense. Here a few weeks ago I got a notice from a doctor saying I owed $15 for anesthetics. I do not think that that should have come through with a person on $64.80 a month.

We are asking very little, and we will do everything to help, but we cannot do it without your help. Thank you.

Senator SMITH. Thank you very much, Mrs. Dean.

STATEMENT OF CHARLES C. O'DONNELL, LYNN, MASS., NATIONAL PRESIDENT, SENIOR CITIZENS AND ASSOCIATES OF AMERICA

Mr. O'DONNELL. Charles C. O'Donnell, national president of the Senior Citizens & Associates of America for going on 34 years.

I will take a very, very few minutes because I spoke in Springfield but I want to say that in regard to our medical program on the King-Anderson bill, now, that is going to be a good start. Now we here in Massachusetts have accepted the Kerr-Mills bill which the Members of Congress—that is, the Senate and the House—enacted, and very few States have accepted it.

I might tell the lady from Rhode Island to get on the ball down there in Rhode Island and see that they accept that Kerr-Mills bill.

Now we want to continue the Kerr-Mills bill because as some of these people are in these homes, that is, the hospital and the nursing home, the 180-day limit comes. Now if there is a basis of need under the Kerr-Mills bill and the basis of need can be set by the State, now in our State they are allowed to have $2,000 and a married couple $3,000.

If you will excuse me, I want some of the people in here to know that you have done some very, very good work in starting off.

There is no lien on the property, there is no limit to your insurance, like old age assistance. Now, in Massachusetts the hard part of the bill is—the Federal Government does not require this but we have a clause in it—the house voted to repeal that children's clause and go along with the Federal Government on that, 175 to 1, but the senate defeated the bill.

I would suggest that if it was possible that in order for the States to receive the benefit of this legislation that if you have the same provisions like a no lien law there would be no children's obligation. I have had an experience with that myself. My savings have been wiped out twice through death and illness and I certainly would not ask any of my boys to contribute.

So those people who are here understand. Now let's give the Senators and Congressmen a little credit; they have started something, they have the Kerr-Mills bill. Now we want to keep that. Now we go along with the King-Anderson bill and that will be reached on the middle-class group. The hardest hit today is the middle-class group. That is, if you have a little money, but you are not in need; where if you have plenty of money, you are well taken care of.

Now there is one thing we must watch out for and that is that we don't take all the money; that is, that we don't substitute pills for bread. Now 40 percent of all the costs for taking care of our aged is for medical expenses. Out of that 40 percent, 85 percent of the money is spent for 15 percent of the people. Now 40 percent of the expenses, get this in your mind, of your expenses is spent for medical and that 15 percent of the people receive 85 percent of the benefits.

Now we got a lot of people on the outside, and we want to take care of them through an increase in the social security, and we do not need

a lot of these so-called experts riding on their back. If you want us to support some of these experts, we will pass the hat and take care of them. There are too many of them getting in the act, and there are too many of them riding on our back. Let them go to work. Let them make an honest living.

Senator, I don't like to say this publicly, but I wish you success in your future endeavors. You are coming down to our level.

Senator SMITH. Thank you.

STATEMENT OF ROBERT HAMIL, QUINCY, MASS., MEMBER, FEDERAL RETIRED EMPLOYEES

Mr. HAMIL. Senator Smith, I come from Quincy. The majority of the people with their applause seem to favor this legislation with the exception of a small percentage out here. I want to go on record as saying I support this legislation.

Senator SMITH. Thank you very much.

STATEMENT OF CATHERINE B. BYRON, PRESIDENT, SUNSET CLUB, LAWRENCE, MASS.

Miss BYRON. My name is Catherine B. Byron, and I am the president of the Sunset Club of the city of Lawrence, Mass.

We senior citizens of the city of Lawrence would like to see the whole nursing service go into effect, especially for our aged that live alone. At the slightest illness our senior citizens are put into the hospital, and from the hospital to the nursing home.

The nursing homes that we have visited have been very undermanned due to the shortage of help in that particular field. In the old age housing projects we do think, too, that nursing service attached to each project would be most helpful. We think that the nursing service would be beneficial in many ways. It would take the burden off the hospitals and nursing homes and give our senior citizens a much better outlook for the future. Thank you.

Senator SMITH. Thank you very much, Miss Byron.

I might say at this point I know of the fine work the golden age group is doing in Lawrence. I had occasion just recently to visit their new civic center, which is certainly a great step in the right direction.

Miss BYRON. That is the Sunset Club, not the Golden Age Club.

Senator SMITH. Yes.

STATEMENT OF JOHN F. KINDER, EXETER, R.I.

Mr. KINDER. My name is John F. Kinder, and I come from Exeter, R.I.

I want to speak on the King-Anderson bill. I have read the bill, and I think the way it is written up is perfectly all right except the conjectural clause, the $10 deductible clause. About 60 percent of those on social security do not have sufficient income to even pay that much or even pay the office cost. So instead of full hospital care, it should be full medical care for the aged, even including the doctor's fees. Every door is closed to those on social security for an opportunity to strengthen their income in any manner.

I realize that a good many of the States have put up bills against discriminating in hiring the elderly. That is a good idea but the law will just stay the way it is because there is no way of proving a manufacturer did turn a man down on account of his age. The Government would have to give them the same right as they accord themselves, to select from a group of three which one they want to go to work. Therefore there is no way to enforce the hiring of the aged.

I would suggest that if they do not increase and cover all the medical aid they should set up some type of Federal employment for the aged with the State and the Federal Government cooperating together something like they did for the youth. They could set that up by having each State pick out what projects they wanted for their aged.

Give the aged an opportunity to earn enough to strengthen their income so they will be able to take care of themselves. There are many of those on social security that are trying to live on around $700 or $800 a year, which is impossible. It does not take much figuring to see that none of that could be put out for medical care. I know, I have needed medical care myself, and when you have to go and pay an office bill of $5 and you have to go three or four times a month and you are trying to take that out of $100 and meet your other expenses, you have not got it. So you have got to forego something or you have to forego the medical care.

There is no other way because you have not even got enough to take care of your immediate needs of food, housing, and so forth. So unless they pass the bill that will cover the full medical care, there will be 60 percent of those under social security unable to use it and the bill would not be very much good. Thank you.

Senator SMITH. Thank you very much.

STATEMENT OF MARY P. HUDDY, PRESIDENT, GOLDEN FELLOWSHIP CLUB OF WOLLASTON, WOLLASTON, MASS.

Mrs. HUDDY. Senator Smith and gentlemen, may we have a little change of pace for a moment. I am Mrs. Mary Huddy, president of the Golden Fellowship Club of Wollaston, the first club of its kind organized on the Southern Shore. We have over 100 members. Our particular problem is transportation. So many of our members are on either social security, which is low, or State aid. They cannot walk; they are old. Many of them are over 80. In fact, I am myself over 80 and I could not walk to the meetings.

Of course the South Shore may be a little different than some of the others but there were no transfers, I understand.

Talking with one of my ladies yesterday on the phone she explained her absence because she said it is two fares. Now she lives right in Quincy. That is 50 cents to come and 50 cents to go home. She only pays 10 cents when she comes and we serve them a beautiful lunch and they have a chance for recreation. In fact, it is rather a necessary place for many people who do not have the chance to mingle with others of their age.

Now I am wondering—of course this is more for the South Shore—but I am wondering why we in that age group could not be allowed a reduction of fare, the same as students have, then we could get to

the meetings; we could enjoy the companionship of others, and I think it would be a rather healthy thing all through. Thank you.

Senator SMITH. Thank you very much.

STATEMENT OF SALVATORE ZAMMITTI, SOMERVILLE, MASS.

Mr. ZAMITTI. Senator Smith, ladies and gentlemen, I am not quite 65 yet. The present setup where you have a minimum of $40 a month and a maximum of $120 per couple—if someone is married, the wife is 4 or 5 years younger, I mean does not get any money for her so it is $120 a month; that is the maximum.

Now how in the world can any man in Washington pass up a bill for $40 a month minimum for somebody to retire at the age of 65 or $120 for a couple when if you get four or five or three rooms to live in it cost between $90 and $120 with gas, electricity, and whatever facilities you have? What about for clothing, heating, and everything?

Now of course the medical care has already been taken care of here and I am sure that they are going to do something about it because that is one of the main objectives to us elderly people. I hope, Senator, while you are here that you will take a message from these people here to Washington that the present setup as it is, $40 a month minimum and $120 per couple, it is a disgrace to this country when we feel proud of being Americans, good Democrats and the richest country in the world and we cannot give to other elderly people who are the pioneers of yesterday who have made conditions for the younger generation of today.

Now I know that my boys, if they go out and get a job they get $90 or $100 a week while I started with $5 a week. I worked hard about 48 years. I have a little money, yes, but how long is that going to last me if I get about $80 or $90 if I retire at the age of 62? Why in the last 6 or 7 months I have been out of work. The question of age comes up to the front now. "All right, we will get in touch with you." What am I going to do meanwhile?

I have a little money in the bank. I take it out and before I know it I have to go on the welfare. What other people do not understand is that the money in welfare is paid through tax by other people who work. Well, why should the community have to pay so much money for welfare when we can have this money from the payroll of workers and the business people? I am sure that General Motors can surely pay a little more money to help the elderly people when they are retired, to get at least a minimum based on the cost of living, not just to get a crumb and give it to you like a dog and say that is all you get.

Now some of you gentlemen probably make $10,000, $15,000, $20,000 a year. That is all right, but what about the man that has been working all his life for $2,000 a year, $3,000? When you retire, how can you retire?

There are workers in the clothing industry, some of them I ask, What is the matter, 68 years old and you are working? What am I going to live with, $80 a month? How am I going to pay my rent?

I never was on welfare; I have to go on welfare. I have 1 year or 2 years of my life. Therefore, Senator Smith, I say this much, that the best thing to do if it can be done in Washington—I make this as a suggestion, I might be out of order—is that there should be no

minimum and no maximum. There should be at least $200 a month for elderly people, at least as a minimum for everybody. I do not see why this specification. If I have been working for $2,000 a year, why should I get $40?

Now I come under the high bracket but that is beside the point. What about my next-door neighbor, he gets $70 or $60 a month? How is he going to live with that? I make that as a suggestion and I hope they take it up.

Senator SMITH. Thank you.

STATEMENT OF HON. JULIUS ANSEL, WARD 14, STATE REPRESENTATIVE, GREAT AND GENERAL COURT OF MASSACHUSETTS

Mr. ANSEL. Senator Smith and members of your committee, I am Julius Ansel, of the Suffolk District. As a member of the legislature I want to commend you, Mr. Chairman, and your colleagues on this committee to study this problem. I think it is a contribution to whatever the future holds in store for our senior citizens.

I am going to be extremely brief. I know you want to hear from the citizens themselves. There are several problems that disturb me. We increased in the legislature the allocation for old-age assistance, and when the citizen went down to apply we found that they were computing the prior social security allowance and not collecting in toto the old-age assistance allowance increase made available by the great and general court.

This year, as a result of the increase of fares on the Metropolitan Transit Authority, which I opposed rather strenuously and I am still opposing, I filed a bill that will permit an increase of $10 a month on old age so that these men and women can get to their daily meetings and enjoy the social life which I think is important to them to their longevity of living. If that passes, the local welfare office will compute the social security allowance on a budgetary plan, they will get the total $10. That situation should be rectified.

I have been deluged by calls from men and women who would be entitled to an increase by the result of the allocation made possible by the legislation to find that in computing the total amount they were made ineligible.

No. 2, I want to talk about public housing. My distinguished colleague, Representative Harlan, who has been a fighter for housing in Massachusetts, filed a bill and it was passed, $25 million one year and $35 million another. I think the Federal Government ought to demand of the housing authorities in Boston and in Massachusetts a speedy operation in the construction of public housing. And I do not think in connection with that, Mr. Chairman, that public housing on a Federal level ought to be factory structures. I think they ought to be homey, I think they ought to be accessible, and I do not think they should be projects like we have in Columbia Point.

I am giving you my thinking. We are in the majority. We will support any recommendations that your committee may determine that come under the jurisdiction of the State level. I hope the medical aid bill will pass. I hope the life of the elderly will be made more pleasant. Let's forget the price of the dollar. We spend millions across the ocean, let's spend millions for these men and women.

Senator SMITH. Thank you very much.

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STATEMENT OF JOSEPH LANGWEIL, VICE PRESIDENT, JEWISH ADULT CLUB, QUINCY, MASS.

