

PROBLEMS OF THE AGING

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

Part 12.—Hilo, Hawaii

DECEMBER 1, 1961

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|-----------------------------|---------------------------|
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| Part 2.—Trenton, N.J. | Part 9.—Honolulu, Hawaii |
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| Part 5.—Eugene, Oreg. | Part 12.—Hilo, Hawaii |
| Part 6.—Pocatello, Idaho | Part 13.—Kansas City, Mo. |
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PROBLEMS OF THE AGED

FRIDAY, DECEMBER 1, 1961

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

The subcommittee met at approximately 10 a.m., in the courtroom of the Federal Building, U.S. Senator Oren E. Long of Hawaii (chairman of the subcommittee) presiding.

Present: U.S. Senator Oren E. Long of Hawaii and U.S. Senator Wayne E. Morse of Oregon.

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

Senator Long (presiding). The meeting will please come to order.

This is the fourth and the last meeting of the subcommittee of the Senate Special Committee on Aging.

First of all, I want to express my appreciation of the splendid turnout here. This has characterized each of the four meetings. We had about 300 in Honolulu. That isn't very many for that segment of the population. We had 96 by actual count in Kauai. And I am not certain what the turnout was yesterday on Maui, but the room was full; in fact, it was overcrowded.

First, I want to express my appreciation to a very busy Member of the U.S. Senate who looked forward to this trip and, at perhaps some sacrifice, planned his time deliberately so that he could give a week of it to the Aloha State. I say that he gave time because it just happens that the senior Senator from Oregon will be running—and running successfully, I am certain—for his fourth term in the Senate of the United States. From comments that I have heard him make during the past 5 days, I think that he has found real satisfaction in coming here, not that he needed to justify his attitude. From the very beginning he was an ardent advocate of statehood for the two Territories, Alaska and Hawaii. And what he has witnessed here this week has, if there was ever any doubt in his mind, I am certain removed any possible doubt from his mind as to the wisdom of that point of view.

I wish at this time for the record to list the members of the staff and to pay tribute to them. A gathering like this doesn't just happen. Somebody does a good job of planning. I wish particularly to mention Mr. William G. Reidy, staff director; Miss Dorothy McCamman, our expert on social security and professional staff member; Mr. John Guy Miller, counsel for the minority. From my own staff,

Mr. Charles James, formerly of the University of Hawaii and now my legislative assistant in Washington; and my Hawaii representative, Mr. George Shiroma.

We have also had the complete and most effective cooperation of all of the agencies here in the State. You people help by your presence here, as have others.

Now, the purpose of this meeting is not to give answers—not on the part of Senator Morse or myself to give you the answers. We have convictions on the problems of aging. Certainly, we both have had a long-time interest in it, particularly Senator Morse. We do have convictions but we are also seeking added information. We want to know about your problems. We want your suggestions.

May I reemphasize that we are not here on behalf of any particular law that is now in the statute books or any pending bill before Congress. There are such bills and we have both worked on them but their merits are not our main concern today.

This morning, in addition to what I will refer to as the professional witnesses who will be here, we are interested in hearing from some of our good friends, the senior citizens. So far, that has been the feature of each of the meetings, and the comments that we have heard have been most interesting and most helpful; and I am certain that this meeting will bring forth the same valued comments.

Now, if for any reason anyone present does not desire the opportunity to appear and to make a statement at this time, we urge you to submit a written statement. For that purpose, we have on the table envelopes and letterheads for your use. Any time up to 30 days, will you share your thinking with us and your suggestions and your recommendations? Everything that is said here this morning will appear in the record, and any statements that you submit in writing later on will become a part of it. The record will go through our committee under the chairmanship of Senator Pat McNamara of Michigan to each Member of the Senate and, since it is a public document, it will then go here and there throughout the 50 States to people who are interested in it.

I thank you for your presence here this morning, and we look forward to 2 or 3 very interesting and constructive hours.

At this time, I would like to call on the senior Senator from Oregon to share with us some of his thinking on this, briefly.

STATEMENT OF HON. WAYNE MORSE, A U.S. SENATOR FROM THE STATE OF OREGON

Senator MORSE. Senator Long and friends, I have made a practice on these hearings of not making any statement, but it so happens that I am going to have to leave at 12 o'clock this noon and will not be able, Senator Long, to remain with you throughout the hearing. And I do want to take just a minute or two, to say goodbye to Hawaii, and to express a reaction or two that I have had since I have been in the State.

First, on behalf of Mrs. Morse and myself, I want to thank you, Senator, and the members of our staff and those associated with us in these hearings and the people of Hawaii for the wonderful hospitality that has been extended to us. The last time I was here was in

1957, and during that time I made a survey in regard to statehood as far as reinforcing my already formed opinion in regard to the desirability of statehood for Hawaii, and I have never regretted the course of action I have followed. The Republic has been greatly strengthened by the addition of the 50th State to the flag.

Your hospitality has been wonderful and your education has been wonderful, because I look upon these hearings as seminars, dealing with a whole series of very important public policy questions in regard to which we, as a free people, are not of unanimous opinion. Of course, that is the strength of freedom.

After all, you remain free as long as you retain the very essence of democracy, which is that you remain the masters of the state; and the state remains your servant. And, as the Senator says, we are not here in regard to any particular bill, although the testimony is bound to bear upon a whole series of legislative problems.

And, of course, we sit here—at least, I sit here as one who has a very definite point of view in regard to legislation that I think the public policy requires—as cosponsor of some of that legislation, I shall continue to tie the facts as I find them to that legislation.

Of course, my basic tenet in regard to this type of legislation is that I hold to the point of view that one of the responsibilities of a free society of self-governing people is to translate into legislation the great moral values and moral principles that we claim, as a people, to hold dear as a part of our spiritual philosophy. I happen to believe that it is the responsibility of Government to translate into legislation the spiritual and moral tenets that we claim ought to govern a society of people who believe in moral values.

And when you get into this problem of medical care, into this field of care for the aged, into a consideration of the various aspects of social security—that's exactly what you are dealing with; you can't run away from it—we have honest and sincere differences of opinion as to how best to carry out our moral principles, but we certainly, I think, have to agree, as free men and women, that we do have a responsibility to practice what we claim are our spiritual and moral beliefs that we are "our brother's keeper," that we do believe in putting into practice the Golden Rule. And I have always taken the position that those principles are not limited to the environs of our churches. Those principles have to motivate us in our daily lives.

And with that philosophical statement—at least as to what my personal philosophy is—I want to say, because there will be those who are bound to disagree with my point of view—I want to say that there is nothing new about the great controversy that exists, legislative-wise, in this whole field of social security and medical care and aid to the aged. As you know, Senator, I consider myself the most non-partisan person in the room, for I have belonged to all of them at one time or another and have never changed my philosophy or my principles—just my party. I want to say, though, that in many fields I am a disciple of great Republican leaders. You heard me discuss this at the banquet the other night—the fact that I am a disciple of the great Arthur Vandenberg in the whole field of foreign policy.

Well, in this field, I am partly a disciple of probably the leading conservative of our history, Alexander Hamilton, Secretary of the Treasury. Although long before the formation of the Republican

Party, he was considered to be probably the Father of the Republican Party. And I would just like, in a sense of good humor, although it is an historic fact and it relates to the problem of today, to point out that I like to look at Alexander Hamilton as the father of the proposal for the principle of the social security system for the care of the sick, because it was in 1798 that Alexander Hamilton proposed to the Congress of the United States a bill that in principle is identically the bill that I have been advocating in the Senate of the United States since 1958. In fact, I introduced into the Senate the Morse version of the Forand bill that would provide for medical care for the aged under social security, and it went much further—it goes much further than the Forand bill. I include complete medical care and I also include all those that are not covered by social security. In my bill, I take the position that the aged not covered by social security, as far as the other phases of social security are concerned, should be brought in, as far as medical care is concerned, in the bill.

Well, Alexander Hamilton, an ultraconservative greatly concerned about property rights, as I am, thought it was unfair, for example, that the local taxpayers should be paying such a large share of the cost of the medical care of seamen who came off the ships in New York and Philadelphia and Boston and Baltimore, and other great ports of America, sick, who had been abroad and collected scurvy and tuberculosis and all the epidemic diseases of the time. The local taxpayers had to pay for their care. They left us healthy people and thousands of them came back as sick people. So he introduced a bill—quite different, may I say good naturedly, from the Kerr-Mills bill, which is so limited and places so much of the burden on the local taxpayer. He introduced a bill that would provide for a Federal health insurance plan for the seamen, and it was passed. And it was the beginning—don't forget, it was the legislation that led to the formation of the U.S. Public Health Service and the Department of Health.

And all I say, Senator—not for controversial purposes, but so that people know what my biases are—You know, I admit I have biases; Most people call their biases convictions, but I admit biases—biases in connection with this philosophy that I talked about. Of course, Alexander Hamilton spoke at a time long before Bismarck and Karl Marx, and they didn't call him a creeping Socialist, as they do me. He was standing for a great social principle that I am going to stand for, but modified as we find it necessary to modify it in accordance with the facts that are developed in just such hearings as these. And I am about through. This is the last statement I will make on this educational tour of ours, Senator, but modify it in accordance with what is necessary, in order to, in a democracy, get a uniformity of opinion to the degree that we can call it majority opinion.

But I would be untrue to my President if I didn't say that on this general principle I bespeak the objectives of the President. The President has made very clear his position and support of a social security approach to this matter for the care of the aged. I intend to continue to be of what assistance I can to bring about that. I think it is coming. I know where the objections come from, but I want to say to my friends in the medical profession that what we have got to do is to, in some way, somehow, iron out on the anvil of conscionable compromise a workable program which is going to have to be, in

my judgment, much better than the Kerr-Mills bill. The Kerr-Mills bill doesn't even permit the selection by a patient of his own doctor, and that is why Senator Humphrey has pending before the Senate an amendment that will do that. I am always at a loss to understand the enthusiasm of the physicians for the Kerr-Mills bill and at the same time the great objections to the bill that I sponsored, when my bill at least guarantees the selection of the physician by the patient.

And, of course, it raises this whole question of the uniform application of the cost of the medical care to all the people of the country, just as Alexander Hamilton, back in 1798, thought ought to be the principle—limited, of course, to the very segmented group of the population known as the "disabled and sick seamen."

I haven't done this before, Senator, but I have taken these few minutes to lay out the framework of this great legislative controversy, with a plea on my lips. We have to approach it, not emotionally; we have to approach it not by assuming that those who disagree with us have horns just as we think that those who disagree with us shouldn't jump to the conclusion that we are barred men and have horns just because we don't agree with them, but try to find where the best area of agreement can be, keeping in mind what our ultimate duty and objective really is and carry out the moral obligation that fellow Americans, less fortunately situated than the rest of us, are entitled under a system of free government to see to it that we put into practice the teaching that we are our brother's keeper; also keeping in mind that what we decide in this sphere in the last analysis we are deciding for ourselves because even some of us who may not quite yet be considered in the group of "the aged" we will soon be there. And I think we have a duty in our generation to lay the foundation for a program in our country that really will take care of the aged in a much better way than they are being taken care of in many parts of our country, because it is true—and I close with this—that hovering over the housetops of millions of homes in our society is the lurking fear that if a serious illness or accident breaks out under that rooftop, it not only will wipe out the lifesavings of the person afflicted, but of a sister or a brother or a son or a daughter.

And I happen to believe that we have reached the point in the development of our society where this great system of economic freedom of ours is capable of seeing to it that people can live out their lives without that fear, knowing that in their earning years they will have contributed to a social security fund that will guarantee them complete medical assistance—not just partial—without any of the escape clauses that the fine print of too many insurance policies contain. Give them assurance that they are going to get full medical care, irrespective of their economic status.

That is the great controversy. I have outlined it. I don't ask for agreement, but as one who believes in a democratic society I renew my pledge that I shall do my very best as a member of the committee, Mr. Chairman, to see if we can't work out a workable compromise that will carry out a moral obligation of adequate care for the aged of our country.

Thank you very much.

Senator LONG. Thank you, Senator Morse.

As has already been indicated, the Senator will have to leave a little early, but I can assure you that because of his interest he will stay as long as he can.

We appreciate your presentation of your convictions. I know you haven't arrived at them lightly. And I can assure you that if there are people in this audience of the citizens of the county of Hawaii who disagree with you, they will express their disagreement freely and perhaps with an equal show of conviction. That is the purpose of the meeting, an exchange of ideas.

We would be pleased at this time to have the chairman of the county board of supervisors, Mr. Thomas Cook, as a witness.

STATEMENT OF THOMAS COOK, CHAIRMAN, COUNTY BOARD OF SUPERVISORS

Mr. COOK. Hon. Senator Oren E. Long, Hon. Senator Wayne Morse, members of your panel and committee, I would like to extend to you the greetings from the administration of Hawaii County. We most certainly are happy that you are here today and I am certain that from this hearing will come ideas and the expressions from our people, here in Hawaii County, which we hope will guide you in making laws that will be of benefit to the aged people of our country.

We do realize, and we have for a long time in Hawaii, that this problem of the aged is one that affects everyone here. It is something we are all interested in and we do know that the people in the United States have an average per capita of aged that is the greatest in the world. We have more old people in the United States than they have in any other country. This is due to many reasons. One of the reasons is our way of life—the way that our country allows us to live. Another is medical science—modern medical science, which has prolonged life.

We realize a lot of these people—some of them are here today and will make remarks—are still active, both physically and mentally. They are people who still have a place in our community, regardless of their age. There are others who are not as active and, possibly, some will be the responsibility of the Government. But from this meeting this morning I hope that you are able to get some information that will be of help to you.

Senator Morse, we are very, very happy to have you here, and I would like to extend an invitation to both you and Mrs. Morse to return sometime when you have time and enjoy the scenery of our island and perhaps do a little fishing in Kona.

Senator MORSE. We accept.

Mr. COOK. Thank you very much.

Senator LONG. Thank you, Mr. Chairman.

We will now hear from a member of the State commission on aging, who is the industrial relations director of the Hilo Sugar Co.—Mr. Anastacio B. Luis.

STATEMENT OF ANASTACIO B. LUIS, MEMBER, STATE COMMISSION ON AGING, INDUSTRIAL RELATIONS DIRECTOR, HILO SUGAR CO.

Mr. LUIS. Honorable Senator Long, Senator Morse, members of the staff, before I go into the subject matter that I am supposed to present this morning, I would like to express the appreciation of myself and the commission for the assistance that has been extended by the county chairman and the members of the board for assisting us and helping us make this hearing a success—the turn-out today testifies to that fact—and also to Mr. Minaai for his help in promoting this meeting.

We are pleased that this subcommittee is devoting its attention to the subject of aging in its broad form, and I am sure that by your coming here today our people will realize the magnitude of this problem; and we appreciate the opportunity to appear before you and discuss some of the basic issues involved. We hope the broad framework of these hearings can provide the basis for constructive approaches to the problems of aging.

It is possible that most of us, if not all of us here today, are experiencing for the first time the opportunity to appear before such distinguished gentlemen, and to say that we are somewhat nervous is putting it mildly. However, we were assured that this meeting is not the type of investigative hearing that we often see in television and that we are here to speak our minds and express our views on the problems of aging.

From there, I would like to proceed to my prepared statement on implications of aging in plantation communities.

As has been already stated, I am the industrial relations superintendent of Hilo Sugar Co., one of the 12 sugar plantations on the island of Hawaii.

The company with which I am connected is an average-sized plantation, having 305 employees, and I believe that the implications of aging in this company are also true with other sugar plantations in the county of Hawaii.

Presently, there are two categories of pensioners at Hilo Sugar Co.—(1) those who retired under the old informal pension plan; and (2) those who retired under the present industry-union negotiated pension plan which replaced the old plan as of January 1, 1954.

The figures that I am going to give will try to point out some of the classifications in my statement.

There are 81 pensioners remaining under the old plan whose average age is 73. These are grouped as follows:

TABLE 1.—*Old informal pension plan*

| | Married | Widow | Widower | Single | Total |
|-----------------|---------|-------|---------|--------|-------|
| Japanese..... | 23 | 23 | 8 | 1 | 55 |
| Filipinos..... | 1 | | 1 | 6 | 8 |
| Portuguese..... | 1 | 4 | 1 | | 6 |
| Koreans..... | 1 | 1 | 1 | 2 | 5 |
| Others..... | 3 | 3 | 1 | | 7 |
| Total..... | 29 | 51 | 12 | 9 | 81 |

You will notice that the widows are larger in number than any other group.

Perquisites under the old plan:

1. Free medical care if treatment is given by company doctor.
2. Free housing and water if living in company-owned houses.

Those are the features of the old plan.

Through collective bargaining, the new plan came into being on January 1, 1954. Those who have retired under the new plan are divided as follows:

TABLE 2.—*New pension plan*

| | Married | Widow | Widower | Single | Total |
|-----------------|---------|-------|---------|--------|-------|
| Japanese..... | 21 | 5 | | | 26 |
| Filipinos..... | 6 | 1 | 1 | 29 | 37 |
| Portuguese..... | 1 | 2 | 1 | | 4 |
| Koreans..... | | | | | |
| Others..... | 1 | | | 1 | 2 |
| Total..... | 29 | 8 | 2 | 30 | 69 |

You will note that the single pensioners have more than tripled.

Under this system, the following perquisites are provided:

1. Free medical care is also provided under this new plan provided they go to the company doctor.

2. Pensioners covered under this new plan pay house rents the same as those charged to regular employees—which is much lower than the community rents.

One of the provisions of the new pension plan is to pay to a non-citizen pensioner a lump sum settlement if he repatriates to his native land. Of the 37 Filipinos who retired under this plan, 15 or 40.5 percent repatriated. This indicates that many of the single pensioners will return to the Philippines, thereby making our problem less.

I made a survey of the employees who will retire in the next 10 years and they are broken down as follows:

TABLE 3.—*Employees who will retire in the next 10 years*

| | Married | Single | Total |
|-----------------|---------|--------|-------|
| Japanese..... | 29 | 3 | 32 |
| Filipinos..... | 10 | 37 | 47 |
| Portuguese..... | 7 | | 7 |
| Koreans..... | | 1 | 1 |
| Others..... | 5 | | 5 |
| Total..... | 51 | 41 | 92 |

There again it is indicative that the Filipinos who will retire in the next 10 years will be in the largest majority, and most of them are single Filipinos.

Now, what are the implications of these people?

Under the old pension plan:

(1) The average age of those covered under the old plan is 73 and there are more women than men.

(2) Housing is not an immediate problem except for a few who would be better off in a care home.

(3) No medical care problem provided they use company medical facilities.

Under the new pension plan :

(1) By nationality, more Filipinos are being pensioned, 78 percent of whom are single.

(2) About one-third of the Filipinos may return to their homeland, thereby alleviating the problem of housing.

(3) Medical care is not a problem provided they receive medical treatment from the company doctor.

(4) Eventually, the community must provide these single pensioners personal care homes.

What about the future of the retirees from the plantation ?

(1) About 30 percent of the present employees will be retired in the next 10 years, which is a big percentage as far as the present employees are concerned. In fact, it has been said that about 77 percent of the present employees will be retired in the next 20 years.

(2) The majority of present employees who will be retired in the next 10 years will be Filipino single men. One company reported that of the 103 single men who will be retired in the next 10 years, 98 are Filipinos.

(3) If the present pension plan will remain in effect, medical care will be provided, and it will not be a problem.

(4) However, we can see that more nursing or personal care homes will be needed for the single pensioners.

I would like to make this recommendation in my closing remarks :

(1) A more inclusive study of the aging population in the plantation communities should be made to give direction and proper approach to the problem.

Senator LONG. Thank you. Do you have any questions, Senator ?

Senator MORSE. I would like only to make this very brief comment: I think your company is to be highly commended for the pension plan and the health plan that it has inaugurated. As one who, over the years, has arbitrated some of the major labor disputes on the mainland, I have participated in taking the record on the request of workers for pension plans in collective bargaining arbitrations; and I want to say that yours is one of the best. It is a very sound approach and I commend you for it.

Of course, as we all know, it becomes part of the cost of operation; therefore, it is taken into account in tax deductions to the extent that the law allows a consideration of this as part of the cost of operation. In all my arbitration hearings, I took detailed evidence in regard to what the final cost was going to be to the companies concerned and to the workers concerned from the standpoint of a consideration of tax deductions. I always said in those decisions that all of us in the country have an obligation, taxwise, to be of assistance to a company that has the forward, social outlook that companies such as yours, that have been willing to go along with a health program and a pension program. Sometimes that is misunderstood.

Let us not forget that every single industrial company that makes up this system of economic freedom of ours is also performing a great public service in connection with its employees; and when they are willing to put into operation the kind of a plan you have put in, and that other great sugar companies have put in, they are performing a great public service.

We sometimes seem to think that just because a company is a private enterprise that it isn't making a public contribution by way of these so-called fringe benefits. It is. And to the extent that it does, in my judgment, part of the cost ought to be spread among all of us—and that is exactly what happens when you give them the kind of tax consideration that they enjoy. I'm all for it.

Mr. LUIS. Thank you, Senator, very much.

Senator LONG. One question I would like to ask. You referred to the fact that the records show that a good many of the workers from the Republic of the Philippines have returned, and you predict that more of them would return. How does that affect their retirement privileges—health and any other compensation? Is there any understanding with them?

Mr. LUIS. Well, the only understanding there, Senator, is that a lump-sum settlement will be given to them when they leave the State; and from there on—

Senator LONG. Is there any statement that shows how that lump sum is determined and its relation to what they have been receiving and the number of years that they have worked? Do you have in your plantation register—

Mr. LUIS (interrupting). Well, yes. It is figured according to a formula—the number of years he has been with the plantation—and so on.

Senator LONG. Would you include that in as a part of your testimony so that we might produce it? I think a great many people would be interested in that.

Mr. LUIS. I will be glad to do that, sir.

Senator LONG. If you will send that to us and make it a part of your report.

Thank you.

Mr. LUIS. Thank you.

(Formula appears on p. 1630 of appendix.)

Senator LONG. Mrs. Myrtle Ward, county administrator, department of social services. Mrs. Ward?

STATEMENT OF MRS. MYRTLE WARD, COUNTY ADMINISTRATOR, DEPARTMENT OF SOCIAL SERVICES

Mrs. WARD. Senator Long, Senator Morse, members of the panel, ladies and gentlemen: I am here as the county administrator for the State department of social services—the division of public welfare.

I have a prepared statement for your use, which is rather brief, and I will read from and comment upon it as I go along.

The Hawaii Division of the Department of Social Services functions according to State plan in offering services and/or economic assistance to families and individuals who apply. The several federally matched categories of public assistance are also administered. Services to children in their own homes, foster home finding, foster home placement, adoptive home studies (agency initiated or requested by the Third Circuit Court), and placement of children for adoption are also a part of our services, as well as family counseling.

Under reorganization, the functions of sight conservation, veterans' affairs, and juveniles on parole from the State training schools have been added to the Hawaii division. In 1961, the medical care program was transferred from the respective counties to the State for administration and service and this function became a part of the Hawaii division in July 1961.

The following statement is submitted to show the State and Federal activities in relation to aged in money payments.

In this county during the fiscal year which ended June 30, 1961, there were 290 persons—that is an approximate figure, because, of course, it varies from month to month—who received old-age assistance payments in this county. The average payment per month was \$70.78. And the total assistance per month averaged \$20,565.62.

I think this figure will be interesting to you because I do not believe that many people realize how much money is spent in the department for assistance to people. The total assistance for the fiscal year ending June 30, 1961—and this is just for one category; this is for old-age assistance, only—was \$246,787.49. Of this amount, \$153,816.50 was from matched Federal funds; and \$92,970.99 was from State funds.

Now, the services provided include social services, as required, to the aged in their own homes, medical care and dental care, and whatever social services in addition to this are needed. If the aged persons are in need of nursing and convalescent care, this is provided for in the geriatrics treatment center, which is administered by the county government. Boarding homes are provided for those persons who are ambulatory.

Medical assistance—which began, as I mentioned, in July of this year—is for medical assistance to aged.

This service was given to 76 people, and the average payment per month for that service was \$145. The total, since July 1, 1961, spent for medical service was \$11,060. The total expense for the fiscal year ending—which we expect to spend is estimated at approximately \$132,720. These are matched funds also. Seventy thousand eight hundred and forty-six dollars comes from Federal funds; and \$61,874, from State funds.

In Hilo and on this island, we have a rather unique program—though I would hardly call it a program—a unique situation, let's say—for many aged people who don't have homes of their own. They live in these little "hotels" where they are allowed, in many instances, to prepare their own meals; and they have the freedom to go and come as they like and have their friends there. The operators of these "hotels," who, incidentally, happen to be mostly Korean women, look after these aged persons in what may be described as a motherly fashion. They keep in close touch with the division's social worker for health and other needs of their clients. And while, to some, the standards of living in these hotels are not as high as they might be—that is, you can't gear them to your own personal standards—they are, in most instances, so much higher than the aged person has been accustomed to before he moved to the hotel. There are approximately 15 to 20 persons—that's normal—living in these so-called hotels.