Mr. LANGWEIL. Senator Smith, my name is Joseph Langweil, vice president of the Jewish Community Adult Club. Also, I am a veteran of World War I. I have belonged to the International Typographical Union for over 42 years. I am a pensioner.

The social security was based on the pension of my union. We have had a pension for 55 years and it has increased. At the present time I am in favor of the King-Anderson bill as we have today the social security which is law. We feel any time that we want to retire we take that privilege.

I am what you call the middle class. We feel that the medical bills are getting higher and are getting so that our resources are getting lower. We, a rich country like ours that can boast a high standard of living, why can't we now take care of our aged in the medical field so that we can boast throughout the world that we are taking care of them?

The Kerr-Mills bill is inadequate. Who wants to go before any committee under the Kerr-Mills bill and beg for charity? We have paid the social security which is the greatest thing in the world: It is cheap and it is reasonable and we get good service out of it. Why can't we have an improvement on the medical aid so that we can have more money?

We do not save the money that we get from our social security: We distribute it so that we can all have more buying power so that you will not have any depressions. There are a lot of things I can talk on in the Social Security Act, but let us look at it on the human side, not on the materialistic side. Why worry about debts and all that? We have come through it all the time. Let us take it as a human way so that we can go on and advance to show the world that we mean what we say, that we have the highest standard of living in the world. Thank you.

Senator SMITH. Thank you very much.

STATEMENT OF HELENA HERIOT, BOSTON, MASS.

Mrs. HERIOT. I am Mrs. Helena Heriot and I live here in Boston. I am 84 years old and have worked until 2 years ago. Two years ago they raised my rent from $145 to $200. I am not on an old-age pension. I had a little nest egg which I have used up, mostly on medicine and rent. Last month I was not able to pay my rent. They wanted to know if I would give them my social security check, which I did. Two days later he attached my savings account and I didn't know it and I sent out bills for my electricity and my gas and telephone which were all shut off.

Now this month I did not have the money to pay the rent, so yesterday I got a sheriff's notice that they will "sheriff" me out in 14 days. I have lived here in this one apartment for 25 years. I have paid $70,000 in rent. I had a small rooming house on Commonwealth Avenue. Now I am not the only widow in that building who has suffered from these owners. They change hands about every 2

years. The new owner has come in now and has ordered me out, "sheriffed" me out. I have spent a great deal of money on doctors' bills and now I have not any money to pay my rent. Thank you.

STATEMENT OF JOSEPH ROSEN, VICE PRESIDENT, GOLDEN AGE CLUB, DORCHESTER, MASS.

Mr. ROSEN. Ladies and gentlemen, my name is Joseph Rosen. I live in Dorchester. I am going to be 70 pretty soon. I am a senior citizen. I am a vice president of the Golden Age Club and I represent over 350 members in our club. I want to say I did not prepare any speech but I talk from my heart because I know the people in our club, all independent people. Some had small grocery stores, some had other business; they were always independent, they never asked anybody for anything. I know most of them do not have a bank account to live with when they get to this age. They cannot afford any luxuries; they cannot go to their doctor any time they get sick.

They are too proud to go get in some hospitals. They go around from one place to another to find out why they did not go to the other place, why they come here. These people that do not go when they get sick, they suffer because they do not have a $10 bill to pay their doctor. That is why I say that this medical bill should go through now. They should not hide it under the table like they do all the time. Thank you very much.

Senator SMITH. Thank you very much. I appreciate this testimony and I know it does come from the heart, and I know the testimony of all these people that are talking here comes from the heart.

STATEMENT OF ROSE SHOCK, FRIENDLY GOLDEN AGE CLUB, PROVIDENCE, R.I.

Mrs. SHOCK. Senator Smith and senior citizens, my name is Rose Shock. I belong to the Friendly Golden Age Club in Providence, R.I. I am here under the sponsorship of the Jewish Community Center.

I am 100 percent in favor of the medical bill and I am also in favor of this social security. I am a Gold Star Mother, I lost my boy in the war, and I get a little money. Social security, I have been getting lately $29.90 and that was raised to $39.90. Now I am getting $42.90.

I moved into an apartment 16 years ago for $45.60. I am paying $90 today, and how can I live? Where will I get money for food, for clothing, and medical expenses? It just happens I am still a little on the go and I work a little bit, but that won't last forever.

I said this in Rhode Island to some of our conferences, that I am in favor of and I would like to ask you to pass this bill.

My husband died, and now all his belongings belong to me. Why can't the widow get the same social security the husband was supposed to get?

I want to repeat what other speakers have said here to you, Senator Smith.

I would like to say to the young fellow that spoke here before, we are the senior citizens that lived in cold-water flats; we are the senior citizens that give the boys and girls a fit world to live in; we are the ones

that walked miles and miles to a bus. Some of you have three automobiles in your garages, some of them have at least two. Now we come to you. You should help us to fight the bill, that we should live a little more comfortable. You have air conditioning, steam heat; we didn't have it when we were your age.

We did all kinds of work; we worked 12 hours a day, day and night. We were the ones that were fighting for 8 hours a day. Some of you work less, you make 10 times as much money. This was not the place for you to come and say what you said.

I am glad, and I want you to know that we depend on you. Yes; you are going to pay higher taxes, but it is worth it. We made a beautiful America for you, it took us to do it. We were glad to do it. Thank you.

Senator SMITH. To the ladies and gentlemen that come from Providence, R.I., I would like to point out you have two very able Senators from your State, Senator Pastore and Senator Pell, who are extremely interested in this problem, this great problem of the aged.

STATEMENT OF WILLIAM X. WALL, LAWRENCE, MASS., MEMBER OF THE STATE SENATE

Mr. WALL. Mr. Chairman, Senator Benjamin Smith, and members of the U.S. Senate Select Committee on Matters of the Aging, I have been keenly interested in the problems of our increasing number of older citizens. It is my opinion that many great problems faced by older people arise because most of them have extremely low incomes. The public must be educated to the fact that because age has come to an individual it does not mean that he or she must be discarded as useless. I think our society now is beginning to awaken to the fact that the nimbleness and dexterity of youth along with this instability is a poor replacement for the patience, the wisdom, the experience, the reliability, and the stability of the individual advancing in years. On the other hand, there are those who are unable to be gainfully unemployed and must be cared for.

With reference to housing for elderly people I would like to say that the need of companionship with others of like age who share the common mutual problem known only to the elderly is crying for recognition. This situation manifests itself in the desire on the part of the elderly to have their independence and to be as independent in old age as they were over the span of a lifetime.

A large part of our aged population must live in totally inadequate rooming or lodging houses often located in the slums due to the fact that rents are relatively high and beyond the reach of the aged. Some of the most disgraceful housing is that occupied by the aged. Although the problems of the aging are the responsibility of individual local governments and the State, this entire matter is increasing steadily with each passing year due to the increased number of older people living longer, and Federal assistance is desperately needed to aid in reaching a satisfactory solution.

Mr. Chairman, with age usually comes increasing health problems. This comes at a time when the income has been sharply reduced. Many persons postpone going to the doctor or buying essential drugs because to do so would mean less food or draining on their savings.

Mr. Chairman, I would like to conclude and say that research is needed to establish the maximum level of patient care at the level of the majority of the aged's financial resources. Research is, of necessity, a slow-moving process but I am sure that with everyone feeling the urgent need of satisfactory provision for the senior citizen, assistance will be available at every turn to the end that a desirable solution will not be long in coming to us all.

I think, Mr. Chairman, you must have noticed by now that although the responsibility for the aged is a local one, the crying need for Federal assistance is openly apparent to all interested in this problem. Without such assistance for the low-cost housing already instituted in Massachusetts for the senior citizen would not have been possible. This type of housing is exceedingly popular and the demand far exceeds the available facilities.

I regret, Mr. Chairman, Senator Smith, that you were not able to visit two of our institutions, and at this time I would like to invite you to observe the above-standard administration to the aged and infirmed at the Protectory of Mary Immaculate at Lawrence and St. Ann's Home for the Aged under the supervision of our illustrious humanitarian, Richard Cushing, archbishop of Boston.

Mr. Chairman, you congratulated the senior citizens of Lawrence in your visit the other day. I now congratulate you for the time you spent at Lawrence and what you are going to do for the senior citizens in Lawrence.

Mr. Chairman, I would like to close my remarks and make this observation. I say this from the bottom of my heart. Our senior citizens should be able to spend the rest of their lives, if they wish, watching the robins in the spring and the leaves tumbling in the fall in reasonable comfort. Let us see that they have it.

Mr. Chairman, thank you for allowing me to present my views as I believe them to exist today.

STATEMENT OF LEON MOORE, GOLDEN AGE COUNCIL, GREATER BOSTON

Mr. MOORE. I am in favor of the King-Anderson bill.

My name is Leon Moore. I am here in three capacities: (1) As a citizen of the United States; (2) as a full-time worker in charge of the Golden Age Club in Boston, you heard from our vice president; and (3) I am also the coadviser to the Golden Age Council of Greater Boston which represents 18 Jewish community clubs.

I and my organization for which I work are 100 percent in favor of the King-Anderson bill. We feel, and I certainly do feel, that the AMA constantly stresses the fact that this is going to lead to socialized medicine. I do not feel that, and I am speaking as a member of the youth and younger generation. We, the younger generation, have Blue Cross, Blue Shield to cover any unforseen things that do happen to us. They constantly say this will lead up to the socialized medicine in our age group. I do not think this.

As a further instance of belief in the King-Anderson bill the Golden Age Council—I would like this for the record—is going to have on Sunday, January 21, at the Cradle of Liberty, a mass meeting. We are inviting all the Golden Age Clubs of all of Massachusetts and we wish that, if possible, the Senator would come. We would certainly want him. We are going to have a prominent speaker.

Also in conjunction with this we are having petitions sent out to all the Golden Age Clubs throughout the State of Massachusetts favoring the King-Anderson bill. Right after this mass meeting, about a week or two later, I personally am going to Washington with the representatives of the Golden Age Council and present these bills to Senator Humphrey himself.

Senator SMITH. Thank you very much.

I want to say at this time that in my travels throughout the Commonwealth and the hearings we have held in Hartford and Springfield before coming here to Boston that the attitude of this young man who just spoke before you is indicative of the feeling of many, many, many of the young people of this Commonwealth. I know it is true throughout the Nation. These people are ready now to help, not thinking about taking care of themselves in their old age but are thinking of the elderly people that have already reached their old age. These people as far as I can see are ready to make the sacrifice now.

STATEMENT OF GERTRUDE O'LEARY, BOSTON, MASS.

Mrs. O'LEARY. Senator Smith and our American citizens, I want to refer to the Kerr-Mills bill. My name is Gertrude O'Leary and I am a Bostonian.

I wrote to Washington and asked for a copy of the social security amendments in which the Kerr-Mills bill was contained. I received it and I called city hall. They did not know anything about what I was referring to. I also called the statehouse. They did not know what I was talking about.

My mother is 85. She was operated on in the Boston City Hospital in January. My father died when I was 16 and we have always had to work. At present I am not working. I was retired on account of my health. I did manage to go to school and graduate with a degree in advanced bookkeeping in 1956. I worked for a short time and the doctor ordered me off the job.

I would like to say that former Secretary of Labor Mitchell spoke about this. Now there is no reason why a person should not be able to work over 40 because I still think people 70 and 80 can still work as long as they have ability to work. Age has nothing to do with ability.

When some woman from the welfare came out to the house and inquired about the hospital payments, I asked this woman what was the amount of the hospital bill and she said she did not know. She asked me how much of a pension I was receiving. I said, if you don't know what the hospital bill is, I refuse to answer your question. So she asked my mother.

I think the Kerr-Mills bill is really starting off to be a good thing, but being handled by the welfare I do not think it is being handled properly because the welfare still thinks a person is really looking for charity when actually they are not because my mother did not ask for welfare, she asked for medical assistance. I am still waiting to hear from the welfare with regard to this particular thing. I still think that there should be some way of helping a person to rehabilitate himself so that he can be able to continue on and work and not be prevented from doing so because of age.

Senator SMITH. Thank you very much.

STATEMENT OF JOHN GARDNER, SAUGUS, MASS.

Mr. GARDNER. My name is John Gardner, Mr. Smith. I come from Saugus, Mass. I am going to cut it short, no verbiage, to make a couple of points which should have been made with more force although a number of the speakers previously have emphasized them.

One is, too many experts. There are more experts it seems to me than there are senior citizens.

The next thing is that none of the bills proposed are adequate. Let's not quibble about a few pennies here or there. Cut out the charity completely. Everybody over 60 gets a minimum of $200 a month and completely free medical aid and no strings attached to it whatsoever. We are a rich country and we can afford it.

I would like to answer Dr. Jerome Whitney who testified in Springfield and it was reported in the Globe. He said, "Pay for this through social security, taxes will go up; we are on the old merry-go-round," Well, what I can say is this: that what he is saying is that the elderly citizens will have to go without because they cannot be paid for on social security. Let him put forth a program for addressing. We all know it can be paid for. Let's stop shooting off all these rockets and dropping bombs. That is where the money can come from.

Senator SMITH. Thank you very much.

STATEMENT OF EDWIN C. CROSBY, GOLDEN AGE CLUB, BROOKLINE, MASS.

Mr. CROSBY. Senator Smith, I am Edwin C. Crosby from Brookline. I am sorry that Senator Saltonstall and his friend are not here, they both left.

Everything in this country today is a racket. I don't care what it is, there is no question about it. You have got your labor unions, you have your medical society, you have your laws, you have your real estate group—everything is a racket.

We have got probably 70 million people; we do not use our influence. We are more people than any combination of labor unions. We have a vote—How many people here vote? Not many. They do not bother to vote, so we are to blame for the condition we got. Seventy million of us, we do not vote, we do not ask our families to vote. I bet nobody ever writes a letter to their Congressmen asking them what they want. How do the majority know what they want?

Senator Saltonstall got a wonderful hand here this morning. I wonder how many times he ever voted for the legislation we are working for right here?

Senator SMITH. Thank you very much.

STATEMENT OF ANNA P. HEWITT, GOLDEN AGE CLUB, NORTH PROVIDENCE, R.I.

Mrs. HEWITT. Senator Smith, my name is Anna P. Hewitt. I am the former representative of North Providence and I belong to the Golden Agers. Mrs. Sanderson is our president. She was ill and asked me to come here today to represent her.

Here is a message that I would like to bring to everyone here today. I had a chance to speak to Senator Pell about our medicine aid and our

social security and different things not long ago. He said, "Mrs. Hewitt, I will tell you one thing; the Senate is willing to pass the bill but the House does not seem to want to. Now the only recommendation that I can make to you is to have anyone that has any friends outside of Providence write to their representatives and ask them why they do not get on the ball and want to pass these different bills for the Golden Agers. If they do," he said, "the Senate is ready but we cannot do it unless they do so."

So I am going to ask everyone here today to please write if you have any friends in California or anywhere and ask them to have their representative tend to their business on the bill or bills for the Golden Agers. That is something we need very, very badly.

Now I own my own home, I have lived in the town of North Providence 45 years. I have worked practically all my life as long as I could. I worked until 10 years ago. My husband and I have worked on small wages, on $12 and $14 a week. I have worked in the mill from 7 until 6 at night; didn't make much money but we managed to keep our home together and own our own little home.

Then I was stricken by cataracts and I have had five operations on my eyes which came along and took $8,000 of our money. At the present time I spend 56 cents a day—it was 5 years last June—for two tablets that I take for my eyes or I would not be able to be here today. My eyes bulge and I cannot travel alone, I always have to have someone with me.

In that way I am speaking for myself and for others that are afflicted the same way that I am.

Now here a short time ago, about a month ago, the tax assessor came along and raised our rent to $73.80, and we have not a grand home by any means. Will you please tell me where all that is coming from? Roosevelt wanted us to keep out of the poorhouse but it looks to me as though we are going back to it if we do not get some aid.

Now I do hope that everyone will try and help us in Washington. That is where we have got to start, is right there. I do hope that everyone will try and get in touch with the different representatives. That is the only way we are ever going to get anything. They just keep passing the buck from one to the other; you speak to one and then the other.

Well, we will see what we can do. We will see what we can do, but they never do anything. So now let's get going and see if we cannot do something for the Golden Agers. I know I have worked very hard and I know there are a lot of other people here that have worked very hard. I am 70 years old and I would like to enjoy a little bit of the rest of my years as long as I am able to see.

Senator SMITH. Thank you very much, Mrs. Hewitt.

I would certainly like to say at this time that there are 21 members of the Senate Special Committee on Aging, and I wish there were 100 members and that each one of them could hear some of the testimony that you people are so effectively giving today. I am sure if they could all hear that, they would be in a much better position to pass the kind of legislation that you people are in favor of.

Mr. O'DONNELL. Let us give the Senator a big hand.

STATEMENT OF SAMUEL SEINIGER, BOSTON, MASS.

Mr. SEINIGER. My name is Samuel Seiniger. I live at 219 Park Drive in Boston.

Senator Smith and members of the committee, one of the previous speakers spoke of change of pace and my short subject is going to be a decided change of pace. The reason is that this suggestion which I submit respectfully will cost the social security nothing.

For those people who are in the age bracket between 65 to 72, recently a change has been made in the social security laws so that if they could earn from $1,200 to $1,700 they were able to keep half of that difference. May I respectfully suggest further broadening of that.

If the earner of $1,700 and up were given a 50 percent carryover credit of his or her forfeited payments from the social security system, to become effective at the age of 72 in additional annual payments, it would reduce the incentive to quit work, loaf, evade, or cheat, thus substantially reducing the present load on the social security system.

I want to spell it out. For example, if the recipient is in the $100-per-month category, or $1,200 per year, and continues in full employment from 65 until 72 years of age, the social security system saves 7 times $1,200, which equals $8,400, and risks potential refunds of 50 percent of $1,200, which equals $600, per year additionally if recipient survives the age of 72.

Now as we all know the social security system is a vast insurance system which is intended ultimately to pay for itself. Now this suggestion instead of costing the social security system actually should save it. At the same time, if someone intends to continue working, he has an incentive to do so. Thank you.

Senator SMITH. Thank you very much.

At this time I would like to call on Dr. Mary C. Mulvey, Administrator, Division on Aging, Providence, R.I.

STATEMENT OF DR. MARY C. MULVEY, ADMINISTRATOR, DIVISION ON AGING, PROVIDENCE, R.I.

Dr. MULVEY. Thank you. I had not intended to make a statement when I came up. I came with the Golden Agers and we are together from Rhode Island. Certainly I am proud of their performance here today.

I cannot say that I am quite surprised with the younger generation and that is why I come up to the microphone particularly. I didn't intend to, as I stated.

I wish to speak on the issue which the spokesman for the insurance company raised this afternoon. He attacked the social security system of financing, and to me he was hitting at the basis of our democratic way of life because I think the social security system, the program, is the greatest thing that ever happened in our country.

I am not saying that the payments are adequate in every way for our senior citizens, you have heard the testimony to that effect this afternoon, but you certainly have made liberal strides and are trying to continue in that direction.

Now I would like to say this. An important principle of our American social security system and one that has been followed consistently in the development of the OASDI program over the years since it was established in 1935 has been to provide for sound financing. No aspect of the program has received more careful attention by you Congressmen. The Secretary of Health, Education, and Welfare is by law required to appoint an Advisory Council on Social Security Financing to make a periodic review of the financial soundness of the program.

The last advisory council, made up of distinguished economists, private insurance actuaries, bankers, social insurance and financial experts, as well as representatives of management and labor, in 1959, gave this summary of what they found. They said: "The method of financing in the old-age survivors and disability insurance program is sound, and based on the best estimates available the contribution schedule now in the law makes adequate provision for meeting both short-range and long-range costs."

And again I quote: "The contribution schedule enacted in July in the last session of Congress makes adequate provision for financing the program on a sound actuarial basis."

In enacting the several improvements in the program of 1959, Congress has included provisions for the financing of those improvements and for the future development of the program. We can feel confident that Congress will continue to make full provision for financing program changes.

Another important point of our social security financing is that the use of a payroll tax, a tax on earnings, has the effect of automatically increasing income to the program as earnings levels rise. The increase in income permits benefits to be adjusted somewhat in accordance with current levels of living and current prices. This is a very important point if you are providing service benefits like hospitalization benefits and so forth.

These characteristics, the objective to provide economic security after retirement, the method of financing the existing program, the work related benefits, the principle of paying benefits as an earned rate, the universal coverage of the program, are what have led President Kennedy and our own retired Congressman Forand and many others to propose a system of health insurance under the social security as the most practical approach for meeting the health costs of our aged population.

What he said got me teed off, and while I am here I would like to read a quote of Dr. Larson who is the president of the American Medical Association. This was in our Providence Journal a couple days ago, and this is what he says:

> In many respects the aged group is better off than any other group in the Nation. Their liquid assets are higher and have risen faster than any age group. A much higher percentage own their homes free of mortgage. Their financial obligations are significantly less and they enjoy tax advantages not available to younger citizens.

Senator SMITH. Who wrote that?

Dr. MULVEY. Dr. Larson, the president of the American Medical Association speaking to the house of delegates on November 27. This appeared in our Providence Journal the next day, November 28.

Senator SMITH. Thank you.

Dr. MULVEY. Casual observation of the testimony today would certainly attest to the falsity of that statement.

Senator SMITH. Thank you very much.

STATEMENT OF ANN STRASBURG, MEMBER, QUINCY JEWISH COMMUNITY CENTER, QUINCY, MASS.

Mrs. STRASBURG. My name is Ann Strasburg. I live in Wollaston, Quincy, and belong to the Quincy Jewish Community Center. I am a widow, my husband has been dead 4 years. He left me with a home, a little money. That is going very fast for medication and medical bills.

Now what I want to know is, why people in my condition—I am not the only one, there are many more—why we cannot get a reduction in taxes, some sort of reduction, to help us hold on to our homes. I could sell my home. What would happen to that money? It would not last very long. I would have to pay high rental.

I do have two daughters. They want me to live with them. That is not for me, not with the youngsters. They are wonderful girls but I cannot stand the youngsters.

Now I say that in this country of ours widows who want to live in their home and are willing to work, work in their gardens and keep their home up, why isn't there a way to make it possible for us to stay as we were when our husband left us?

Also, I want to repeat what someone else said about the transportation. It costs 25 cents for me to go up to the corner. I have a heart condition. I cannot walk; I have no car. It costs me 25 cents to go a few blocks to get a few groceries. That is 50 cents, up and back. That is a lot of money. My monthly income is my social security. Now, how can I do that and clothe myself—and I make most of my clothes—and come out on top? I do not want to owe anyone any bills. I am not the only one; I repeat, there are thousands more like me. I am speaking for them.

Now when you speak of going into the hospital, I have been very sick. I did not go to the doctor. I finally did go. I was afraid. I have not gotten my bill yet. I am afraid when I do get the bill. I am going to be shocked into sickness when I do get the bill because there were many X-rays, many tests. I am very happy now, I feel better, but I hate to get that bill.

Now I do say we should get student rates on the bus. We should get deductions on our taxes somehow. I for one am very anxious, and I really mean anxious, to pay a few cents, 15 cents, 75 cents, a dollar of my social security every month provided I get back some medical assistance and also drugs.

Thank you very much.

Senator SMITH. Thank you very much.

STATEMENT OF ARCHIE KENEFICK, STATE REPRESENTATIVE, GREAT AND GENERAL COURT, LOWELL, MASS.

Mr. KENEFICK. Representative Archie Kenefick of Lowell.

Senator, I am very happy to be here and speak on behalf of the golden age senior citizens. I am a member of the State legislature.

I am a member and have been a member for 7 years past of the pension and old-age committee. I have sponsored legislation that affects the senior citizen and will continue to do so. We have several bills affecting them that we will hear in the next session of 1962.

Senator, I am also a member of the Lowell Golden Age Club, one of the greatest. I think I would be remiss in my duties as a legislator if I did not appear here before you, Senator, and have you carry back the sentiments to your other 20 members on that committee, which I know that you will carry back and give them the sentiments of the senior citizens of Massachusetts.

I know that the committee will do a good job. I know that your committee in Washington is the same as the committee that we have here in Massachusetts that is trying to do a good job. I know that in the very near future we will have the King-Anderson medical bill.

The Kerr-Mills bill came before the committee which I sat on. I had to accept it, there was nothing else to do but accept it for the time being. I hope it will be a short time. There are things in that bill which I did not approve of. One, the need clause. I do not believe in the need clause. I do not believe in the embarrassment of the children going before a board and being very much embarrassed on their needs. Therefore, I was against that part of the bill but I had to accept it.

I refuse the commitment on the committee to try to wind up the difference. I refuse it. I said, "No, I am positively opposed to the need clause in the bill."

I know that President Kennedy and this committee that you are on, you have the King-Anderson bill before you and I think that in the next session, I hope you will be able to work on it.