A few so-called care homes are in operation in this district, although these are essentially room and board arrangements and provide for about seven aged persons. The primary requirement for these persons is normal home living where their meals, laundry, and general care are provided for them on a board payment basis which is made to the aged person himself, who, in turn, pays the person in whose home he is living for that care. The care home idea has not caught on well in Hilo because the standards of the department of health as outlined in public health regulations, Department of Health, State of Hawaii, section 46-13, Revised Laws of Hawaii 1955, chapter 12B, appear to be too high for the average person wishing to engage in caring for a small number of aged in their own homes.

The Hawaii division pays for nursing and convalescent care for 69 aged persons who are living in the geriatrics treatment center which is, as I mentioned before, county operated. The rate of payment per person for this service is \$175 per month.

Now, some of these people have incomes of their own, which we supplement; that is, they have their old-age and survivors insurance, pension; and some, from other sources; so that in instances like that, the department pays the difference between what their resource is and what the charge at the hospital is.

Programs in this community should be geared toward accommodations for three or four persons per unit and away from institutional care or old folks homes where large numbers of aged persons are required to live together. The identity of the individual is oftentimes lost in situations like that. The reasons for this are quite obvious since any institution-like facility, either for children or aged, lacks much in warmth and homelike relationships which mean so much to the individual.

Hawaii division has begun an experiment in community planning for the care of the aged in Naalehu, District of Kau. A committee, whose membership is a good cross-section of the community—plantation people, service clubs, church groups—is engaged in developing a facility for the care of four aged men in good health who are plantation pensioners. The renovating, remodeling, and furnishing of a plantation building, with a housekeeper to prepare their meals, laundry, upkeep of the home and look after their daily welfare, will be ready about the middle of December. I was down there yesterday, incidentally, and I hope that when this facility is in operation that many people will visit it to see what can be done for people in their own community. This fine example will encourage other districts on Hawaii, especially in the plantation areas, to look into similar possibilities and work with this division to complete other projects for the care of the aged.

It is our belief that we have not scratched the surface in planning for the aged in this community. We need:

(a) Better interpretation of the needs of the aged and aging to the community. The Department of Social Services has been so involved during the past 18 months in the integration of the inherited programs of State reorganization that the problems of aging has not had much emphasis on a communitywide basis. We take full responsibility for this.

(b) We also need to consider the possibilities of developing a home-maker or housekeeper service which can be offered to those aged persons who live in their own homes but are unable to do many things for themselves or who live with relatives who work and are out of the home during the day.

(c) We also need to encourage local interest in developing nursing and convalescent homes and care homes for the aged and aging.

Senator LONG. Thank you, Mrs. Ward. Senator?

Senator MORSE. Mrs. Ward, I have just a question or two. In talking about the care home idea you point out that the only difficulty is that the standards of your existing laws seem to be too high to encourage people to take the aged in on a care home basis. Do you think the law should be changed?

Mrs. WARD. I think we have to set up certain standards for these homes. I honestly believe that. But I think we have to, may I say, "get the show on the road" and perhaps be a little flexible in some of the instances so that people would be willing to take older people into their own homes and care for them and then when they are in these homes, to help them build up these standards, setting some limitation of time on when those standards should be reached.

Senator MORSE. Senator Long and I visited a care home on one of the islands—Kauai. It was a remarkable home. There are others on that island and I hadn't heard anything about the problem of standards being too high there and, therefore, I wondered if you lack uniformity in the standards that are required throughout the islands. If they can do it there, why are you having difficulties on this island?

Mrs. WARD. The standards are the same for all the islands, Senator Morse—

Senator MORSE (interrupting). That's what I thought.

Mrs. WARD. The emphasis and interpretation are probably a little different.

Senator MORSE. A matter of administration.

Mrs. WARD. I think so.

Senator MORSE. You spoke about a very wonderful facility which arouses my enthusiasm at once—where you have your local community project, where your churches, your service clubs, and your civic organizations are going to work in setting up a community care project, but it covers only, in your example, four men. What about the administrative cost of such a project if you have such a limited number of people that are to live in the home?

Mrs. WARD. Well, the administrative costs—in fact, the entire costs, except the renovation of the building and its upkeep, will be handled with State funds from our Department.

Senator MORSE. And you think it will be economical, administratively, to have homes with only four in it? Is there any particular reason why this should have 4 rather than 10?

Mrs. WARD. Yes. The facility that was given to us for this purpose—it was actually given to this group for the purpose—in renovation it provides for only four bedrooms. It is an interesting fact that on this same piece of ground there are two other houses which belong to the plantation, we want to see how this thing is going to go, first; and if we can really demonstrate what can be done in a small

way, we believe we can expand it and do the same thing and take care of more people on the very same grounds that we have now.

The community has reached a point where everybody is pitching in to do something for this project, and the community itself, the group itself is now in the process of becoming incorporated for the handling of these funds and the administration of this "Hale Pau Hana, Inc., project.

Senator MORSE. If it meets with the pleasure of the chairman, I would like to take a minute or two because I think you are an excellent witness and a witness who can particularly help the committee with information on the following points, and I would like to have your observation.

In connection with the assistance program under the Kerr-Mills bill, which was put into operation on July 1, I would like you to make a statement as to the kinds of medical care that is provided under this new arrangement.

Second, any limit on the duration of hospitalization or nursing home care under this program.

Third, what expansion in the medical care program are you contemplating or already putting into effect under Kerr-Mills?

And fourth, what are you doing here, in this State, in regard to the free choice of physicians under Kerr-Mills?

Mrs. WARD. Well, I will try to answer your questions, the last one first.

We do have a Government physician plan on this island, as we do all over the State. There are 10 Government physicians scattered around the island, and in many of these areas the only physician there is the private physician and the Government physician, too, you see; so that in rural areas like Waimea, Laupahoehoe, Kau, and Kona, the choice of the person would have to be the choice of the doctor who was there, who also happens to be the Government physician, also; so he really has no choice that he wouldn't have anyhow.

Senator MORSE. But that's not true in a highly populated area.

Mrs. WARD. No, it definitely is not, it is not true; but, again, we have a geographical situation here that is different from most of the other islands—with farflung districts.

Senator MORSE. So that there may be no possible misunderstanding, let me make clear that on this matter I am doing everything I can and will continue to do everything I can to assist the doctors because as long as Kerr-Mills is on the books, I want to perfect it, I want to make it better, and on this one, the doctors and I see eye to eye. As a group, it is supporting the Humphrey amendment, as I am, and I think that we have a very good chance early in the next session of getting the Humphrey amendment adopted. It would give the Kerr-Mills bill a very important guarantee—the right of patients to select their own doctor under the law.

Mrs. WARD. Well, in spite of the fact that we do have government physicians in this county, if a person has a private physician he may use that physician's services; but we do have to have the understanding that we can't pay the bill. But the physicians in this county are very understanding and very helpful in saying, "Well, I've taken care of John Doe for a long time and just because he is having a

bad time economically, I'm not going to push him off and not serve him now."

Senator MORSE. But under the Humphrey amendment, you would pay the bill. It would be under the limitations of the amendment, but you would pay it; and we seem to think that is pretty basic.

Mrs. WARD. In respect to the length of time for nursing and convalescent care, in this county there are no restrictions. The person remains in the facility just as long as he needs to remain there, as long as the doctor says he needs to remain there; and when his illness is terminated and he is able to go, then we make some provision for him some place else.

In the hospital facility itself at the present time there is a 15-day limitation on illnesses, but there is no restriction on extending that as long as a person needs the care. There have to be some safeguards in all these things, but by good judgment and being able to work closely with the doctors, we find that nobody needs to have any real complaint about the number of hospital days. They stay just as long as they need to stay, according to the doctor's recommendations.

Senator MORSE. Well, that is wonderful. There is only one other point—we found it in other places, not in Hawaii, but in other places. I don't know what the situation is here in Hawaii. It may be true here, I don't know—I seek the information. But we have found that in some of the States that thus far the Kerr-Mills bill in application has amounted, for the most part, to the Federal Government picking up part of the cost tab, whereas the purpose of the Kerr-Mills bill is to be of assistance in expanding medical care that previously existed into enlargement, and not with the idea of the States being relieved of the expenditures they were previously making, but they were to be assisted under the Kerr-Mills bill in giving more care and an expanded care. Would you say that that is what is being done or is being contemplated in Hawaii?

Mrs. WARD. I don't believe that I can answer that honestly because I honestly don't know. The program is so new that the ramifications of the Kerr-Mills bill, so far as the money angle is concerned, and what States are—I'm not too familiar with that and so I wouldn't want to make a statement in that regard, but I can see exactly what you mean in another area which is, I think, medical care, too, and that is dental care.

Senator MORSE. Exactly. Exactly.

Mrs. WARD. And I can see that area needing a great deal of expansion throughout the State, and particularly on this island where we do have a great need for dental care for older people and we are not providing it to the fullest extent that we would like to at the present moment.

Senator MORSE. I quite agree with you. It is probably too soon yet to see what the trend is going to be here. And here, again, I happen to know and have talked to many doctors about it, that their own local medical associations in various parts of the country are going to work on this because they recognize that this was one of the purposes of the Kerr-Mills bill and they want to carry it out and we are going to get their cooperation in regard to it. I think you are going to get quite a few medical association programs at the very local county

level submitted, recommending the type of expansion of services under Kerr-Mills that Congress certainly intended when it passed the bill.

Thank you very much. You have been a very fine witness.

Senator LONG. Just a minute, Mrs. Ward. In connection with this last discussion, I believe, for the record, it would be helpful if we could have the number of individuals who received medical care through your agency, say, between July 1 and September 30, 1960; and then for the same period in 1961. There might be something in that that would throw some light on the way the Kerr-Mills bill is operating.

I think, also, in connection with that, if we could have an estimate of the amount of money it costs to investigate the eligibility for medical care for an applicant, perhaps an average for those two 3-month periods.

Mrs. WARD. You are referring now to the number of individuals who receive medical care—of any particular age group?

Senator LONG. It would be for aged persons.

Mrs. WARD. That is what I meant.

Senator LONG. Thank you.

Then, in your comprehensive paper I didn't get any reference to dental services, particularly; and I wonder what dental service is provided. Is it on a basis of emergency care only or do you go beyond that?

Mrs. WARD. It is on the basis of emergency care only, and that is one of the things that we don't like. We would like to be able to provide complete needs for dental care for people. Each county, strangely enough, has had a different system in the administration of dental care, and in this county, the dentists who are willing to participate in the program receive a certain amount of money according to the number of units that they expect to handle each month. It is most inadequate. I don't see how they are willing to do it with the money that they get, frankly, because it is most inadequate.

Senator LONG. The community has an adequate number of dentists? Or are they—

Mrs. WARD (interrupting). I don't speak authoritatively on this but I believe more dentists would participate if we could give some assurance that they would get somewhere near adequate pay for the services that they are giving, but these dentists here have just gone all out. They have been wonderful to us for the kind of things they have been willing to do for people at almost nothing. I don't see how they can afford to do it, but they are so willing and so generous that they do.

Senator LONG. Thank you. That is a splendid report. There is a problem and you are aware of it, and in time we will be working toward a solution.

Ordinarily, at our meetings we don't seek testimony from representatives of Federal agencies, inasmuch as these agencies are reporting directly to Congress. Our committee knows very well the role that social security plays in the big metropolitan communities of the country. We don't have, however, as a committee, very much information on the impact which our social security program makes in the smaller communities such as here in Hilo. Therefore, this committee has asked Mr. Walter Minaai, District Manager of the Social Security

Administration here in Hilo, to tell us of the role of the social security in this area—of its particularly local aspects, and of such other matters as the committee should also know and have for its record.

I therefore wish to ask Mr. Minaai to please appear as a witness, if he will.

STATEMENT OF WALTER N. MINAAI, DISTRICT MANAGER, HILO, HAWAII, BUREAU OF OLD-AGE AND SURVIVORS INSURANCE, SOCIAL SECURITY ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. MINAAI. Hon. Senators Oren E. Long, Wayne Morse, and committee members, Special Committee on Aging, U.S. Senate: My name is Walter N. Minaai, District Manager, Hilo, Hawaii, Bureau of Old-Age and Survivors Insurance, Social Security Administration, Department of Health, Education, and Welfare. I hereby submit some significant service area characteristics of the Hilo District Office, which should be of interest to the committee in its study of the problems of the aged.

The Hilo District Office serves the counties of Hawaii and Maui, which consists of the islands of Hawaii, Maui, Molokai, and Lanai, with 10 full-time employees. This staff serves 104,187 people, widely dispersed over a total of 5,159 square miles, an area larger than the State of Connecticut and 80 percent of the State's land area. In comparison, the majority of the State's population of 632,772 people live on the island of Oahu, where 500,409 people squeeze into only 604 square miles. It is also significant that over half of the people in the Hilo service area live in rural districts. According to the definition adopted in the 1960 census, one category of urban population comprises all persons living in places of 2,500 inhabitants or more incorporated as cities, boroughs, villages, and towns. In the Hilo service area, only the towns of Hilo on Hawaii, and Wailuku, Kahului, Puunene, and Lahaina on Maui, with a total population of 43,635, are considered urban places. Consequently, the remaining 60,263 inhabitants are dispersed throughout rural areas of the four islands; and most of them are engaged in agricultural activities.

The lack of public transportation on these islands requires the district office to service the rural areas on a scheduled basis by field representatives. One resident representative, permanently stationed at Wailuku, Maui, is responsible for the program administration on the islands of Maui, Molokai, and Lanai.

An analysis of the State's population characteristics shows the following percentages of people 65 years and over:

| | <i>Percent</i> |
|----------------------|----------------|
| Hawaii County----- | 7.5 |
| Maui County----- | 7.0 |
| Kauai County----- | 7.1 |
| Honolulu County----- | 3.9 |

The above figures indicate that there is a residue of an aging population on Hawaii, Maui, Molokai, and Lanai, despite a decrease in population.¹

¹ Source: U.S. Census of Population, Hawaii, 1960.

The cosmopolitan characteristics of the inhabitants in our service area also make program administration difficult and complex. The racial characteristics of Hawaii's population by counties are as follows: Hawaii, 82.2 percent nonwhite inhabitants; Maui, 82.8 percent; Kauai, 81.9 percent; and Honolulu, 64.3 percent.

Of Hawaii's cosmopolitan people, the Japanese and Filipinos immigrated to these islands in the late 19th and early 20th centuries; consequently, most of them are now in the aging category. A large number of them reside in Hawaii and Maui Counties; their presence creates communication problems because of their inability to understand English.

As of December 31 1960, \$6 million annually was being paid to 8,416 old-age, survivors and disability insurance beneficiaries in the counties of Hawaii and Maui. These benefits are of substantial value to these areas because of the depressed economy.

The foregoing brief information reveals that the Hilo District Office administers the social security program in a large, substantially rural area, composed of an aging population, widely dispersed in small agricultural communities. These characteristics make it difficult to administer the program economically and pose other problems not apparent in a metropolitan area. Therefore, these factors must be considered in the implementation of any aging program.

Thank you for this opportunity to appear before this committee.

Senator MORSE. One question, Mr. Minaai. What percentage of your working population now contributes to social security?

Mr. MINAAI. Well, 9 out of 10 people are covered under the program; so I would say 90 percent.

Senator LONG. Thank you, Mr. Minaai.

We regret that the next witness on our list, Dr. Henry M. Bockrath, is ill and unable to be here this morning. In his absence, however, we are fortunate to have with us Dr. Norman Sloan, chief, Adult Health Branch, Hawaii Department of Health. Dr. Sloan?

STATEMENT OF DR. NORMAN R. SLOAN, CHIEF, ADULT HEALTH BRANCH, HAWAII DEPARTMENT OF HEALTH, ON BEHALF OF DR. HENRY M. BOCKRATH, DISTRICT HEALTH OFFICER FOR THE COUNTY OF HAWAII

Dr. SLOAN. Senator Long, Senator Morse, members of the committee, ladies and gentlemen, Dr. Bockrath sends his sincere regrets that he is unable to be here this morning. He is suffering from an attack of pleurisy which has confined him to his home. He has asked me to appear and present this statement, but because of his illness, we have not been able to prepare the final copies for your perusal and I will have to deliver this myself. If you have any questions, I will be happy to try to answer them. We also have with us here this morning the acting chief of public health nursing for the county of Hawaii, Mrs. Kanuha.

The county of Hawaii, which is geographically identical with the island of Hawaii, has more than half the land area of the State; but a relatively small part of this is suitable for living area and cultivation. The civilian population by the 1960 census was 61,200, about 10.6 percent of the nonmilitary population of the State. Of

these, 4,587, or 7.5 percent, are aged 65 and over; this is the highest percentage for any island. The overall State percentage is 4.6; that for the United States, as a whole, is 9.6. I would remark that here, as on the other neighbor islands, the high percentage of the aged is largely caused by the young people leaving the island to seek better economic opportunities on Oahu.

It was stated elsewhere that the numbers and percentage of the aging are increasing throughout the State; this is specially true here.

This county is keenly aware of its responsibility in preparing institutional facilities for the aging and disabled, with rehabilitation facilities where indicated. I will not go into this in detail because you will be hearing about these facilities from others. We are particularly interested in this. The White House Conference on Aging called for a "broad spectrum of institutional facilities, on a local area base" with attention to care and adequate financing. The broad spectrum would include progressive patient care in hospitals (allowing the patient to contribute to his own care as much as possible); nursing homes; and care homes.

While realizing the above need, it is still recognized that people should remain in their own homes, or return to them promptly, when possible. To assist this, we need home care programs, which, fully developed, include medical and nursing care, occupational and physical therapy, and homemaker and housekeeper service. As you heard on Oahu, there is a program for developing a home care service in the city of Honolulu, and we hope that something of this sort can be extended in the near future to the other islands.

We favor continued care of the medically indigent—which has long been recognized as a governmental responsibility in Hawaii—with liberalization of the program, aided by Federal funds under the Kerr-Mills Act.

Other health needs of the aging are similar to those found elsewhere in Hawaii. These include:

(1) Extended provision for control of chronic illness, by early diagnosis and treatment. Examples are diabetes, glaucoma, cancer, tuberculosis, and dental defects.

(2) Extension of rehabilitation services, for the aged, diseased, and injured, and extension of information as to availability and value of these services to physicians, to other professional workers, to patients, and to their families.

(3) Further research on specific health problems such as cancer, diabetes, high blood pressure, and arthritis.

(4) Continued and extended programs of accident prevention.

(5) Encouragement of periodic health examinations.

(6) Further development of mental health programs.

I would like to close briefly on some general needs, which were pointed out by the White House Conference and with which we are in full accord:

Planning on an interdisciplinary, communitywide basis.

Coordination of health services. The section on health and medical care of the White House Conference stated:

A major obstacle to continuity of care and coordination of services lies in the fractionation of health services away from agencies concerned primarily with health matters.

I would like to say, for myself, that while we have had excellent cooperation with the Department of Social Services, the Division of Vocational Rehabilitation under the Department of Education, and others, there is still need, I believe, for better integration of these services under one head for some particular service, rather than some of these fragmentations.

Continuity of health care, with return to the home when possible, and good followup.

Progress is being made in all these directions, and with continued community support and cooperation, this progress will continue.

I thank you, Senators, for this unexpected opportunity to testify before you.

Senator MORSE. Dr. Sloan, I probably will not see you again on this trip after I leave this morning, but I want this record to show my appreciation, and I know Senator Long shares it, for the great help you have been to us on this trip. You have traveled with us throughout the islands and your counselling with us has been very, very helpful, as was your statement this morning, and I want to thank you very much.

Dr. SLOAN. Thank you, Senator.

Senator LONG. Thank you, Dr. Sloan.

The next witness will be Mr. Thomas Vance, administrator, Hilo Hospital.

STATEMENT OF THOMAS VANCE, ADMINISTRATOR, HILO HOSPITAL

Mr. VANCE. Senator Long, Senator Morse, and members of the staff, we appreciate this opportunity to present some of our problems to you, but, first of all, I think we should present the audience with a picture of local benefits—financial and otherwise—which have come to us through various national programs that the two U.S. Senators here present have solidly supported.

We have just completed a new general hospital. In its construction, we had \$649,000 in Hill-Burton grants that came to us at various times and which is a tremendous help to a community of this size.

Two weeks ago, the medical advisory commission, serving the State health department, granted us a \$200,000 appropriation for reconstruction of the geriatrics treatment center, which you visited this morning—and we very genuinely appreciate your taking the time to drop in for just a few minutes to see the type of patient that we have and the program that we have established for them.

And, in addition to that, both the county of Hawaii and I are deeply indebted to Senator Long for securing an exact definition of Federal funds that are available to us in various categories and the procedures required in order to secure those funds. Legislation, as far as the layman is concerned, is a rather complicated thing and frequently we have to secure the services of an attorney to give us an interpretation of the law. Then, after that, we have to secure the services of some other attorney in order to interpret the first attorney's interpretation of the law. And so, finding that we didn't know just exactly what Federal funds were legally available to us, I summarized all the pertinent questions pertaining thereto and sent them to Senator Long.

Within a week I received definite, concrete answers in regard to funds for which we were eligible and the exact procedures we would have to follow in order to secure them. That has served, incidentally, to increase tremendously the volume of Federal support, particularly for our needy nursing home cases on this island. We are genuinely appreciative for the assistance that you gave us in that regard, Senator Long.

Senator LONG. Thank you for the mention.

Mr. VANCE. I think the group should also know that at the time we secured these funds for meeting needy nursing home cases, our maximum was a maximum of \$41.50 per month per patient. That has been greatly increased under the Kerr-Mills bill and is now a little over 53 percent of costs, which gives us a much better break and, in the utilization of this fund we plan to expand programs and services.

So we want you to know that we appreciate the interest of the Federal Government and particularly the interest of the two U.S. Senators present who have been so keenly interested in these particular programs.

The first presentation that we wish to give you is in regard to the tuberculosis hospital. It might seem rather strange to bring that into the problem of aging, but tuberculosis has now become more of a problem of aging than it has become a problem of tuberculosis, as you can see from the survey that we have handed to you, the largest single age bracket in the tuberculosis hospital is in the age range 70 to 79 years. It is also interesting to note that in 1961, there were 16 tuberculosis deaths. Only one, however, died of tuberculosis. The others died of various conditions which end the lives of very elderly people.

We have had a tendency to believe that the problem of tuberculosis has been licked merely because of the rapid decline in the number of people who are in tuberculosis hospitals. Only 7 years ago, we had an average daily patient census in the tuberculosis hospital of 190; today, it is a little over 60. The average length of stay 6 years ago was 685 days; today, it is 306. Seven years ago, we had 5 on an outpatient basis; today, we have 105. And we are treating just about as many people with tuberculosis now as we were 7 years ago, even though the inpatient population is down from 190 to 60.

There were 12 teenagers and children in the hospital 7 years ago; today, we have none. The average age of first admissions to the tuberculosis hospital is climbing slowly.

Seven years ago the average age of admission for patients that were treated and discharged was 48½; today, it is 53. With the chemotherapy that is available at the present time for those suffering from tuberculosis, it doesn't take too long until the disease is arrested and no longer contagious—after it is arrested, however, there is the problem of placement for elderly people who have been withdrawn from their homes for a period of a year, together with the fear of the home to readmit a tuberculosis patient. This has resulted in a large number of tuberculosis patients who no longer require hospitalization but we still have them because we are unable to arrange placement for them.

Senator MORSE (interrupting). With the chairman's permission, I will take just 30 seconds to stress what you have just said because

it relates to an obligation that each one of us owes to a great program in this country that we have sponsored for many years but needs renewed support. Most people have been laboring under the false impression that we have conquered tuberculosis. They have labored under the impression that because there is a shorter hospitalization period that it means that we don't have as large an incidence. There may be some variable in regard to the incidence, but it is still exceedingly high, as your testimony has just brought out again; and I want to mention, with Christmas approaching, the great obligation we have to the tuberculosis Christmas seal program because due to the fact that many people think that the problem isn't as serious as it used to be, there is quite a falling off in the purchase of TB Christmas seals. And here is testimony that certainly ought to enhance the purchases all over our country because it is one of the great humanitarian public services that we can render and I am so glad that you brought this out in your testimony this morning.

Mr. VANCE. Yes. I think we should again emphasize the fact that 7 years ago, when the inpatient population was more than 3 times as high as it is today, we then treated 210 patients during the year for tuberculosis. This past year, 1961, we were still treating 185, almost a negligible decline in the incidence of tuberculosis. You see, the patient census has gone down because of earlier recovery and because of the large number of people that can be treated on an outpatient basis.

The next report that we have prepared for you is a statement of basic policy. This was worked out with our county chairman, Mr. Cook; members of the board of supervisors; and the rural hospital superintendents as a guide in the development of proper nursing home services—trying to point out the fact that in planning our nursing homes emphasis has been limited very largely to tender loving nursing care. We have not given the consideration that we should to the fact that among these elderly nursing home patients we must maintain their interest in life or they are done for. That means an active program of occupational therapy, physical therapy, recreation, reading, games, exercise—in order to develop and maintain interests for these people.