Again let me thank you for allowing me to speak here on behalf of the Golden Age Clubs in all of Massachusetts and especially the Lowell Golden Age group.

Senator SMITH. Thank you very much for the fine work you have done in this field.

STATEMENT OF HARRY ROYLE, PRESIDENT, GOLDEN AGE CLUB, NEW BEDFORD, MASS.

Mr. ROYLE. Harry Royle, president of the Golden Age Club of New Bedford, Mass.

We have three Golden Age Clubs in our city. I pride myself with being in the one I am in charge of, which is the best. I hope I am right on that.

I have heard an awful lot of beefing today, this morning and mostly this afternoon, of what we have not. I have heard very little so far of all we have to be thankful for. As I look around and see all you people nicely dressed and looking happy for the most part, I think to myself of the song, "Enjoy Yourself, It Is Later Than You Think."

I think most of you probably have cars at home; I know I have. I can remember about 25 years ago I always worked in the cotton mill and I used to think, "What will happen when I am about 60 years old and they tell me, 'That is all there is, there is no more, you are out of work'?" When social security came in I thought it was wonderful and I still do.

For myself I would rather have a little medical benefit than a raise in social security at my age. I am 74 years old. I think that is the main problem for the older people of Massachusetts and the country —to get a little medical aid or all the medical aid they can. I know there are very few cases where they are really in need and in want, but for the most part we get by very, very nicely. I think that we should all be happy and thank all those who are responsible, and more so thank God for what we have.

Thank you, Senator.

Senator SMITH. Thank you very much.

STATEMENT OF WILLIAM H. SHUMWAY, BOSTON, MASS.

Mr. SHUMWAY. I notice you have asked for the age and a very few have given it, but inasmuch as mine has been published in the newspaper I will have to admit I am 77 years old. My wife is also an oldster. I would not dare give her age but I will tell you that I am just 1 day older. I have several relatives who are oldsters.

I have been for the last 4 months organizing this Boston chapter and I have had contacts with probably 50 to 100 people in the oldster class. I have learned a great deal from them as to how they feel. A great deal of how they feel has been spoken of at length here so I will not go into detail. I will speak briefly on it.

First, I find that 99.44 percent are in favor of the King-Anderson bill but a lot of them feel it does not go far enough. I would also say I find a lot of feeling that so far the amount of money that has been spent on the Conference of the Aged in Washington, the brochure that was sent out and the committees traveling has been so far a waste of public taxpayers' money. We have had a lot of talk, a lot of publicity, but no deeds and no action. That is a feeling of a great many of us.

A lot of them feel that social security is entirely inadequate. They have not any investments to draw on, that they cannot live on social security as they should live and they think it should be increased to a minimum of at least $200 per month.

In regard to the medical bill, I find a lot of them had an adverse feeling against going to welfare or the department of the aged. They feel it is degrading to a certain extent; they feel it is charity, and no one wants charity. They want and are entitled to it, but not charity. They feel that going to welfare or the old-age assistance is charity and they would rather let their medical and dental attention go rather than apply for charity. That is one reason why so many of them favor the King-Anderson bill.

There is one point that has not been brought out which I want to speak about and that is the employment of the aged. We have a very paradoxical situation there. You have the Government and the unemployment service agitated to the businessmen and employers to hire older people if they have the ability, and yet your State unemployment office right here in Boston has an age limit on whom they will hire. Now, if that is not paradoxical, I do not know what is, and I know that from personal experience.

I said I was 77. Two years ago I had to retire. I had a certain amount of unemployment coming to me which I took and then I went

to 6 Somerset Street here and had an interview to get a job. The minute I told them my age, "Oh, we cannot help you, Mr. Shumway." I said, "Well, I can help you here. I have been in the business of securing executives 32 years. You have a certain number of those jobs and I could handle them here."

They replied, "We know that, Mr. Shumway, we know your reputation. We know what you have done but we cannot hire people over 70. I am awfully sorry, we cannot use you."

Thank you.

Senator SMITH. Thank you very much.

STATEMENT OF BLANCHE BALCOM, NATICK, MASS.

Mrs. BALCOM. Senator Smith, my name is Blanche Balcom. I come from Natick, Mass. I do not think my age group has been represented. I come from the middle-aged age group. I have taken care of my mother and I am now taking care of my mother-in-law. I have educated three boys. I do not know what is going to become of our age group. We have sent our children through school and now we should be saving money for our old age and we cannot do it.

I just recently paid hospital bills of $1,500 for my mother-in-law which I am glad to do while I can, but it is going to be the same old story. When we get to our old age, my husband will not retire at 65, we are going to be in the circumstance of these people now, that we will have to have some assistance because we have not been able to save. Then my sons, each has four children—they may have more before long, I do not know—they will not want to support us, they can't.

I feel that something should be done on the social security and I hope you will be able to do something.

Senator SMITH. Thank you very much, Mrs. Balcom.

STATEMENT OF ALICE DAKIN, BETHANY CHURCH, QUINCY, MASS.

Mrs. DAKIN. I am Alice Dakin, of Quincy, president of the group of senior citizens from the Bethany Church. I would like to make this very brief and change the subject if I may.

I am very much interested in hobbies and find that so many times we reach the age of 65 when we have to retire. We are not prepared, and I think it is like that they would try and get up a hobby. When I was 60 I started hobbies and I have spent 15 years going to the high schools, they have so many different courses to offer. I want to say for myself I have taken a number of things.

I would say that anyone here, senior citizens, that do not already have a hobby, that they would find one because it gives you new friends and it sort of gives you a lift in life and I think they would benefit by it.

Thank you.

Senator SMITH. Thank you. You certainly have a very important point. Individual older citizens certainly can help themselves greatly in this period of their lives.

STATEMENT OF JOHN M. REGAN, PRESIDENT, RETIRED BETHLEHEM SHIPYARD WORKERS, QUINCY, MASS.

Mr. REGAN. Mr. Chairman, my name is John M. Regan. I am happy to be president of a group of approximately 400 men in the city of Quincy which has a population of about 85,000. Out of this 85,000 there are roughly 7,500 above the age of 65. I have come in contact with many of the problems of the aged. Some of these people through thrift in years when incomes were not so high as they are today own a modest equity in their homes. Others are not so fortunate because of sickness, hospitalization, and accompanying medical expenses.

Sickness, hospitalization, and medical expenses is a threat which is common to the people. The threat of the atom bomb comes only a poor second to that of hospitalization. Many of those senior citizens have given sons and daughters to the services of their country in the U.S. Armed Forces. Some of these never came back, others came back physically or mentally disabled and have problems. Far too many never returned and are in Flanders Field or other fields in foreign countries.

This is the past many of our old-aged folks look back on, with hospitalization and medical expenses threatening to impoverish them in the future. These old-age citizens want to work, too young to die, are too proud to accept public charity and welfare. I ask that the hospitalization and medical expense be administered as is social security and discontinue his threat of poverty in his remaining years. I appeal to the Senators and Congressmen who represent them in Washington to so vote and place this on the statute books as the law of the United States in the coming 1962 session.

I thank you.

Senator SMITH. Thank you very much.

STATEMENT OF MANUEL J. MACHADO, PRESIDENT, LOWELL GOLDEN AGE CLUB, LOWELL, MASS.

Mr. MACHADO. Senator Smith, my name is Manuel J. Machado, president of the Golden Age Club of Lowell. We have 590 members and we meet twice a month. We have 300 at the meetings. I am in favor of the medical bill. Thank you.

Senator SMITH. Thank you very much.

STATEMENT OF HENRY HANSON, DORCHESTER, MASS.

Mr. HANSON. My name is Henry Hanson, speaking under the caption of senior citizen. I think there may be people here who are more interested in the environment of the rest home rather than its mechanics of economic management. Our Government spends great amounts of money on employees, scientific men, to provide sceneries for animal life. Man belongs to the animal kingdom, and I think it is little less than mental torture for a hospital in the city to send their patient a block down the street to a rest home who has arisen in the morning to the crowing of a rooster or to sleep through the night while the frogs croaked in the hollow or the crickets chirped outside.

The idea of the rest home is to provide a compatible atmosphere. I think the Government in providing the money, if we are going to

spend our last days probably in the environment of a rest home, should see to it that they are strategically placed both topographically and geographically so that the patient will be in a natural environment conducive to recovery of good health.

That is not the case in all circumstances. I think it probably is not feasible at the present time but it should be considered as a long-range thought on the subject of rest homes. Thank you.

Senator SMITH. Thank you very much.

The next speaker will be Representative William Bolger who I know is extremly interested in this whole problem.

STATEMENT OF WILLIAM BOLGER, STATE REPRESENTATIVE

Mr. BOLGER. Senator, I will speak very briefly. I am a member of the legislature from South Boston. I am not a member of any Golden Age Club.

Today I am celebrating my 11 months in public service. I came here today to find out somewhat generally about the administration's proposal to provide medical care for the aged. I will abandon that and just speak very briefly upon the remarks of another young man who came to your microphone earlier, Mr. Jack E. Molesworth. I believe his opinions are quite out of harmony with the opinions of the other young people in our society. I would suggest to Mr. Molesworth, if he is still here, that he come with me to my district in South Boston and become forcefully aware of the needs of the people who now depend upon Federal aid for their existence. Let Mr. Molesworth come and see the needs and I think his attitude will change.

That is where he is most wrong, in his attitude of the younger people of the society, that they do not care to bear the responsibility of a debt. I suggest that he is completely wrong when he says that this is the feeling of the younger people of the society. I wish that there were time to stand here and to dispute the false economic premises upon which he bases his objections to this very human, proper and Christian legislation. Thank you, Senator.

STATEMENT OF MARTIN BUTLER, SOUTH BOSTON, MASS.

Mr. BUTLER. Senator Benjamin Smith, I come here today for a purpose. Knowing some day I hope to grow old, it is God's blessing to grow old.

My mother worked for the Boston-Harmony Railroad and she has a small pension. When my father died and left my mother with seven small children I was at the age of 3. My mother went to work for the Boston-Harmony Railroad. She took the place of father and mother and went out and supported the family and raised them.

I think it is altogether fitting and proper that here in this Commonwealth with President Kennedy's medical aid to the aged, it is the finest thing that ever came out of Washington. This day here and now as I stand here speaking, I know as the clock ticks and ticks my life is going on to another life, that of the aged, and that group I hope to be my friends of tomorrow.

Knowing of the young group here in America that has to go out and do the work that has to be done and receive bodily injuries which they have to carry for the rest of their lives, knowing some might

be like myself, but now I know that I carry a burden and I thank my God every day that I am able to carry this burden. I hope I have said something in favor of the old people here in this Commonwealth and throughout the country. I thank you.

Senator SMITH. Thank you very much. Are there any other witnesses who wish to be heard at this time?

STATEMENT OF ROBERT R. RICH, ATTORNEY, LOYAL PROTECTIVE LIFE INSURANCE CO., BOSTON, MASS.

Mr. RICH. Senator Smith, I did not come here prepared to talk today but I want to correct something on the record. My name is Robert R. Rich and I am in the insurance industry.

A previous speaker indicated that the insurance industry had already spoken to you here this afternoon. As far as I know that is not correct. That individual indicated that the insurance industry consistently attacks the social security system. I think as a Member of the Congress you know that that is not true. Over the years the insurance industry has supported the basic social security law and a great many amendments to it.

We in the industry have been behind the Kerr-Mills bill. We in our various capacities have supported numbers of bills in the State legislatures and elsewhere which would help the aged. We are totally cognizant of the problems of the aged and we are doing our best to find solutions to help them. We do not want them to be indigent, we want to help them as much as we can.

We do not in most cases believe that the King-Anderson bill is the solution to the problem. I call to your attention that last year in Connecticut there was a bill passed which provides the major medical care for the aged under the sponsorship of the insurance companies of that State. We hope that something like that will soon be enacted in the Commonwealth of Massachusetts. We are doing our best as an industry to help the aged.

Senator SMITH. Thank you very much.

STATEMENT OF MARGARET T. C. MURPHY, NEW BEDFORD, AREA VICE PRESIDENT, NATIONAL RETIRED TEACHERS ASSOCIATION

Miss MURPHY. My name is Margaret T. C. Murphy, of New Bedford, Mass. I am area vice president of the National Retired Teachers Association, consequently I am speaking on perhaps an entirely different viewpoint. Retired teachers in Massachusetts do not have social security. We have about 6,000 retired teachers in Massachusetts. Those who have retired previous to 1952 have very low pensions; in fact, most of them are below $2,500 and many more are receiving about $1,600.