So we are presently making a survey of the capabilities and the potential of our nursing home patients to participate in activities that will maintain their interest in life so that we are not merely meeting some kind of an obligation to provide some minimal service, but are maintaining for these people, the constructive citizens of yesteryear, a program that is vital to them and one that is interesting to them.

The next study that we would like to present to you is one at the Geriatric Treatment Center. This is a study which we have made primarily to find out what the situation is among the patients and the residents that we have there—what can they do, so as to get a factual determination of their abilities, their potentials—

MEMBER OF THE AUDIENCE. We can't hear you.

Mr. VANCE. Excuse me. To get a survey of their abilities, their potentials, their capability for participation, and their interests so as to plan an appropriate program for them.

And, as has already been pointed out, we now have the funds with which to build a proper facility—one that will be fireproof, safe, with facilities for recreation, occupational therapy interests, games, reading rooms, TV—in order to maintain an active interest in life on the part of the patients that we have there.

Again, this survey shows, from the standpoint of age factors, that the largest single group is in the age bracket of 80 to 89. The next largest single group is in the age bracket 70 to 79.

We have recently undertaken an intensive physical therapy program for a selected number of these people, but the age factor is against any appreciable improvement.

Senator MORSE. You show one patient, 20 to 29.

Mr. VANCE. Yes. This patient, 20 to 29, is blind, diabetic, and physically deteriorated.

The next study we would like to present—and this is one, frankly, on which we would like some help if you feel that our case is justified—and that was something that happened to us after the planning of our new hospital facility was completed, something that happened to us at the time of statehood. When statehood became effective, the law in relation to veterans' hospitalization requires that veterans go to U.S. hospitals except in territories and possessions. The date that we became a State, our status as a territory ended and we were no longer eligible to contract with the Veterans' Administration. However, we at that time had under construction the completion of a \$4,000,000 hospital, which, when interest is added on bonded indebtedness, will cost us \$5,000,000 by the time we get through. Upon termination of our contract with the Veterans' Administration, we found that we had an overdesigned hospital and a patient load that is not economical.

Senator Long, I know, has had this problem under consideration both for Hawaii and Alaska. Alaska's position in this regard is much more acute than our own because the closest Federal hospital for Alaska is in Seattle, Wash., which virtually means that hospitalization under the act is virtually out. Here, because of over-water transportation, ambulance service to the airport, airline transportation to Oahu, ambulance service again from Oahu to the U.S. hospital, Tripler General—this is something, I might say, we just got caught on because if we had not become a State, certainly we would have been subject to criticism if, at the time of planning, we had not planned for the veterans. Then, prior to the completion of the project, this patient census was removed under the regulations of the U.S. Government.

Senator LONG. If I may comment at this point, briefly, I feel that in Washington, especially in the Veterans' offices, there is an active interest in this problem. People recognize the unfairness of the situation in Alaska and Hawaii. I am certain that in time it will be worked out. Proceed.

Mr. VANCE. The last study that I wish to present to you is a care home survey that was made on the island by Mr. Luis, one of the prior speakers, who, incidentally, is chairman of the hospital management committee, in an effort to find out what the needs are for expanded care home service, primarily here on the island. This, possibly, should be called an initial survey. It has not been followed

through by Social Service investigation, but it was an initial step in order to get some idea in regard to the number and the type and the character of people who are not able to provide for their own care because of age, affliction, physical disabilities, or whatever they might be. And we would have to say that this is purely tentative. It will have to be followed through with a much more thorough investigation before we can come up with any sound approach to the actual need for care home facilities.

I appreciate this opportunity to present to you some of our basic problems in hospital and nursing home services in the community. Thank you very much.

Senator MORSE. Mr. Vance, this data, or, these data that you have presented to us are the best prepared material that we have had. I have sat here in great admiration at the condensation and yet the coverage that you have presented to us in the data.

I want to tell you about one sentence in your statement on planning for proper nursing home service, and I not only want to say "amen" to you but to stress it because some way, somehow, we've got to get this point of view across to the country.

You say in this statement:

Increased Federal support, therefore, should not be used to lower costs borne locally, but to develop proper nursing home services to the full extent of the patients' physical and mental capacities.

And how right you are. Put yourself in our seats for a moment. One of the great difficulties we have when we want to get the Federal Government to join with the States and assist them with a State problem, which also has national responsibilities connected with it, there is always the tendency for those that don't support that kind of a program to say:

"All you are doing is proposing a program that will permit the States to pass the financial buck to the Federal Government—and they will then taper off and not provide the services that they should have been providing at the local level anyway, but services that we all know need to be supplemented."

And you have hit the nail right on the head with that sentence. Now, we want to be of assistance to the States but we don't want the States to shirk their responsibilities and turn to the Federal Government to assume part of the burden that they really owe a program at the local level.

We have this—may I quickly say—this whole matter of an educational program, but I have been such a stickler about this that those of us supporting my bill—that we have it clearly written in that bill that if any State starts to taper off and not give the educational support that they were giving prior to the proposed Federal assistance, then they are cut off. We are not to come in and do the State's job for it, but we do think the Federal Government ought to come in and do its share of the job for which there is a Federal responsibility.

And I am so glad that you have this sentence in your statement, and I wanted to take the opportunity of emphasizing it. I will not take the time, Mr. Chairman, to read it, but I would like to put in the record at this point, for Mr. Vance's assistance and others in the community interested in the Health Services and Facilities Act,

PL87-395, certain other assistance that you could get from the Federal Government within the funds that the Congress has passed in connection, for example, with the construction of hospitals and nursing homes, Federal aid for rehabilitation centers—again, on a joint Federal-State matching basis. The record, Mr. Chairman, ought to contain that material because it is so pertinent to the testimony you have given this morning.

Mr. VANCE. May I also point out in that conjunction that this statement was considered by all of our county officials. It is not a statement of some vague objective that we would like to accomplish with the increased funds. We are carrying it out; with the approval of the county chairman and the board of supervisors, we have added six people to the staff at the geriatrics treatment center—three registered nurses, two practical nurses, and one physical therapist—in order to improve the services that we are giving. So we are not only saying that this is what we ought to do, but I think we are moving in and doing it.

Senator LONG. Senator, I want to say that while you didn't know what to expect, I did—having worked with Mr. Vance for something over 35 years in the public-school program as a fellow cabinet officer and as a member of my family, my official family, while I had the privilege of being governor. I have observed his work since in another field, that of hospital service, and he always does a good job.

(The material referred to previously follows:)

HILO HOSPITAL TUBERCULOSIS DIVISION, HILO, HAWAII

The following table presents pertinent data in regard to the incidence of tuberculosis and other factors of significance.

Analysis of changes in tuberculosis and its treatment

| | Fiscal years | | | | | |
|--|--------------|---------|---------|---------|---------|---------|
| | 1953-54 | 1954-55 | 1955-56 | 1957-58 | 1959-60 | 1960-61 |
| Peak patient census..... | 205.0 | 188.0 | 179.0 | 139.0 | 109.0 | 94.0 |
| Average daily census..... | 194.2 | 177.1 | 172.6 | 119.3 | 93.9 | 81.0 |
| Number of admissions..... | 112.0 | 124.0 | 104.0 | 61.0 | 82.0 | 80.0 |
| Number of discharges..... | 113.0 | 146.0 | 109.0 | 92.0 | 90.0 | 110.0 |
| Deaths (due to TB or other causes)..... | 14.0 | 15.0 | 15.0 | 9.0 | 10.0 | 16.0 |
| Number of patients receiving outpatient chemotherapy..... | 5.0 | 24.0 | 84.0 | 98.0 | 92.0 | 105.0 |
| Average length of stay of discharged patients, including deaths..... | 432.9 | 575.1 | 545.1 | 541.3 | 435.7 | 396.0 |
| Average length of stay of discharged patients, excluding deaths..... | 447.1 | 685.2 | 500.9 | 482.6 | 372.5 | 305.6 |

You will note that from the high census (average 181.3) for the 3-year period 1953-54 to 1955-56, the year 1960-61 shows a census decline of 55 percent while the number of admissions declined by only 29 percent. Including inpatients and outpatients, in 1953-54 there were 199 patients under treatment; today there are 185—a decline of only 7 percent. The incidence of tuberculosis, therefore, has not been greatly reduced.

Chemotherapy, with its new wonder drugs for tuberculosis, has made it possible to shorten the period of hospitalization for those suffering from tuberculosis and to effect earlier discharges with follow-up therapy on an outpatient basis. Outpatient service is certainly cheaper than inpatient service, but the increase of 100 outpatients treated per year within the past 7 years does require considerable staff, even though not all of the 105 outpatients were under treatment

simultaneously. Admissions and discharges to this service occur throughout the year.

The year 1954, with its high discharge rate, shows the favorable results effected upon the introduction of chemotherapy in the treatment of tuberculosis.

1. The high discharge rate was accompanied by a heavy increase in outpatient service; from 24 that year to 84 the following year.

2. Some long-term chronic patients, considered incurable prior to chemotherapy, were treated and discharged during the 3-year period 1954-55 to 1957-58. Chronic time and recovery time were combined when chemotherapy was first introduced. For example, one patient was treated and discharged after 20 years of hospitalization and is presently gainfully employed.

3. For new admissions, the period of treatment is sharply declining, as indicated by the 305 days for average length of stay in 1960-61.

It is interesting to note that deaths from tuberculosis are minimal. The following table shows the cause of death for the 16 patients who expired in 1960-61.

| Cause of death : | <i>Number of cases</i> |
|--------------------------|----------------------------|
| Tuberculosis..... | 1 |
| Heart disease..... | 5 |
| Cancer..... | 5 |
| Bronchopneumonia..... | 3 |
| Cerebral thrombosis..... | 2 |
| Total..... | 16 |

The one TB death expired at age 88 after 19½ years of hospitalization. Indirectly, age factor was a heavy contributor to deaths. The average age of those who died during the year 1960-61 was 77 years; the average age of those discharged was 56 years. The following table shows the age distribution of the patients in the house as of October 9, 1961, exclusive of those admitted under act 234, S.L.H. 1959.

| Age group: | <i>Number of patients</i> | Age group—Continued | <i>Number of patients</i> |
|---------------|-------------------------------|---------------------|-------------------------------|
| 20 to 29..... | 3 | 60 to 69..... | 11 |
| 30 to 39..... | 3 | 70 to 79..... | 17 |
| 40 to 49..... | 4 | 80 to 89..... | 6 |
| 50 to 59..... | 14 | 90 to 99..... | 1 |

Tuberculosis, which was once a disease of young people, is now primarily a problem of the aged. In 1953, the average age of those admitted was 48½ years; 6 years later it was 53 years. In 1955, there were 10 patients under 20 years of age; today there are none.

In conclusion, it is apparent that there has been but a very slight decline in the incidence of tuberculosis. With the ever-increasing length of man's span of life and the higher incidence of tuberculosis among the aged, it is possible that we can no longer expect a continuing decline in tuberculosis as a health problem. The great reduction in hospital census has been due to two factors:

1. Earlier recovery and shorter periods of hospitalization due to the development of new wonder drugs used in treating tuberculosis.

2. The high increase in the number of tuberculosis patients who are being treated not as inpatients but on an outpatient basis.

HAWAII ISLAND HOSPITAL ASSOCIATION PLANNING PROPER NURSING HOME SERVICE

The following was prepared by the hospitals of Hawaii Island as a guide in the development of nursing home services and facilities.

The following concept is basic in planning a proper nursing home facility and service:

The aged are the constructive citizens of yesteryear whose toil pioneered the abundance we now enjoy. They have earned their full share of today's bounty.

On a highly personal basis, one might also consider the fact that: As these now are, someday we may be.

Federal support for needy nursing home patients until June 30, 1961, was flat maximum of \$41.50 per patient per month. Effective July 1, 1961, Federal support was greatly increased and is now 53.8 percent of cost in Hawaii. It is apparent, however, that nursing homes must and will be subjected to more

rigid licensing requirements by the State department of health. Such licensing requirements will include far more than safe decent housing and tender loving care. Increased Federal support therefore should not be used to lower costs borne locally but to develop proper nursing home services to the full extent of patients' physical and mental capacities. This will require a varied program of activities which will keep patients constructively busy and maintain their interest in life. In order to plan proper nursing home service, the following is necessary.

A. Make an analysis of each patient.

- (1) Age and sex.
- (2) Degree of ambulation.
- (3) Physical therapy capabilities and requirements.
- (4) Occupational therapy capabilities and requirements.
- (5) Social history.
- (6) Diagnosis and medical history.
- (7) Medication and treatment.
- (8) Recreational capabilities and needs.
 - (a) Reading.
 - (b) Crafts.
 - (c) Games.
 - (d) Limited physical exercise.

B. Plan programs to fully utilize patients' interests, needs and capabilities, both immediate and potential.

C. Institute plans to train personnel for new therapeutic procedures involved in proper nursing home care.

HILLO HOSPITAL GERIATRICS TREATMENT CENTER DIVISION

(A nursing home for the chronically ill)

Residents as of Nov. 29, 1961

| | Married | Single | Widowed | Divorced | Separated | Total |
|------------------|---------|--------|---------|----------|-----------|-------|
| Male..... | 6 | 44 | 10 | 6 | 1 | 67 |
| Female..... | 1 | 3 | 12 | 1 | 0 | 17 |
| Grand total..... | 7 | 47 | 22 | 7 | 1 | 84 |

State of ambulation

| | |
|--------------------------|-----------|
| Bedridden..... | 37 |
| Partially bedridden..... | 28 |
| Ambulatory..... | 19 |
| Total..... | 84 |

There are only two patients who are not gotten out of bed for some portion of the day. Even this is only temporary for these two cases.

Classification

| | |
|----------------------------|-----------|
| Nursing home patients..... | 79 |
| Care home residents..... | 5 |
| Total..... | 84 |

Age distribution

| | Female | Male | Total | | Female | Male | Total |
|---------------|--------|------|-------|-------------------------|-----------|-----------|-----------|
| 20 to 29..... | | 1 | 1 | 70 to 79..... | 8 | 24 | 32 |
| 30 to 39..... | | | | 80 to 89..... | 6 | 28 | 34 |
| 40 to 49..... | | | | 90 to 99..... | | 3 | 3 |
| 50 to 59..... | 2 | 3 | 5 | Grand total..... | 17 | 67 | 84 |
| 60 to 69..... | 1 | 8 | 9 | | | | |

Major cause of hospitalization

| | | | |
|----------------------|----|----------------------|------------------|
| Stroke..... | 52 | Amputation..... | 3 |
| Diabetes..... | 10 | Gastric ulcers..... | 3 |
| Rheumatism..... | 8 | Emphysema..... | 3 |
| Poor vision..... | 7 | Hypochondriasis..... | 3 |
| Cataract..... | 6 | Alcoholism..... | 1 |
| Total blindness..... | 5 | | |
| Fractured hip..... | 4 | Total..... | ¹ 109 |
| Asthma..... | 4 | | |

¹ Exceeds total of 84 because of sufferers from multiple major conditions.

Special problems

| | |
|---|----|
| Patients requiring external urinary drainage..... | 14 |
| Other incontinent patients..... | 8 |
| Total incontinent patients..... | 22 |
| Patients requiring spoon feeding..... | 15 |

Mental status

| | |
|---------------------|----|
| Mentally alert..... | 12 |
| Senile..... | 56 |
| Vegetating..... | 16 |
| Total..... | 84 |

Physical therapy

| | |
|--|----|
| Total, patients and residents..... | 84 |
| Not participating in physical therapy program..... | 32 |
| Total..... | 52 |
| Participating in physical therapy program : | |
| Walker and activity of daily living..... | 14 |
| Wheelchair and extremities exercised..... | 30 |
| Bed patients, extremities exercised..... | 2 |
| Walk with aid, pulley exercise, parallel bars..... | 3 |
| Walk with cane, pulley exercise bars..... | 3 |
| Total participating in physical therapy program..... | 52 |

Care home placement record

| Year | 1959 | 1960 | 1961 | Total |
|------------------------------|------|------|------|-------|
| Placed..... | 4 | 10 | 0 | 14 |
| Returned to institution..... | 2 | 2 | 0 | 4 |
| Net effectively placed..... | 2 | 8 | 0 | 10 |

AN OVERSIZE HOSPITAL WITH LOW OCCUPANCY UPON TERMINATION OF VETERANS
CONTRACTS WITH LOCAL HOSPITALS

When Hawaii was a territory, veterans were eligible for services in local hospitals under the Veterans Act which makes an exception of territories and possessions in the requirement that needy veterans go to U.S. hospitals in order to receive free services.

Hawaii became a State on August 21, 1959. Hilo Hospital thereby lost its exempt status and the contract between the hospital and the Veterans' Administration therefore terminated automatically as of that date. Hilo Hospital however, was then in the midst of a \$1,476,107 building project to complete the last units required for a modern \$4,096,237 hospital complex of 238 beds to serve both general and tuberculosis patients, including veterans in both categories. After adding interest costs to bonds sold for the foregoing construction, the total cost of the new hospital facility will exceed \$5 million.

The original plans, including facilities for veterans, were prepared and let to contract in good faith. In fact, the hospital managing committee, at that time, would have placed itself in an unethical and untenable position if it had not provided sufficient beds for local veterans.

The transfer of veterans to the U.S. military hospital in Honolulu (Tripler General) leaves Hilo with an overinvestment in physical plant, but worse still, with an average daily patient occupancy of less than 70 percent; an unsatisfactory ratio for economical operations. This is a hard blow to a small community. Personal incomes in Hilo are not high and hospital costs must be kept in line with the income level of the community. This is impossible in an over-size physical plant with a low average census. There is nothing to indicate the likelihood of a population growth in the Hilo area which would offset this situation.

Two factors serve to accentuate the need for care home facilities on Hawaii Island:

1. The earlier importation of single men for labor on the plantations results in the need for increased care homes. Hawaii Island has a larger percentage of plantation labor than any other island. Single, immigrant laborers are without family and friends and a greater majority, therefore, are dependent on care homes or institutions when they become incapacitated and no longer able to provide for their own care.

2. The birth rate on Hawaii Island is approximately four times that of the death rate. For example, in 1960, there were 728 births as compared to 175 deaths. In spite of this, the island has a declining population. This means a large volume of outmigration which traditionally takes place among young people who have a good potential for employment in other areas. This also adds to the disproportionately high ratio of elderly residents on the island.

The foregoing, coupled with the normally increasing problem of providing proper care for the aged made it necessary to undertake an islandwide survey in an effort to determine the nature and extent of the problem. No such survey is ever complete. The following, however, presents the results based on partial data secured.

Hawaii Island survey—Requirements for care home facilities

| | Number of persons recommended | Sex | | Age | |
|---|-------------------------------|------|--------|--------------|--------------|
| | | Male | Female | Average | Range in age |
| | | | | <i>Years</i> | |
| Plantation A..... | 7 | 7 | 0 | 77 | 58-91 |
| Plantation B..... | 8 | 5 | 3 | 74 | 60-88 |
| Plantation C..... | 3 | 3 | 0 | 56 | 50-64 |
| Plantation D..... | 8 | 4 | 4 | 71 | 58-91 |
| Plantation E..... | 5 | 4 | 1 | 84 | 80-89 |
| Plantation F..... | 8 | 8 | ----- | 64 | 50-76 |
| Plantation G..... | 7 | 7 | ----- | 74 | 69-79 |
| Plantation H..... | 26 | 15 | 11 | 72 | 58-90+ |
| State department of health..... | 8 | 7 | 1 | 74 | 62-92 |
| Transfer of domiciliary cases from GTC..... | 8 | 7 | 1 | 77 | 61-93 |
| Total..... | 88 | 67 | 21 | ----- | ----- |

Four plantations did not report.

The foregoing study was made over a year ago, undoubtedly some of the aged people reported at that time have since passed away. One must assume, however, that for everyone who has died one plus has moved into the category of those requiring some form of resident or nursing home care.

There has been no social service investigation of the foregoing referrals which, when done, will doubtless indicate that care home placement is neither necessary nor advisable in many cases. The number may therefore be reduced by one-third. In Hilo there is no single source for referrals as was the case on the plantations where all such cases are known to personnel or industrial relations directors. The foregoing table does not show the number in Hilo requiring care home services, which number doubtless is considerable.

The following presents detail on four specific cases which are typical of those listed in the foregoing tabulation :

| | Resident W | Resident X | Resident Y | Resident Z |
|------------------------|----------------------------|---------------|--|--------------------------------------|
| Age..... | 64..... | 91..... | 60..... | 71..... |
| Sex..... | Male..... | Male..... | Female..... | Male..... |
| Racial extraction..... | Filipino..... | Chinese..... | Part Hawaiian..... | Portuguese..... |
| Family..... | Relatives on Kauai..... | None..... | Sons..... | None..... |
| Housing..... | None..... | None..... | (?)..... | None..... |
| Health..... | Disabled..... | Diabetic..... | Cerebral vascular accident..... | Observation..... |
| Financial: | | | | |
| Amount of pension..... | None..... | \$20..... | County of Hawaii pension, \$120 month..... | Veterans' pen- sion, \$78.75..... |
| Social security..... | \$50..... | \$33..... | None..... | None..... |
| Insurance..... | \$373.19..... | None..... | None..... | None..... |
| Other assets..... | \$3,498..... | None..... | Land—South Kona..... | None..... |

The health data in the four cases noted above is also typical. This means that a considerable number are in need of nursing home services; not just care home facilities.

Senator Long. The next witness is Dr. David Woo, Rehabilitation Service Officer, Hilo Hospital.

STATEMENT OF DR. DAVID WOO, REHABILITATION SERVICE OFFICER, HILO HOSPITAL

Dr. Woo. Senator Long, Senator Morse, and members of the committee, as a member of the medical staff of the Hilo Hospital having something to do with the care of the aged, I will attempt to present what we are trying to do on a local level to develop a program of rehabilitation in connection with the problem of medical care of the aged and chronically ill patients in our community. This undertaking may be only a minor detail in a very insignificant spot in comparison with the overall national picture, but we hope that your committee will give us cognizance in your final deliberations.

This represents a spontaneous activity, initiated by certain starting funds as authorized by the last State legislature. We hope that this could be implemented by funds from some other agency in the future so that this pilot plan could be broadened and continued for the benefit of all concerned.

The rehabilitation service at the Hilo Hospital was put in operation since January 1, 1961, under Act 234, SLH 1959. The team consisted of a consultant psychiatrist, special consultants in orthopedics and neurosurgery, a liaison physician of the medical staff, physiotherapist, occupational therapist, nurses, social worker, and other nurses aids and assistants. A survey of the needs for rehabilitation was made among the chronically ill, disabled, and aged throughout this county and Island of Hawaii, and a program was projected to remedy the situation. Also, an educational program was necessary to inform the physicians and medical facilities, especially in the outlying towns, of the availability of this program and the way in which the patients may be helped.

Five categories eligible for hospitalization in the unit were defined and each case is only admitted after being screened by an admissions committee.

The categories are listed as follows:

(1) Physical rehabilitation for crippled or incapacitated children and adults.

(2) Long-term medical, nursing, and rehabilitative cases with reasonable prognosis for improvement or recovery.

(3) Asthmatic patients.

(4) Mental cases requiring long-term care in an open ward.

(5) Terminal care for the acutely ill who still require intensive medical and nursing care after 30 days in the general hospital division.

(6) Excluded:

(a) The acutely ill during the first 30 days of general hospital care.

(b) The chronically ill with little or no prognosis for improvement or recovery.

(c) Custodial residents.

All patients at the Geriatric Treatment Center (GTC) were interviewed with the idea of possible rehabilitation benefits, however remote. Those who showed any indication of being benefited by this program were evaluated by the psychiatrist and a treatment routine was developed and prescribed for each particular case with admission to the Rehabilitation Service of the Hilo Hospital. Periodic review and evaluation of the progress made of these patients by the team at intervals were conducted.

The attached summary shows the statistics we have been able to accumulate in the first 10 months of our operation.