We have no minimum pension, we have no maximum pension. Our pension is computed on age, years of service, and a percentage. Consequently, you see, no one throughout the State has the same pension. When we are sick, when we have prolonged illness, we have to rely on the rest home. When you pay anywhere from $65 to $85 in a rest home, your pension check does not go far. Consequently, my plea

would be for adequate rest homes that would be to our advantage. Thank you.

Senator SMITH. Thank you very much.

ADDITIONAL STATEMENT OF DR. MARY C. MULVEY, ADMINISTRATOR, DIVISION OF AGING, PROVIDENCE, R.I.

Dr. MULVEY. All I want to say is that I addressed my remarks to the gentleman that made the attack on the social security system and I was of the opinion that he was speaking for an insurance company. I did not get his identification at the time but I did not attack insurance companies. I rebutted what the other gentleman had said about the social security system.

Senator SMITH. Thank you very much. The record will show that.

STATEMENT OF ERNEST D. HOWE, PRESIDENT, COUNCIL FOR THE AGED OF LEOMINSTER, LEOMINSTER, MASS.

Mr. HOWE. Senator Smith, my name is Ernest D. Howe and I am president of the Council for the Aged of Leominster which was organized in 1957 by the mayor who was very much interested in the elderly people of Leominster. We have over 2,200 elderly people in Leominster.

I was a past president of the Golden Age Club and another Golden Age Club past president was put on the committee. I was elected chairman and am still chairman now. I do not want to take too much of your time. I have some other things I would want to speak about but I am going to confine my remarks to the four articles that I think should be taken up.

The first is more housing. We have two units in London, very good ones. We want more.

The second is some way to reduce excessive prices on drugs for the aged. You know how high those are. I know myself because I have to pay for them.

Third, for the Nation or the State to provide some kind of insurance for the aged, such as reasonable prices that they can pay to help pay the extensive costs of sickness when it comes to them.

As an example of that, just for a second, I was taken sick a year ago. The doctor said that I could stay in the house if my wife wanted to take care of me until I got better and I would not need to go to the hospital. I have two sickness and accident insurance policies. I found out after I had been in the house for 3 months, confined most of the time, that neither of the insurance policies covered me because I was not in the hospital.

Now that is my point. I think we should have insurance for the aged that covers them either in the home, in the rest home or in the hospital because many of them when they are taken ill only need to be in the hospital possibly 2 or 3 days or a week and then they can go to the rest home or to their own home. If they have the kind of insurance that I have, it is cut off completely. The insurance policies of the insurance companies should be arranged by the Nation or the State in some way that they can cover both the home and the housing project or the rest home where they are confined, and that would help all of the aged people in many ways.

The fourth thing, as has been said here this afternoon, I think more work should be provided for the disabled who are willing to work to earn what they can, to help pay their bills and help the city hall to help them get along themselves. Many of them are willing to work but can't get jobs.

I would like to say that we have a Golden Age Club which was established 10 years ago in Gloucester, one of the first ones in that locality. We have seven or eight Golden Age Clubs and our Council for the Aged was established 5 years ago, one of the first ones in that section. Thank you.

Senator SMITH. Thank you very much. You are certainly to be congratulated for the fine work you have done in the Golden Age group in London.

STATEMENT OF NICK MAGLIANO, BUSINESS AGENT, AMALGAMATED CLOTHING WORKERS, BOSTON, MASS.

Mr. MAGLIANO. Senator Smith, my name is Nick Magliano. I am a business agent of the Amalgamated Clothing Workers, Boston. In addition to social security payments that they receive, they also receive $50 a month which we know even both combined they are not enough, and how many people here do not have the $50 supplement.

In 1941 my parents were sent a letter saying, Mr. and Mrs. Magliano, we need a son for the Army, and they sent my brother Tony. In 1942 they said, Mr. and Mrs. Magliano, we need another son, and we sent my brother Veno. In 1944 we sent another one, my brother Eddy. At the time the Government needed my parents, my parents responded. My mother is 73 years old. My father has bronchitis, he is 82 years old.

When the Government needed my parents, they said "Yes." Now my parents need the Government. Are we going to say "No?"

Senator SMITH. Thank you very much.

Are there any other witnesses this afternoon?

STATEMENT OF WILLIAM WATSON, PRESIDENT, GOLDEN AGE CLUB, LEOMINSTER, MASS.

Mr. WATSON. My name is William Watson. I am present president of the Golden Age Club in Leominster which has between four and five hundred members. We have been going for 11 years and the people there in our community are very interested in this social security medical aid which is before the Senate at this time.

I tried to keep the people in the rest homes and hospitals as happy as I could by taking my car, and others were doing the same, and visiting them in the rest homes and the hospitals to give the people that are in these places who have no friends and no relatives a little comfort, and they are always glad to see us. I think that other Golden Age Clubs could do the same thing by visiting these different people that have nobody only themselves.

I believe that is all. Thank you, Senator Smith.

Senator SMITH. Thank you very much.

Are there any other witnesses this afternoon?

STATEMENT OF FLORENCE H. DOE, BOSTON, MASS.

Miss Doe. Senator Smith, my name is Florence H. Doe. I am 76 years old next week. I live in Boston in a depressed neighborhood but the State is not able to cover my rent which is very small. I would like to make a couple of points that have not been made this afternoon.

One is that the Congress has increased the amount of social security several times. I happen to be receiving $75 a month for social security which is not much to live on, as you all know, in the city. Because it is not enough to live on, it is necessary to have supplement, and the only supplement we have is the old age assistance for which we are all grateful in the Commonwealth. But still I repeat that the Commonwealth is not able to cover my rent because of the rules that they have made themselves.

Now with reference to the increases in social security which we have been given by the Federal Congress, we hear a great deal about it all the time in the papers and everybody thinks that the people on social security are getting more money, but the fact is the people who are on an old-age assistance budget in this State do not get any more money to live on although we need it. So I would like to ask you and the other Members of the Senate to see if something can't be done so that when the amount of social security is increased by the Congress that the recipients of social security will receive that money and have their budgets increased instead of having our State budget so stationary that we never can have anything more to live on.

That is something that I have tried to find out who is responsible for. I have been here and there attempting to do some research on the subject. Wherever I go I get a run around and everybody says that somebody else is responsible. The State planning board said that the Federal Government is responsible because they have made certain restrictions which make it impossible for the State to give any more money to recipients of social security, and it was given to people that never did a stroke of work in their lives. You know what I mean.

So then I went to the Federal Government and the Federal Government said that it is the State that has the responsibility of this. So I have not been able to find out who is responsible and I do not have any money to hire a lawyer to look into it myself. I would like to have my Senators look into this matter and find out who is responsible that the members of social security do not receive the increase that the Government claims to give to them.

The other point that I would like to make is that it would be economical nationally for the country and the State to keep the old people in their homes; that is, to see to it that these people are given enough to live on so that they will not have to break down. Now I happen to know that most old people break down because they do not know how to eat. I personally know how to eat because I studied the subject.

I recently was in the hospital for a major operation, the second one I have had within 3 years. The first house doctors that we had told me that I am one of the healthiest women that he ever saw. So there is nothing the matter with me, ordinarily there is nothing the matter with me. All I want is enough to live on in my home.

How can I live in my home and keep my home when I do not have enough money to pay my rent? I am not the only one that does not have enough money to pay the rent. My rent is reasonable.

Not only that, but in order to keep our morale, to keep alive, to keep our personality, we need some money for social business and especially to get around the city. Anybody that knows anything about the transportation in Boston knows that it is getting worse and worse, and they also know that you cannot get very far on the amount of money that is allowed for transportation to the old people.

Senator SMITH. Thank you very much. I think you have touched on certainly some very pertinent aspects of the problem and we appreciate your testimony very much.

Miss DOE. Thank you.

Senator SMITH. At this point I would like to say that I have had the privilege of conducting three of these hearings in our committee's nationwide study this fall. Two weeks ago we heard expert witnesses and heard the public speak in Hartford, Conn. This week we have taken testimony in Springfield and now here in Boston.

I want to say that I am very happy to have had the fine audience we had here today in Boston. This is the largest turnout that we have had, and you have made a real contribution to the success of our hearing. I am certainly impressed with the interest shown by you people who have come from other cities, from Maine and Rhode Island.

The opportunity to listen to you and people like you in these town meetings has been an impressive experience to me. The fact that has come through to me so strongly is the spirit and interest shown by the statements the people have made to us, and these statements certainly have come from the heart.

It is clear that the older people desire not charity or a protected existence, but to live independently as much and as long as they can, and to have the means to take care of themselves. These are legitimate desires of older people to which we must address ourselves and find really adequate answers. I certainly shall do my part in this effort, and I look forward to serving the people of this State and Nation in this very important field.

Thank you very much for your testimony. At this point I will insert various communications received by me.

(The communications follow:)

448 PARK DRIVE,
Boston, Mass., December 4, 1961.

Senator "BEN" SMITH:

When you were at the statehouse last week, I (unfortunately) could not attend—I was working.

However, as you were dealing with old-age problems, it seems to me that something should be done about our earnings after 65.

I am on compulsory retirement since July 1. I don't want to be retired—I want to work—also with my social security of $115 per month (plus a tremendous pension of $72 gross, less taxes due, after being back with my organization for 29 years of unbroken service), shows that whether or not I felt like working I would have to.

I know a great many people I have worked with are looking forward to retirement and that's fine, if that's what they want, and can afford it. But my case is different—I want to work—but if I do get work, I can only make $22 per week, gross, and stay within my social security figures. I know I can make more than $1,200 and forfeit some portion of it. But it seems to me that if you have worked from 12 years of age—until 65—you have earned the right to be able to make more than $22 a week.

I know I can give up social security completely—and probably get myself a full-time job—if anyone will hire me—but probably would only get $60 or $65 a week, which would make very little take-home.

I should think the Government would do something, such as no limit to what we can earn, after all, at our age, it would be a mere drop in the bucket, and still collect our social security. We have earned our social security by contribution and are entitled to it, and even if we should earn $3,000, $4,000, or $5,000, we are still paying taxes plus social security. It certainly couldn't last many years, probably 5 years at most.

All these laws that are passed are intended for a good purpose, I know, but somehow or other the lone individual takes a beating. A man who made the same salary as I made and who is married, gets the same as I plus three-fourths more for his wife, and if he dies, his widow and children are all taken care of to the extent of $250 to $300 a month, and this all comes from the same total of contributions that I have made.

It's the same way with the Government housing projects. Their purpose was ideal. You had to really have practically nothing, you couldn't own a car, yet when Columbia project opened, the cars were practically on top of each other. There is always someone who knows someone politically. If you don't, you're lost.

All I want is an opportunity to work for as long as I can and be independent—but you certainly can't be independent on $22.50 a week.

This is the deal that makes the world hop aboard the "gravy train." When I tell someone I am working part time they say "I hope they're paying you under the table" and when I say they are not they tell me I'm crazy—other people get paid that way. That may be true, but I don't want to start being dishonest at this age of my life.

So some kind of legislation should be passed to allow us our earnings with no limitations. What harm would there be—and we certainly couldn't get wealthy—and also it would only be for a few years at most.

Hope I haven't bored you and hope I got my point across.

I just had a happy thought—realizing how long it takes to propose, vote, and finally pass a new law—that I imagine I probably won't be around when something is done. However, please see what can be done for people who live alone and who want nothing more than the satisfaction of being independent.

Also I forgot to mention as one gets older they start buying all kinds of insurance to protect them in every instance—I know I have—but you can rest assured that whatever befalls me it will be the thing I don't have insurance for.

Sincerely,

JULIA L. O'CONNOR.

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22 HANCOCK STREET,
Boston, Mass., November 27, 1961.

U.S. SENATE COMMITTEE ON AGING,
Sheraton-Kimball Hotel, Springfield, Mass.:

I am 84 years old, living on social security and old-age assistance in Boston, Mass., on $99 a month. It isn't easy.

Unable to attend the meeting in Boston, I would like you to know that many thousand aging people live in the Scollay Square area in that city in difficult situations.

Many blocks of buildings were razed here for new State buildings. Homeless people, mostly aged, were forced to move. The only available rooms in the vicinity were raised in price from $4 to $5 more a week. Most of these rooms have little light or heat, meager facilities, and inadequate eating places.

Worst of all are the medical problems. I went to the Massachusetts General Hospital where personnel are not able to supply my needs because I have not the fees necessary. I also find the medical aid of the old-age assistance not geared to the necessities of the infirm. We, the aged, do not understand the aspects of the present Federal medical aid to the needy.