(The summary referred to follows:)

HILO HOSPITAL, HILO, HAWAII

Summary of rehabilitation services authorized under Act 234 (1959), in reference to utilization of vacant tuberculosis beds and funds for the rehabilitation service derived from savings in the tuberculosis hospital appropriation

| Patient | Age | Sex | Diagnosis | Type of disability | Length of stay | Treatment prescribed | Disposition of case |
|----------|-----|----------|--|---|-------------------------|---|----------------------|
| JC..... | 69 | Male.... | Parkinson's syndrome..... | Unsteady hands..... | 56 days..... | (1) Wheelchair; (2) feeding; (3) speech improvement. | Discharged. |
| AJ..... | 56 | ..do.... | Progressive muscular dystrophy... | Completely disabled.. | 6 days..... | (1) Complete nursing care; (2) frequent suctioning. | Expired. |
| BC..... | 71 | ..do.... | Fracture left hip with nailing..... | No weight bearing on left foot, mental confusion. | 76 days..... | (1) Wheelchair; (2) ambulation and weightbearing with cane; (3) lie in prone position ¼ hour b.i.d. | Discharged. |
| DG..... | 63 | ..do.... | Congestive heart failure, arteriosclerotic heart, obesity. | Difficult to ambulate because of obesity. | 56 days..... | (1) Weight reduction; (2) increase in ambulation. | Do. |
| ED..... | 50 | Female.. | Cerebral thrombosis due to arteriosclerosis and essential hypertension. | Right hemiplegia..... | 54 days..... | (1) Wheelchair; (2) speech improvement therapy. | Do. |
| MM..... | 65 | Male.... | Chronic arteriosclerosis..... | Left hemiplegia..... | 38 days..... | (1) Parallel bars; (2) leg brace..... | Returned to GTC.* |
| EF..... | 68 | ..do.... | Arteriosclerotic cerebrovascular accident. | ..do..... | 38 days..... | (1) Wheelchair..... | Do. |
| MM..... | 65 | Female.. | Fracture of surgical neck of left humerus, hypertensive heart disease. | Immobility of left arm. | 191 days..... | (1) Diathermy; (2) wheelchair; (3) activities of daily living; (4) daily exercises. | Discharged. |
| MN..... | 75 | ..do.... | Cardiovascular accident..... | Right hemiplegia..... | 62 days..... | (1) Functional wheelchair..... | Transferred to GTC.* |
| MF..... | 76 | Male.... | Chronic gout, arteriosclerotic heart disease, diabetes mellitus. | Left hemiplegia..... | 92 days..... | (1) Sling to left arm; (2) ambulation, parallel bars to cane. | Expired. |
| EM..... | 53 | Female.. | Hypertensive cardiovascular disease. | ..do..... | 43 days..... | (1) Functional wheelchair to walker; (2) gait training; (3) toileting; (4) dressing. | Returned to GTC.* |
| KN..... | 88 | ..do.... | Fracture of left hip and removal of cataract, left eye. | No weight bearing on left leg. | 97 days..... | (1) Ambulation with walker..... | Do. |
| RY..... | 84 | Male.... | Senility..... | Unable to stand and needed to be fed. | 10 days..... | (1) Ambulation..... | Expired. |
| SR..... | 69 | ..do.... | Cerebrovascular accident..... | Right hemiplegia..... | Still hospitalized..... | (1) Wheelchair; (2) leg brace; (3) self-shower. | Still hospitalized. |
| SCK..... | 77 | ..do.... | Fractured left hip..... | No weight bearing on left foot. | ..do..... | (1) Unable to train due to lack of cooperation and comprehension. | Do. |
| MA..... | 60 | ..do.... | Obturator neurectomy, and bilateral transection of rectus femoris muscle origin. | Paraplegic..... | ..do..... | (1) Transfer technique, pelvic brace... | Do. |
| ST..... | 63 | ..do.... | Cerebrovascular accident..... | Right hemiplegic..... | ..do..... | (1) Occupational therapy; (2) self-care; (3) toileting; (4) speech improvement. | Do. |

| | | | | | | | |
|---------|----|---------|-------------------------------|--|---------|---|-----|
| DS..... | 60 | do..... | do..... | do..... | do..... | (1) Wheelchair and self-feeding..... | Do. |
| MG..... | 72 | do..... | do..... | do..... | do..... | (1) Self-feeding; (2) wheelchair; (3) ambulation on parallel bars to cane. | Do. |
| JV..... | 69 | do..... | Pott's disease..... | Unable to stand and walk. | do..... | (1) Wheelchair, walker, showers..... | Do. |
| HY..... | 40 | do..... | Cerebrovascular accident..... | Right hemiplegia..... | do..... | (1) Self-care for daily bathing activities and independent ambulation. | Do. |
| EA..... | 69 | do..... | Asthma..... | Occasional wheezing with severe cough. | do..... | (1) Intermittent positive pressure breathing 2 times daily. | Do. |
| KL..... | 77 | do..... | Parkinson's..... | Difficulty walking, urinary difficulty, occasional angina attacks. | do..... | (1) Wheelchair; (2) indwelling catheter for urinary difficulty; (3) self-feeding. | Do. |

*Geriatrics treatment center.

Summary disposition of the 23 admissions

| | |
|-------------------------|-----------|
| Discharged..... | 5 |
| Still hospitalized..... | 10 |
| Returned to GTC..... | 4 |
| Transferred to GTC..... | 1 |
| Expired..... | 3 |
| Total..... | 23 |

Age distribution

| Age | Male | Female | Total |
|-------------------------|-----------|----------|-----------|
| 40 to 49..... | 1 | | 1 |
| 50 to 59..... | 1 | 2 | 3 |
| 60 to 69..... | 10 | 1 | 11 |
| 70 to 79..... | 5 | 1 | 6 |
| 80 to 89..... | 1 | 1 | 2 |
| Grand total..... | 18 | 5 | 23 |

To sum it up, you will find that we had 23 admissions. We discharged 5. Ten are still being hospitalized. Four were returned to the G.T.C. and one was transferred to the G.T.C. We did have three who expired. These were mainly in the age group of 60 to 89. From 60 to 69, there were 1 female and 10 males. In the age group of 70-79, there were one female, five males—six in all. And in the 80-89 group, there were 1 male and 1 female, 2 persons; making a total of 23.

As you note also, the cases mostly were cases of chronic dystrophy, or inability to walk, fractures, cases of strokes with hemiplegia, and so forth.

We feel that on a local level we have approached the problem of rehabilitation and chronic illness of the aged on the island of Hawaii realistically and methodically. The results of our program are beginning to point to the fact that rehabilitation could assist in lessening the load in geriatric treatment centers, old folks' homes, or nursing homes by having some at least trained and discharged to be able to take care of themselves in the activities of daily living. Cases which had been bedridden for years have been able to be up and about again, if not in a wheelchair then on crutches. The period of convalescence also has been shortened, especially in hemiplegic cases and in fracture cases.

The overall cost of hospitalization has been reduced appreciatively, both from the standpoint of the patient's pocketbook and from the county's finances.

Given sufficient time and money to implement this program, we feel that the problem of the disabled and chronically ill and aged patients could be put on a sound and practical basis as presented.

Senator LONG. Thank you very much, Doctor.

Now we are going to devote a short time to the most interesting phase of the program. I am going to turn to the "Town Meeting on Problems of Our Senior Citizens," and on this—there are a lot of names and I am going to have to be a little hardboiled.

When we turn to this next phase—and then after lunch we will resume the statements of the professional men and women in this—we want you to develop only one thought. We don't want a long

history of your life. It would be of interest, but we want your suggestions, particularly, as to what you think might be of help to you. So, in order to start it—I have two names—I will call first Dr. W. J. Heather, retired college professor.

**STATEMENT OF DR. W. J. HEATHER, RETIRED COLLEGE
PROFESSOR**

Dr. HEATHER. Senator Long, Senator Morse, members of the staff, ladies and gentlemen, I think that I shall not read what I prepared, but I have given the copies to your staff. I think I can shorten it by just saying, first of all, that I certainly thank God for social security; and, second, I want to pay high tribute to the administration of it in this city. It is terrific. They just sit down with you and help carry your load.

Now, I think my case is probably unusual, but I want to deal just quickly with two points, the problems of supplemental income; and the second, hospitalization and medical care. Now, although my case may be unusual, I am sure there may be many others who have different factors to contend with that result in the same problem.

I am 67; my wife is 49. I have a son 14 and a daughter 12; so that at age 67, I am tackling the job of a man of 45. Now, in order to do that as a good American and to be sure to take full responsibility for my family to see that they are not placed in the hands and on the doorsteps of individuals or groups or institutions, I have to look forward to one other thing. At my age, I cannot favorably insure myself for them in the event of my death; and with the age differences, it could happen that way.

Now, this means that the pension I get must be used almost entirely to reinvest as a form of insurance so that when I am gone they will still have an income. Therefore, I am thrown almost completely on my social security, which is the highest \$254, and very much appreciated. With this I must take care of a family, where I should have greater income and did have when I was 45. But I can overcome that with supplementary income. The problem of it is that neither my wife and/or I can earn more than \$1,200 a year unless we give back half of every dollar we earn.

Now, the work that I am able to do because of some 40 years of experience is consultation in personnel development by teaching and lecturing, and I am certain that I don't replace a younger man. I mean it's a separate thing. Now, I don't want a full-time job and I don't need one, but if I could just have enough leeway to give the professional services that I am capable of giving, and could earn more than \$1,200, I would be very grateful for that supplementary income help.

Now, to the second point. Therefore, you see, with this problem of a young family, investing for family insurance while trying to carry on with a low income, I cannot help but think of the possibility of a catastrophic illness or injury. I would have only three alternatives. One would be to try to stretch that social security, and it won't stretch that far; Two, I would have to use that and invade or use up the reinvested insurance program for my family and put them on charity; or, third, sell my home.

I notice, Senator Morse, that you have given great attention to this subject and I greatly appreciate it. I only make these two points to add to the weight of evidence which I am sure you already have.

Thank you very much.

Senator LONG. Thank you, Doctor.

Senator MORSE. Doctor, that is excellent. Indeed, there are case histories like that all throughout the country, and there are many of them.

Dr. HEATHER. Thank you.

(The prepared statement of Dr. Heather follows:)

PREPARED STATEMENT OF DR. HEATHER

This is a contributing statement by William Jerome Heather, age 67 (9-17-61) Post Office Box 123, Volcano, Hawaii, Social Security Claim No. 326-10-4774.

First let me bear witness to the wonderful values of our U.S. social security system. Thanks be to God and to the legislators who created it, and for steadfastly guarding it against all attacks, until now it is as safe a symbol of the United States of America as the American flag. Under that system, however, I face two problems:

No. 1. Supplementary earnings

My case is somewhat unusual but it does have a definite influence on the social security of my family and me. Others may not have the exact same factors as I, but many have others that affect them in the same way.

My family is young. I am 67, wife 49, son 14, daughter 12, so that I have the family expenses of a younger man with sufficient earnings. In addition, I am beyond the age of insuring for their future in the event of my death, and must use my pension income to reinvest for that purpose. This means that my social security income of \$254 per month is too low for my family expenses and I must increase it by supplementary income from earnings. But my wife and/or I are only allowed by law to earn \$1,200 per year without losing half of all we earn above \$1,200. This works an inexplorable handicap and hardship, one which I ask your committee to consider in this phase of the aging problem with which I am faced.

Employment that I can obtain would be in the nature of consultation services, lecturing, and teaching, in which I have had nearly 40 years of experience. My work is and could be such that I would not in any way be depriving anyone younger than I of needed employment. More than that, I do not want, nor do I need, a full-time job, but I can earn more than the \$1,200 from those who seek my professional services.

No. 2. Medical care and hospitalization

My health is excellent, but as I go along meeting my personal American responsibility for my own family so that none of us will fall back on others, individuals, groups, or institutions for social services and charity, I am constantly aware of the possible consequences of a catastrophic illness or injury. As the situation presently is, my only recourse would be to try and stretch my social security income, which is almost an impossibility, or dangerously deplete or use up completely my insurance investment, or sacrifice my home. I am aware of the legislation being considered for relief in this area, especially I am aware of and appreciate deeply Senator Morse's strong position in the interest of solving this problem of the aging with which he has made himself thoroughly familiar and for which he courageously assumes responsibility.

This statement is made to the Senate Committee on Aging for the purpose of adding to the evidence of the need for this law.

Senator LONG. I will now ask Mrs. Maude Beers, retired school principal, to take the stand.

STATEMENT OF MRS. MAUDE BEERS, RETIRED SCHOOL PRINCIPAL

Mrs. BEERS. Senator Long, Senator Morse, members of the staff, and friends, it is a pleasure to be here and to offer the following suggestions about something that could be done to help this problem of the aging.

My first suggestion is that the board of supervisors of the county of Hawaii appoint a county committee on aging, to consist of members from all parts of the island. As you know, our island is so large that distance is a problem. A county committee could be a great help to meet this problem.

Now, a county committee could do a great deal as a resource center to inform the aging and others of what is going on in relation to this topic; and this would be of great assistance for future help, when needed.

This committee could also help to organize groups to study and learn more about the action and possibilities for more help. If the committee included a representative from the department of education, it might help to develop a closer relationship between the young and the old if some instruction could be presented to students. This would lead to a better understanding of what lies before them. We do not stay at one age for more than 1 year, and time passes by so rapidly that we are old before we know it.

My second suggestion is that closer work with churches of all denominations to promote groups for recreation, study, and so forth, would give these groups a better understanding of the sources of help that are available today.