The Beacon Hill area, back of the statehouse, is full of pitiful aged eking out a day-by-day existence on a pittance. Somehow, these needs are not being met with the present agencies, especially in the rooming house and medical field. One doctor charged me $10 for one office visit.

There is definitely much room for improvement in the city of Boston. I expect to enter the Boston City Hospital before you reach the Boston area, as I have not the strength to carry on.

I am having this typed for legibility, and that you may have the viewpoint of a senior citizen.

Yours truly,

JOSEPH B. DONAHUE.

(NOTE.—The committee has been advised that the author of the above letter is since deceased.)

264 BOYLSTON STREET,
Boston, Mass., December 4, 1961.

Hon. BENJAMIN A. SMITH,
Special Committee on Aging,
U.S. Senate, Washington, D.C.

MY DEAR SENATOR: Thank you for your letter of November 17 inviting me to attend the hearing at the Gardner Auditorium last Friday, December 1. I was very glad to be among the many present and think you did an excellent job in obtaining information on the problem of nursing homes for older people.

I should like to add a suggestion for the consideration of the special Committee on Aging. Would it be possible for the Federal Government to give more help to nonprofit organizations in building homes which offer nursing care for older men and women?

The mortgage insurance program of the FHA and the direct loan program of HHFA are giving much help to nonprofit organizations in building housing for older people. As you know, this construction may include the provision of dining halls, community rooms, and small infirmaries. It is primarily intended to house people who are ambulatory and able to care for themselves. This means that a person who is in need of nursing care is not eligible for admission to these units.

For proprietary organizations the Federal Government also provides mortgage insurance for new nursing homes. This mortgage insurance is not, however, available to nonprofit organizations. Hill-Burton funds may provide grants to a nonprofit organization up to 40 percent of the cost, but the nonprofit organ ization must provide the balance of the equity needed, and this is often difficult to raise.

Would it be possible to develop some combination plan for financing nonprofit nursing homes so that the Hill-Burton plan is maintained, but is supplemented by a mortgage insurance plan under FHA, such as is now allowed to proprietary homes, for the balance of the cost not met by a Hill-Burton grant? It would be even better if the balance of the capital could be secured by nonprofit organizations in the form of a direct loan at the lower interest rate now allowed for housing families of low and middle income.

It does not seem reasonable to me to ask nonprofit nursing homes to have to raise more capital in cash than the nonprofit organizations which undertake housing for ambulatory older people. While there is great need for both independent housing arrangements and for nursing homes, the fact that it is difficult for nonprofit organizations to establish new nursing homes results in some people seeking admission to the housing plans in order to gain the advantages of the medical care they offer before they really want to leave their own separate homes.

As much of the testimony at the hearing on Friday pointed out, there is great need for more services to people in their own homes in the community, but it should also be possible for these people to have the best possible medical care at lowest possible prices if and when they come to need nursing care. I believe that the proprietary homes must provide the bulk of this nursing care but I hope that nonprofit nursing homes would demonstrate new techniques in nursing care if it were easier for them to build new homes. At the present time the Federal financing program seems to give an advantage to proprietary nursing homes which nonprofit organizations do not have.

I wish you continued success in your efforts to secure information to improve the care of older people in our country.

Sincerely yours,

CONSTANCE WILLIAMS,
Educational Director, The Women's Educational and Industrial Union.

POST OFFICE BOX 588,
South Yarmouth, Mass., December 5, 1961.

Senator BENJAMIN SMITH,
Senate Office Building, Washington, D.C.

SENATOR SMITH: Since I was unable to attend last Friday's hearing in Boston, I am sending this postscript to my letter of November 25 as called to mind by the scant press reports. The financial statements made by all the oldsters quoted are quite plausible and consistent with today's prices. The proposals by Mr. Ernest O. Howes and Mr. John Gardner, of Saugus, are most modest considering current "just living" costs.

The opposition voiced by Jack E. Molesworth for "Young Americans for Freedom" probably was similar to others brought up on earlier occasions—that it would be unfair to burden coming generations with additional taxes to help present and future aging citizens. And yet I have been supporting ever more elaborate and expensive public schools than I ever enjoyed by my local taxes on my homestead since I graduated from high school in 1907. During that interval the rate has trebled and the valuation on the identical house and land raised sharply according to the ignorance of the elected assessors with real estate values. The Boston widows who testified at your hearing are burdened equally though they pay no direct tax bill but rather through their landlords who demand rent increases steadily. And yet few if any of these high school students, educated so dearly, try for any further technical training. Or if they do make a stab at a semester or a full year in an intellectual atmosphere, they then drop out to take some local labor job after another. Why? Because they "didn't like it," were at odds with the faculty, or failed the demands of study discipline. Meanwhile, we who pay those rising taxes must undergo the discipline of hunger and need.

I am most grateful for all your efforts in our behalf.

Most sincerely,

IRMA L. FARRIS.

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80 EAST CONCORD STREET,
Boston, Mass., December 4, 1961.

Senator BENJAMIN SMITH,
Senate Office Building, Washington, D.C.

DEAR SENATOR SMITH: Please accept, with my compliments, the enclosed reprint of my article on the "Biochemistry of Aging," which recently appeared in Science. I would like to take this opportunity to add a few unsolicited opinions concerning Federal policy in respect to research on aging.

Real progress toward the solution of many problems confronting our aging population requires an expanded knowledge and understanding of the aging process and its many manifestations which can be gained only from adequately controlled research. Research requires trained investigators whose creative abilities are challenged by the aging problem, and adequate financing. Such research is in the public interest and is deserving of Federal and private support. Recommendations were made concerning aging research at the White House Conference on Aging.

It is my understanding that current Federal planning is to incorporate gerontological research into an institute of growth and development which will also incorporate elements of child care, genetics, and mental retardation. I support this development provided gerontology be given adequate representation in its activities. It seems to me that an NIH Institute provides the instrument to create the proper kind of intramural and extramural programs in aging and can develop experimental gerontology through research, research training, and recruitment.

Certain of the problems of the aged may have solutions in the laboratory. We should provide such laboratories and the scientists to staff them.

I attended your hearing in the State House. Unfortunately, my youthful appearance was a disadvantage in getting the floor. However, feel free to use any of the above material in the record.

It seems to me that the aged have little interest in research on aging. They want financial aid for themselves. Even a scientist must admit that the primary problems of our aging population are economic. Even so, research on aging is of value, apart from its value as science. It may help alleviate some of the suffering and reduce the incidence of some of the diseases with which

they are afflicted. It may show how to maintain their efficiency as productive workers and reduce the burden on public welfare. Research may accomplish these goals at relatively small cost compared to the almost astronomical cost of increasing direct support to the individuals.

Unhappily, research on aging may merely lead to more aged, and more problems for Senators. In any event, we should know more about aging than we know now, for with knowledge comes understanding, and with understanding the power to act for the welfare of the public with expenditure of a minimum number of taxpayers' dollars.

Sincerely,

F. MAROTT SINEX, Ph. D.

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BIOCHEMISTRY OF AGING—THE MECHANISM OF AGING PRESENTS A CHALLENGE TO MODERN BIOCHEMISTRY AND BIOLOGY

(F. Marott Sinex, chairman of the Department of Biochemistry at Boston University School of Medicine, Boston, Mass.)

The present development of biochemistry and biology suggests that the question, "Why do we get old?" may be answered in the foreseeable future. There are now several ways of investigating the mechanisms of aging in the laboratory, and new insights are bound to come from work in associated areas. I shall attempt to review in this article some trends in research on the biochemistry of aging.

Mortality data provide one approach to the aging problem. Gompertz (1) observed that a plot of the logarithm of the death rate in the surviving human population against age is a straight line after maturity. A similar relationship has been found in other captive populations, such as rodents and *Drosophila* (2). In human beings, the death rate doubles every 7 to 8.5 years (3). This implies that there is a 100-fold increase in the probability of death between ages 35 and 85 (4).

If separate physiological variables are measured, such as maximal breathing capacity, renal plasma flow (5), integration of complex mental skills, and speed of voluntary responses (6), there is a definite decrease with age, although this decrease seldom exceeds 30 to 50 percent (4, 5, 7).

When an explanation of this impaired function is sought in tissue pathology, a number of changes are observed. In certain areas of the brain there is a decrease in total numbers of viable cells, amounting in some area to 25 to 30 percent, together with a decrease in the total amount of brain tissue—a decrease which may be of the order of 9 to 17 percent. At the same time, aberrations appear in the cytoplasm and nucleus of nerve cells (6).

Decrease in strength may result from a decrease in the functioning mass of muscle as well as from an impairment in innervation. Evidence for the replacement of muscle fibers by connective and adipose tissue in older animals has been reviewed by Andrew (8), who attempts the difficult task of correlating what is known of the changes with age in skeletal, smooth, and cardiac muscle.

The age decrement in discrete renal functions can be attributed to a loss of functioning nephrons. The relationship between number of functioning units and functional capacity in kidney and other tissues is reviewed by Shock in the AAAS publication on aging (7).

In spite of the great current interest in hormones and the aging process, the exact relationships between endocrine function and aging is not well understood. Pincus (9) has reviewed much of the literature on this subject and attaches particular importance to the function of the pituitary.

ENZYMES

To the biochemist the subject of enzymatic activity of aging issue is of great interest. It is not always easy to distinguish between the amount of an enzyme present in a tissue and the activity of the enzyme. It is particularly difficult to measure the amount of inactivated enzyme which might be present in tissue as a consequence of the passage of time. Very little is really known about the rate of replacement of enzyme in resting cells. Barrows, Yiengst, and Shock (10) have stressed the importance of expressing enzymatic activity on a per cell basis, using deoxyribonucleic acid (DNA) content as an indicator of the num-

ber of cells in making comparisons between young and old animals in situations where cells are being replaced by elements of connective tissue.

In certain instances, changes in enzymatic activity can be attributed to a decrease in the number of intracellular elements. Barrows, Falzone, and Shock (11) reported that the decrease which they had observed in the succinoxidase of rat kidney was associated with a decrease in the number of mitochondria per cell. On the other hand, Weinbach and Garbus (12) found that hydroxybutyrate metabolism by liver and kidney mitochondria decreases with age. Of particular interest are the observations of Barrows (13) that the cathepetic activity of the liver increases markedly with age. A phenomenon commonly associated with aging, the graying of hair, may be due to a loss of tyrosinase activity of the melanocytes of the hair bulb (14).

Within recent years there has been a better appreciation of the necessity of correlating morphological changes, both within the cell and in the total cell population, with observed levels of enzymatic activity.

IONIZING RADIATION

Ionizing radiation produces many changes analogous to those observed during normal aging. It decreases life expectancy; there is a shifting of the Gompertz function on the time axis. That is to say, the death rate of animals in any particular age group is greater after radiation. Or, to put it another way, after radiation the observed death rate corresponds to the death rate in an older age group. The slope of the function does not change in animals exposed to a single dose of radiation. As a consequence of radiation injury there is a decrease in the number of viable cells in many tissues, and these cells are often replaced by elements of connective tissue. In many cases the pathological changes which occur resemble those found in normal aging. But this is not to say that the injury sustained from ionizing radiation is identical to aging; the reader interested in more exact comparisons is referred to the reviews by Upton (15), Strehler (16), and Handler (17).

PIGMENTATION

There is an increase in pigmentation of a number of tissues associated with aging. Some of these pigments are extracellular, some intracellular. Many exhibit blue or yellow fluorescence in ultraviolet light. The pigments of heart muscle (18, 19), neurons (20), athermatous plaques (21), and elastin (22) have attracted particular attention. Histological terms such as lipofuscin and ceroid are used to describe these pigments as they are observed in tissue sections. Pearse (23) gives an excellent discussion of the ways in which liquid peroxides, lipofuscin, and ceriod are distinguished histochemically and morphologically. The most generally held view is that these pigments result from the auto-oxidation of lipid.

Harman (24) was among the first to implicate auto-oxidation and the interaction of auto-oxidized liquid with protein as a factor in aging. Auto-oxidation of lipid in vitro is characterized by an induction period in which oxidation is initiated and antioxidants are destroyed (25). Peroxides form, and systems of double bonds conjugate. Carbonyl compounds, particularly aldehydes, appear (26). Many of these products are capable of condensation and polymerization. The products of auto-oxidation are pigmented, fluorescent, tough, insoluble films that precipitate with many of the properties of ceroid (27) and ipofuscin (18, 19).

Attempts to isolate pigment from the tissue of senescent animals have been successful only in the case of the lipofuscin of heart muscle. The cytoplasmic granules of age pigment of heart muscle were isolated by Heidenreich and Seibert (18), using density-gradient techniques. Mildvan and Strehler (28) have reported that these intracellular granules may be identified with tissue particulates known as lysosomes. They found that lipid extracts of such granules chromatographed on silicic acid columns revealed a pale blue fluorescence in the cholesterol ester fraction and a yellow orange band in the cephalin fraction. Chromatography of peroxidized cephalin on paper gave a pattern similar to that obtained from the column fraction.

The yellow age pigment of nerve cells has never been isolated. Heyden and Lindstrom (20) have studied its spectra in tissue sections. Sulkin (29), who is currently investigating the nerve cell pigment, feels that the pigment is lipoidal in origin and resembles ceriod. Duncan, Noll, and Morales (30) feel that the pigment arises in mitochondria.

There is extracellular pigmentation associated with aging in blood vessels. Atheromatous plaques are reported to contain ceriod (21) and lipid peroxides (31). Preparations of acid-solubilized elastin from older animals appear more yellow. This yellow fluorescent pigmentation associated with elastin is also found in ligumentum-nuchae elastin. Partial hydrolyzates of elastin prepared with either elastase or dilute acid are yellow and fluorescent. Fluorescent pigments can be prepared from both partial and complete hydrolyzates (32, 33). Loomeijer (33) believes that lipid-soluble pigments derived from elastase hydrolyzates are derived from auto-oxidized lipid. Work in our own laboratory, as yet unpublished, also causes us to believe that the water soluble pigments of both elastase and acid hydrolyzates are derived from auto-oxidized lipid.

The degree of functional impairment from the accumulation of such pigment is difficult to evaluate. Strehler, Mark, Mildvan, and Gee (19) find that lipofuscin can account for 3 percent or more of the wet weight of cardiac muscle. Nishida and Kummerow (34) report that linoleic peroxide interacts with beta-lipoprotein in such a way as to alter its electrophoretic pattern, and they suggest that lipid peroxides may play a role in the accumulation of lipid in intima. Interpretation of the relationship between auto-oxidation and aging is complicated by the observation that accumulation of age-associated pigments in neurons is accelerated by deficiency in vitamin E, administration of acetanilid, and stress (29).

CONNECTIVE TISSUE

Interest in the role of connective tissue in aging arose from the fact that unquestionably there are differences between the connective tissue of young and of old animals (35). Both the amount and the character of connective tissue may change. In some tissues, the disappearance of cells is accompanied by replacement of the cells by elements of connective tissue.

Changes in connective tissue can arise from a variety of causes, including alterations in endocrine function (36) that stem from changes in the types of cells represented in the total population, or from chemical changes within the extracellular phase. Gross (37) has suggested that chemical changes similar to the extra cellular changes occur within cells during aging, for which the aggregation of collagen might serve as a model.

In connective tissue there are changes in the mucopolysaccharides present. Davidson, Woodhall, and Baxley (38) report a gradual accumulation of keratosulfate with age in cartillage, nucleus pulposus, and other tissues.

With advancing age collagen becomes tougher, more crystalline, and more difficult to dissolve. Elastin in human blood vessels appears less elastic and fragments with age. This fragmentation is associated with the calcification and pigmentation (39).

In the ground substance there may be an increase in density and aggregation. The significance of such changes is difficult to evaluate, but they may influence the nutrition of cells. Gersh and Catchpole (40) postulate that all interchanges between ground substance and epithelium must occur through two basement membranes, consisting of aggregated round substance, the permeability of which which probably decreases with age. However, if a dispersed colloid aggregates into a more aggregated and a more aqueous phase, diffusion through the aqueous phase may increase. In one of the few attempts that have been made to measure diffusion in young and old tissue, Kirk and Laursen (41) actually found increased diffusion coefficients for nitrogen, oxygene, carbon dioxide, lactate iodide, and glucose in nitima and media of older subjects. In some instances aggregation may decrease in senescence. Banfield and Brindley (42) report that the extractability of abdominal skin collagen in 0.1 percent acetic acid increased in subjects between 40 and 80 years of age.

The question of decreased vascularization and arteriocapillary fibrosis of aging tissue is another aspect of the problem of diffusion of essential nutrient. Changes occur with age in the reserve supply of blood and in the distribution of blood to issue. The diminution in cardiac output, with age, of approximately 1 percent a year (15–17) is in part a reflection of increased peripheral resistance. It is important that all the factors responsible for this increased resistance be recognized, and that morphological changes in the barriers between capillaries and cells be analyzed both in terms of physical chemical changes in mucopolysaccharide, collagen, and elastin and in terms of the properties of the living cells of the vessels. The question of the vascularity of aging tissue is reviewed by Landowne and Stanley (43), and by Handler in the recent AAAS symposium on aging (17).

LIABILITY OF MACROMOLECULES

It is possible that aging results from chemical changes in irreplaceable macromolecules (44). Altered molecules may accumulate in postmitotic cells and in elements of connective tissue with limited rates of replacement.

The time dependent chemical changes postulated may be of a variety of types, and may include thermal denaturation involving unfolding of tertiary structures (45), hydrolysis of amide and peptide bonds (46), and oxidation (47). Among the proteins which might not survive a lifetime of incubation at 38° C. is the extracellular protein elastin. Since it is less crystalline than collagen, it does not have the added protection of extensive hydrogen bonding to protect it against thermal denaturation and other deleterious chemical changes.

AGING AND THE GENE

There is evidence to support the belief that many of the changes which accompany aging occur in the nucleus. Such evidence includes the observation of abnormal nuclei and abnormal cell division in senescent animals (8), as well as the difficulty which adult tissue has in initiating the first mitotic events in tissue culture or after stimulation.

Adherents of the theory that aging is centered in the nucleus generally believe either that aging is an extension of normal differentiation or that it is due to accidental genetic noise.

The first group points out that, while we as individuals may view aging as a catastrophe, it probably serves a useful evolutionary purpose in insuring succession of generations. Insect physiologists and plant physiologists are particularly likely to hold this view. Many insects, in the adult form, have a relatively short life expectancy and may even be born without mouth parts. In such insects differentiation produces a phenotype with a limited life expectancy. The death of an annual plant often appears to be the final step in an orderly development. One may therefore argue that aging is a deliberate event, consisting of differentiation to a point where the interdependence of tissue and cells is incompatible with the indefinite life of the total organism. The deaths of individuals, could however, contribute to the survival of the species by insuring a progression of generations and reducing competition for the food supply between young and old. Dobzhansky has ably presented aging as an adaption of evolution (48).

A second group holds the view that aging arises from genetic noise or random somatic mutations. Henshaw (49), Failla (50), Szilard (51), and Strehler (16) have all discussed theories of aging based on somatic mutation. These are reviewed by Glass (52) in the recent AAAS publication on aging.

The rate constant for somatic mutations viewed as chemical reactions would be very small, possibly of the order of 10^{-13}. If genetic material had the thermal stability of purified DNA (53), there would be little probability of thermal mutation, because of the great stability of the hydrogen-bonded DNA helix. On the other hand, in certain cells, genes may be considerably less stable than purified DNA. The rate constant for thermal mutation of *Escherichia coli* and *Bacillus subtilis* is of the order of 1×10^{-6} at temperatures between 55° and 60° C. (54). Human genes of this order of stability might undergo considerable spontaneous somatic change at 38° C. Such deductions, however, must remain speculative until they can be made to rest on firmer experimental evidence. It will be difficult to demonstrate that random somatic mutations do occur in aging tissue, particularly if such mutations are truly random. However, an effort should be made to ascertain whether clones of cells from aging individuals have altered biochemical properties. The graying of hair might be an example of a somatic mutation in aging melanocytes (14).

A particular aspect of genetic interest concerns the instructive theory of antibody formation. Is there an impairment in self-recognition in aging animals due to alteration in either antigen or antibody.

Somatic theories of aging have appeal to those who feel that ionizing radiation also produces somatic mutations, for such theories would explain the similarity between aging and radiation injury.

FREE RADICALS

The similarity between certain aspects of radiation injury and aging may reflect common physiological and cellular impairments or, as suggested by Harman (55), may be due to analogous chemical events, such as free radical reactions (56), occurring in both radiation-induced and normal aging. Concepts

based on the chemistry of the free radicals produced by ionizing radiation have proved very helpful in explaining the biological effects of such radiation (57).

There is a growing body of evidence, based on findings of an accumulation of pigment believed to arise from auto-oxidized lipid, that auto-oxidation occurs insenescent tissues. It is thought that auto-oxidation proceeds by a free radical mechanism with formation of peroxides and of both carbon and oxygen radicals. More attention should be given to the substances which might initiate such reactions in tissue, such as trace metals, hematin, hydrogen peroxide, or oxygen itself. Free radical hypotheses have the attractive feature of suggesting that preventive therapy with specific antioxidants is a possibility.

SUMMARY

It should be apparent that while no one really understands all the fundamental mechanisms underlying the aging process, progress is being made, and theories are being advanced which may be tested in the laboratory.

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METROPOLITAN HOSPITAL,
METROPOLITAN HOSPITAL CLINICS,
1800 Tuxedo Avenue, Detroit, Mich., December 5, 1961.

Senator BENJAMIN A. SMITH,
Committee on Labor and Public Welfare,
Senate Office Building, Washington, D.C.

DEAR SENATOR SMITH: I regret very much my inability to respond to your invitation of November 17 to be present at the hearings of the Special Committee on Aging in Springfield and Boston November 29 and December 1.

As a supporter of Senator Hill's S. 1071 and also H.R. 4222, I would have appreciated the opportunity to listen and possibly participate in the discussion.

The enclosed broadcast which I was asked to give over station WBAI in New York and San Francisco may be of interest to you or Senator Hill.

Sincerely,

ALLAN M. BUTLER, M.D.,
Director of Clinical Services.

BROADCASTS GIVEN OVER RADIO STATIONS IN NEW YORK AND SAN FRANCISCO BY DR. ALLAN M. BUTLER

Because of the confusion resulting from prejudice, misleading and, at times, false statements about financing medical care of the aged under the provisions of the Kerr-Mills AMA-endorsed act, i.e., Public Law 86-778, and of the King-Anderson bill (the administration bill) now before Congress, an attempt to outline briefly what both are and are not seems desirable.

The Kerr-Mills Act, Federal law 86-778, makes Federal support available for State welfare medical care. The means test of eligibility for welfare medicine

varies from State to State; for example, the maximum income per year per person varies according to State from $500 to $1,800, or per couple from $1,500 to $3,000 with maximum capital resources varying from $750 to $7,500, including assets of adult children, who, in some States, must contribute toward support of the needy before any medical assistance can be made available. Where the lower figures pertain many medically needy will not be eligible. Should the liberal eligibility of some States and the unlimited services of the Federal law be adopted generally, 75 percent or more of the 16 million aged might be eligible for unlimited medical care under the State laws that implement the Kerr-Mills Act. Clearly, the costs could add up to a very large sum, of which 20 to 80 percent would be provided by the Federal Government from general tax funds. Yet this law has not been denounced as socialized medicine or even as a foot-in-the-door of socialization, though it surely is and seems a poor form of such.

Question. Dr. Butler, why is Public Law 86–778 (the Kerr-Mills Act) a poor form of socialized medicine?

Dr. BUTLER. Because this bill provides "free medicine," since the majority of those eligible will be paying little into the general tax funds from which the Federal and State Governments will cover costs. Moreover, this law does not encourage individual self-reliance or foresight in making provision for meeting the cost of medical care in old age when you need most care and can least afford it. It does not prevent pauperization by illness. It introduces inherent opportunity for political influence and corruption in the determination of eligibility by politicians or the local bureaucrats that administer the costly means test. It tends to support and extend the poor fragmented quality of current welfare medicine. It limits the choice of doctor by patient to those doctors who elect to serve welfare patients and much of the medical care is given without free choice at welfare or charity hospitals.

Thus the Kerr-Mills Act is almost everything the American Medical Association objects to.

So it is strange indeed that this is the law the AMA endorses, saying it "preserves the quality of medical care—maintaining the patient's freedom of choice."

Question. How about the King-Anderson bill, Dr. Butler?

Dr. BUTLER. The King-Anderson bill (the administration bill) now before Congress is a very different bill serving a different purpose. This bill proposes an extension of the benefits to aged beneficiaries under the old-age, survivors and disability insurance programs of the Social Security and Railroad Retirement Acts, by including defined hospital, nursing home, and home health services.

It thus provides through existing social security the means of prepaying during working years for the medical care of old age. This care will then be received as a respected paid-up right. It will avoid for many the indignity of charity and the poor fragmented quality of current welfare medicine. If the American people through the democratic process freely choose to make this bill law they will freely choose to enable people to practice self-reliance and foresight by prepaying during working years for the medical care required in old age. In so doing, they, as self-reliant people, will lessen the charity burden to society imposed in becoming a welfare recipient of free medicine. There will be no inherent political influence by the bureaucracy that administers a costly means test. There should be no ill-defined cost to be met from general tax funds. There will be the same free choice of physician by the patient that he has had during his working years—indeed, if he has had a personal or family physician he can continue that relationship with the physician of his choice. The bill states that the benefits specified would be provided "in a manner consistent with dignity and self-respect of each individual, without interfering in any way with the [patient's] free choice of physicians or other health personnel or facilities without exercise of any Federal supervision or control over the practice of medicine by any doctor." And later, the bill states, "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine." Yet the AMA says the bill "includes loss of freedom. Your freedom to choose your own doctor. We must all recognize that when the physician is socialized, his patient is socialized." And continuing the AMA says, "It would lower the quality of health care, with remote and impersonal bureaucratic control replacing the confidence and closeness of the doctor-patient relationship."

The fact is that the bill does not socialize the physician, as it does not affect physician services nor does it affect free choice of doctor-patient relationship,

except as it enables the aged patient to have more free choice and a better relationship with his doctor by preventing the aged from being pauperized by costly hospital and nursing home care. Incidentally, the Blue Shield does socialize the physician to the extent that he is paid for services to Blue Shield members by a third party according to a fee schedule. The AMA also states the King-Anderson bill "would lead to the decline, if not the end, of voluntary health insurance." Actually, it would free such insurance of the heavy utilization and costly medical care of the aged.

Question. Dr. Butler, doesn't the AMA denounce this bill as socialized medicine?

Dr. BUTLER. Of course the King-Anderson bill is socialized medicine as is the Kerr-Mills act; Public Law 86–778, veterans medicine, and the medicine of our State, county, and city hospitals. Indeed 25 percent of our health and medical care is socialized medicine financed through Government agencies and much of this socialized medicine is of high quality. In addition, there is the medicine socialized by having financed through private groups distributing the cost by prepayment; such as Blue Cross-Blue Shield, H.I.P. in New York, the Kaiser prepayment services in California, and many others. So we don't need to be afraid of a foot in the door of socialized medicine. Socialized medicine is a major part of our medicine today. We should be concerned with its quality and economy, and its prevention.

The King-Anderson bill would provide paid-up insurance for some 13.5 million social security and 0.5 million Railroad Retirement Act beneficiaries. The Kerr-Mills Act, Public Law 86–778, would give assistance to those not eligible for benefits under the King-Anderson bill and those whose medical care exceeds the benefits of that bill. Thus, the two bills are complementary.

Question. Dr. Butler, I take it you are saying we need both the present law and the proposed bill?

Dr. BUTLER. It is not a question of the one or the other. The King-Anderson bill will prevent the need of extending welfare medicine under the State acts that implement the Federal Kerr-Mills Act or Public Law 86–778. The Kerr-Mills Act will provide the needed care not covered by the King-Anderson bill.

The need and soundness of using social security as a means of obtaining paid-up insurance to cover the cost of medical care in old age has been endorsed by President Eisenhower's White House Conference on Aging and by such high-ranking Republicans as Governor Rockefeller, Marion B. Folsom, and Arthur Larson. The American Public Health Association at its recent meeting in Detroit adopted a resolution stating in part, "whereas the burdens of the costs of good care for the aged can be minimized for the aged, their families, contributors to voluntary insurance plans, charitable agencies, and taxpayers through arrangements, effective through the worker's lifetime, which provide paid-up insurance for the older years and whereas it has become evident that appropriate and feasible ways to provide for sound financing of adequate health services for a growing proportion of older persons in the United States are essential, therefore, be it resolved * * * that the American Public Health Association support appropriate proposals, including social security mechanisms, to provide for sound financing of adequate health services, to be available to the aged individual without means test and on a paid-up basis without addition fees for payment for services rendered in institutions, outpatient departments, and organized home care programs." Thus the association endorses the essential provisions of the King-Anderson (i.e., the administration) bill.

Question. You have told us what several Republicans and the American Public Health Association thinks of the King-Anderson bill. What about the AMA?

Dr. BUTLER. Well, would that the AMA would spend on supporting the King-Anderson bill the millions of dollars budgeted this year for opposing this bill by speeches, full-page advertisements, lobbying, and pamphlets distributed through the mails and from doctor's waiting rooms. Thousands of doctors regret that the AMA by dragging its feet to resist medicine keeping abreast of change is muddying waters that should be kept clean if we are to see the problems of our aged with a clarity essential to their constructive solution. And, thousands of doctors, who are fairly and fully informed as to the need of medical care for our increasing aged, the problems of providing such care, and the proposed solutions, endorse the social security approach of the King-Anderson bill as the best way to assure our assuming in our working years the responsibility of financing with foresight the personal, continuing, and good quality medical care the majority of us will inevitably need in aging and should receive with dignity.

81 CROSS STREET,
MALDEN, MASS., *March 19, 1962.*

The Honorable BENJAMIN A. SMITH,
Senate Office Building, Washington, D.C.

DEAR SENATOR SMITH: From the Boston newspapers I have seen your name mentioned in connection with the various public meetings of aged citizens, in which their need for cost-of-living increases and medical care on the home and office visit level was aired, and I was interested to read your statement: "I wish all the Senate Members were here to hear this testimony." You further stated that you would bring the matter to their attention, and that the first order of business at the next session of Congress would be the social security law.

This information brought comfort and hope to the hearts of many social security pensioners who have been completely neglected as far as cost-of-living increases and adequate medical care are concerned.

Since the newspapers did not carry the time of these special meetings, it was impossible for all interested pensioners to attend, so I beg permission to state the personal problems of my sister and myself, which are duplicated many times over throughout the social security pension groups.

We worked during the depression years for very low wages, mistakenly thinking that we were being patriotic by helping to keep the wheels of industry turning, although we could have been better cared for if we had worked under WPA, or other Government agencies. We kept our jobs during the war years, when wages were stabilized, unless one worked under union rules, so our wages were once again below average. Our beloved President, Franklin D. Roosevelt, established the social security law, but it omitted many fields of service, among them educational, in which I was employed, with the result that I had to earn my social security pension after retirement, on a part-time basis. My sister worked from the time the law was established until she retired in 1949, but continued for some years on a part-time basis. The net result of our labors: Social security pension for my sister, $69 per month; for myself, $71 per month. Since I worked in a college I paid into a pension fund and from that receive $66.67, after 25 years of service, making our net income $206.67, less Blue Cross-Blue Shield which is deducted by the college. Out of this we must pay $65 per month rent, approximately $8 per month gas and electric, and $6 telephone (and since we have each had to telephone for emergency treatment we feel this is a necessity).

Until 2 years ago I was able to type theses and reports and earn a little money toward cost-of-living expenses and medical care, but a bout in hospital put an end to this. Until June this year my sister was able to earn a little money toward such expenses, when she became seriously ill and her activities had to end. For 5 years she has been under the doctor's care for excess fluid and angina, but following this attack she had to have the doctor twice a week at $6 per visit, and pills costing $10.60 per month for one kind, $5.25 per month for a second kind, and two other kinds costing $2.25 and $0.95—quite a goodly sum out of a pension of $69 per month. Consequently, in October 1961 she applied to the welfare department for medical aid. In order to get this we had to reduce our joint savings to $1,000, since a welfare recipient must also be a pauper. In addition, I had to justify my earnings over the previous 10 years in order to satisfy the welfare board that all of the money was not my sister's. In addition to this, I finally had to sign a paper saying that all of the money was mine. I made it quite clear that this was an untrue statement, but they insisted it be signed. Truly the wealthiest nation in the world, and the only one which requires its needy aged to be paupers. Our inability to earn money to help with our medical expenses stems from the fact that my sister is 78 years of age, and I shall be 76 in May—not usually considered productive years. Unfortunately, I need medical care at this time, with badly abscessed ears, which are attributable to my efforts to save on medical care and rely on my own medication, which in the end is more costly, but it is necessary to avoid doctor's fees where possible. In a speech made in Portland, Oreg., by our President, when he was campaigning for his high office, he said:

"With the cost of living continually spiraling upward, with the cost of basic items continually rising, $72 a month or $1,000 a year cannot pay for even the basic rudiments of a decent and dignified old age. And, even worse, the substandard incomes, the poverty and neglect, tend to destroy the morale and self-respect of our older citizens.

"And this poverty and hardship becomes heartbreak and despair when illness threatens. No costs have increased more rapidly in the last decade than the cost of medical care. Medicine and drugs are more expensive than ever before—hospital rates have more than doubled; doctor bills have skyrocketed.

"And these rising costs have had their greatest impact on our older citizens. Almost 20 percent of all those on social security must use one-quarter to one-half of their meager annual incomes for medical expenses alone. Those over 65 suffer from chronic diseases at almost twice the rate of our younger population; they spend more than twice as many days restricted to bed, and they must visit a doctor almost twice as often. And even these impressive figures do not tell us of the uncounted thousands who suffer from lack of needed medical care, from lack of vital drugs and from lack of hospitalization, simply because they cannot afford to pay the bills.

"Of course, some of those who are now uncared for can get free health care. But such public assistance is often painstakingly slow; the tests for giving it are often rigid and unrealistic; the care itself is often impersonal and inadequate."

I have quoted the speech to this extent to give you the context leading up to the last paragraph, to point up the fact that in granting my sister medical aid the board made her an allowance of $10 per month. Presumably this is because we like together, but when she has paid her share of the rent $32.50 she has $46.50 per month to cover living expenses. As I said, I also need medical care; my office visit costs $5 and my pills $6.95 per week. I suffer from arthritis and suffer great pain because I cannot afford to take treatments; also I suffer from low blood pressure and cannot afford to get my shots as often as the doctor would wish; in fact, I wait months between visits to his office unless it is an emergency, as is the case at present with my ears.

I see by Friday's paper that Congress passed a bill for a Federal-State welfare program along lines recommended by President Kennedy, which would boost the budget for welfare payments by $140 million. The welfare recipients in Massachusetts, by the boast of many of them, receive as much as $118 per month. By President Kennedy's own statistics the average amount of social security pensions is $72 per month. On what basis does he and the legislators arrive at the conclusion that the welfare recipients should receive still greater pensions, while the social security pensioners should continue to live in poverty and hardship while the bill which would give them aid is kicked around like a football? The need of social security pensioners is to have their pensions increased to an amount equal to the existing welfare pension in each State, with medical care on the house and office visit level—aill the care now enjoyed by welfare pensioners, many of whom have not contributed in any way. The social security pensioners have at least a small sum upon which the legislators can build; they also, for the most part, have some health insurance, which would pay part of their hospital bills. Surely they are entitled to "the peaceful and decent life which their years of productive labor have fully earned and which a grateful America should gladly provide—which America must provide." (Excerpt from speech made by Senator Kennedy in Portland, Oreg.) Our great need is now, not next May or next June. The $140 million appropriated should be spent now on bettering conditions of social security pensioners. How can intelligent legislators discriminate so disgracefully against one group of hard-working people, and give so much to a group, many of whom contributed nothing? This is America. Such discrimination is alien to our creed.

The social security bill which the President signed giving a cost-of-living increase to widows was the most disgraceful piece of discriminatory legislation ever enacted. As you know, all people under social security paid the same percentage on their salary—the males paid no more for their dependents, but pensions for these people would come out of contributions made by social security contributors without dependents. These men received a much higher rate of pay than women, consequently the widows, in the greater majority of cases, were able to save and invest more for their old age, yet they received an increase which was denied to single people and working widows. By this action the President created a group of people existing on the very lowest level of living conditions and medical care. If, as he stated in his speech at Portland, Oreg., he felt the substandard incomes, the poverty and neglect, tend to destroy the morale and self-respect of our older citizens, he may be assured the social security pensioners in this substandard category have just about hit rockbottom.

Please accept my apologies for this long letter. Legislators are apt to deal with statistics. You heard facts at the meetings for the aged which you have attended, and I hope I am not out of order in adding to the facts which you have accumulated.

Respectfully yours,

LUCIA M. HUNT.

Senator SMITH. I declare the meeting adjourned. Thank you very much.

(Whereupon, at 4:55 p.m., the hearing was adjourned.)

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