And I feel that an educational program should be developed, especially to study the possibilities of help from the Department of Public Welfare, the Medical Social Service, the Board of Health, the Heart Association, the Cancer Association, the TB Association, the Social Security Department, the YWCA and the YMCA Associations, and the Red Cross. All of this would meet the needs and would be a very great help in understanding what we must do to prepare for the aging.

Senator LONG. Thank you, Mrs. Beers.

I want to commend the first few witnesses. They have made it brief. I am going now to call on Hawayo Hiromi Takata.

STATEMENT OF MRS. HAWAYO HIROMI TAKATA, SENIOR CITIZEN

Mrs. TAKATA. Mr. Chairman, distinguished guests and friends of Hilo—Aloha. Thank you for holding this forum to give the people of Hawaii an opportunity to acquaint themselves with the problems of aging.

This is a serious and important matter to the people of modest means, who have already reached the retirement age and to those who are facing it.

I am here to present my views outlining a constructive and economical project, which could be enjoyed and realized by all who are concerned and involved with the various problems pertaining to the aged.

I was born on Kauai 61 years ago and have been widowed for 31 years. I have raised a family and I am now a grandmother of six. These experiences enable me to delve into the psychology of working people in need of help. Social security is of some help but it is not enough. I know the feelings of anxiety in trying to make both ends meet in the struggle of life. I also know the sadness of heart, for in 7 years I have attended seven funerals within my family.

They say that ignorance is bliss, but to me, ignorance is my greatest foe. Thirty years ago I searched, meditated and found a system of healing which changed my whole life—from a body of illness, a depressed mind, into a healthier, happier, and more useful being.

I leave behind me 25 years of serving the public—years of experiences in both developing and practicing this wonderful system. In a year I will attain retirement age and although I have reached maturity, I do not feel old.

In my opinion, we become confused and push ourselves into premature old age unnecessarily, by letting ourselves down, by mistreating our bodies. When we are unable to understand the change that has taken place, when we are tired in body and mind, we become in-harmonious with ourselves and let anger, worry and even panic or hysteria creep in.

Therefore, I feel that the majority of retiring people need a constructive program to keep them busy, beginning with a training program of 3 to 6 months to learn the art of healing, of dieting, which includes both how and what to eat, of living on a limited income, of rebuilding the wornout body, of rejuvenating the depressed mind, and of planning ahead for a new relaxing and well-earned vacation—

Senator MORSE (interrupting). Mrs. Takata, may I interrupt you just a moment to extend to you my apologies. I have to leave and I hate to leave while you are testifying; so please excuse me—

Mrs. TAKATA. Yes.

Senator MORSE. And I want to say to the audience that I appreciate very much this hearing and I am sorry to have to leave my colleague, Senator Long. But I want to say that it is a great pleasure to serve with him in the Senate because here is a man with a great social conscience, and I have come to really love him. Goodbye.

Mrs. TAKATA. This is more for the audience. This is more for the people of Hilo.

I use cosmic energy. It is a drugless treatment, using the hands as electrodes. It aids physical wellbeing and keeps one mentally alert. With proper diet, exercise of body and mind, practiced daily, this system will rebuild our tired rundown nerves and tissues, create new energy, release toxin from the body, put circulation into normal rhythm and restore the functioning of the entire body to normalcy.

This treatment is complete in itself. The result is health and peace of mind. You will then attain health, happiness, security and longevity. Being a universal force, this system can also be applied to plantlife, fish, fowl, and animals.

This system is strictly scientific. It utilizes a force similar to radio waves emanating from a radio station broadcasting sound vibrations, to which we are able to tune in. It also resembles television, which brings both sound and vision into our presence.

This vital energy is the great life force—radiating from the sun. It is sometimes called the radionic or ether wave because it has the dynamic force to cease pain. It is a vital energy because, when applied, it vitalizes our whole system. It is like recharging our batteries.

In acute cases the healing is instantaneous. However, in chronic cases, with deep-seated causes, more time is required. The theory of this system is to "Remove the cause, and there shall be no after effect." This is—

Senator LONG (interrupting). Mrs. Takata, I am going to have to ask you to stop now. We cannot hear this now in its entirety. Later on, if we can, we will come back to you. This is for senior citizens, and you don't qualify yet. We are trying to limit them to about 2 minutes.

We thank you very much and I am certain you have something to offer, but we are concerned not with the group you are working with, but with the present senior citizens. So will you please help us by doing this—

Mrs. TAKATA (interrupting). Yes, yes. May I say—

Senator LONG. And then I will talk to you—

Mrs. TAKATA (interrupting). May I say—may I say one thing?

Senator LONG. Yes.

Mrs. TAKATA. This applies to people from about 65 to about 20 years, and then after that then I believe that they come into the real old age. But this is to the people of from 65 and maybe 20 years on, who still have vigor and vitality but we want to utilize our time for rehabilitation and not push ourselves into the wheelchair.

Senator LONG. That's good advice. We'd all live longer—

Mrs. TAKATA (interrupting). Yes. Maybe we can have a forum.

Senator LONG. Yes. I will call on former Senator Capellas at this time.

STATEMENT OF EUGENE S. CAPELLAS, SENIOR CITIZEN, FORMER SENATOR FROM THE COUNTY OF HAWAII TO THE TERRITORIAL LEGISLATURE, AND PRESIDENT OF THE HAWAII COUNTY RETIRED TEACHERS ASSOCIATION

Mr. CAPELLAS. Honorable Senator Long, Honorable Senator Morse, and members of the United States Senate Special Committee on Aging, greetings.

As a true and independent American, I say welcome to our city of Hilo and to God's country. Yes, God's country because God still keeps His home fires burning at Halemaumau and Mokuaweoweo volcanoes, with Madam Pele, the Goddess of Fire, as His chief cook and housekeeper.

I also want to say thank you, most sincerely, and may God bless you for coming into our midst on such a meritorious and humane mission—that of coming to find out what good and how much you can and will do for our deserving aged people.

My name is Eugene S. Capellas. I am a retired school principal and also a retired State senator. Fortunately, I do not need any aid or assistance from either the State or the Federal Government.

However, as President of the Big Island Retired Teachers Association, I am here on behalf of those aged people who are really and

truly in need of governmental aid and assistance in the last years of their lives.

Let us not forget that our aged people of today were the active and contributing citizens in our American life of yesterday. Hence, too long have they been forgotten, neglected, and ignored.

However, it is most gratifying to note that our America is awakening to the realization that we do owe our aged people some consideration and some compensation for their past contributions in making our social, political, and economic life in America the very best in the whole world.

Yes, both Federal and State Governments are now working toward the enactment of proper legislation, which will provide medical aid, housing, retirement income, et cetera, for all the aged citizens who really need aid and comfort in their old age.

President Kennedy stated the other day in Los Angeles that he will push harder than ever next year for a Federal medical care plan for aged people.

Our Governor Quinn is a strong supporter of the measure and has a strong Commission on Aging working for the movement.

I, personally, have devoted some time to studying our local situation. Therefore, my first recommendation, or suggestion, is that a survey be made in each county of all the aged people over 65 years of age; that a short life history of each be obtained; that all listed aged persons be segregated, or classified, according to their present status in retirement income, their housing conditions, and their ability to take care of themselves.

My second suggestion is that plans for homes for aged people be carefully studied and given the keenest consideration possible, so that the individual apartments to house them will contain and provide comfortable and convenient accommodations, including all the necessary facilities and furnishings.

My third suggestion is that adequate recreational facilities be provided for those who are able to indulge in them; also, occupational facilities of various types must be provided for all the able persons, besides assembly halls for gatherings, social events, and TV.

An adequate retirement income must be allowed to each of the absolutely needy ones, so that they may live in peace and comfort, and in accordance with our American standards of living. Naturally, medical care, when and where needed, is due to all of our aged people, who, in their time, patriotically worked for and helped to make our America the strongest, the richest, the greatest, and the best country in the whole world.

That's my contribution toward our aged people.

Senator LONG. Thank you, Mr. Capellas—Senator Capellas—for that statement. It will appear in the record.

Mr. CAPELLAS. Thank you.

Senator LONG. Now, who else among the senior citizens?

I think I made it clear that if you had a thought that you would like to share with the committee but for some reason do not desire to get up and give it, please write it. You will find envelopes on this table over here.

But we would like to have more than the three who have appeared.

If not, we will go back to our regular agenda. We have until 12:30, according to our plans.

The next witness is Mr. Mitsusuke Nakamura, physical therapist, Hilo Hospital. Mr. Nakamura?

**STATEMENT OF MITSUSUKE NAKAMURA, PHYSICAL THERAPIST,
HILO HOSPITAL**

Mr. NAKAMURA. Senator Long, members of the staff, and friends, I have here an "Evaluation of the Physical Rehabilitation Program at the Hilo Hospital from 1955 to 1961."

Rehabilitation of the elderly involves in coping with numerous crippling afflictions. However, "stroke" or "cerebral vascular accident" comprises the greatest number of patients involved in rehabilitation. This fact holds true whether in large, moderate, or small populated areas of the country.

Take, for instance, a city like New York City—the Bird S. Coler Hospital, a 2,000-bed chronic hospital, has 200 beds in the rehabilitation ward; and they treated 60 percent of the cases for brain damage and 50 percent for hemiplegia. So you can see that a great center like New York treats half of their rehabilitation cases in stroke.

Now, in the Rehabilitation Center of Honolulu, taking a moderately populated area, which has a bed capacity of 22 and an average daily caseload of 13 inpatients and 25 outpatients, and this is what they are finding: "Patients of all ages are admitted; a considerable part of the caseload consists of CVA cases." So in Honolulu, the problem of rehabilitation of aging is mainly in the stroke cases.

Now, in Hilo, where the population is small, the Geriatric Treatment Center, an 88-patient chronic home for the aged, 45 percent of the cases were CVA. And 20 of the 30 bedridden patients were due to stroke. This survey was taken just last April; so you can see that here in Hilo, too, that 45 percent of our cases, or 50 percent right now in the hospital, is from the disabling of stroke.

Since the greater part of the rehabilitation program for the aged is involved in the treatment of the stroke patients, the report will be confined to this group. I chose 1955 as a starter because that is when the physical therapy department was opened in Hilo. Now, we had a small facility then, a space area of 15 by 25, and we used the corridors and the stairs, and we didn't have any occupational-therapy service or social service or speech service at the hospital. Neither did we have any guidance from an expert in physical medicine to guide this program.

I have some data here that I think you will be interested in. In 6 years and 4 months we had 85 stroke patients who were referred to the physical therapy department. Not all patients with stroke were admitted to the department, but 84 of these were.

Now, I think the medical payment part is most interesting because of the long-term care of stroke cases. The self-responsible were 43; that is, the insurance company probably paid for the hospital but 43 percent had to pay for rehabilitation services, and they stayed 3 weeks and 3 days, on the average. And the Sugar Plantation Medical Plan paid 29 percent, and they paid for rehabilitation. And the Department of Public Welfare, 17 percent; county pensioners, 6 percent; veterans, 2 percent; medically indigent, 2 percent; and the State TBC, 2 percent.

Now, relating here to the length of stay, it is interesting to note that the self-responsible's length of stay averaged 3 weeks and 3 days. The Sugar Plantation, who paid for rehabilitation—their cases stayed 5 weeks and 2 days. The ones assisted by welfare stayed 7 weeks. And county pensioners stayed the longest—9 weeks. And veterans stayed 7 weeks; and the medically indigent stayed 8 weeks; the State, 5 weeks.

The self-responsible patients may have been covered for hospitalization and other medical expenses but not for physical therapy. Since self-responsible patients had the lowest average number of treatments, it is indicative that the greater majority could not afford the long-term rehabilitation care that a typical stroke case demands. The plantation medical plan being the next shortest, it is also indicated that they have financial limitations and they have to cut expenses also. But the remainder of the financial resources were more liberal and they had more funds for rehabilitation services.

Now, there were 56 males and 28 females. Fourteen males and two females were transferred to the Olaa GTC unit, and it is assumed that the rest of the 68 patients were discharged to the community. Thus, 68 households were affected with the liability of caring for the stroke to a greater or lesser degree.

And I think it is very important to note here that these 68 individuals who left the hospital and went home, probably quite a few of them were disabled that they had to be dependent on another person in the household. Now, that would have tied—I don't know how many people—maybe the spouse or the daughter or maybe they even had to hire someone, probably; but they weren't able to stay long enough to have the treatment so that when they went home they wouldn't have been a liability to the rest of the family.

I think that a survey on this order should be very helpful. To survey when a patient goes home to see how many people will be tied down with these stroke patients, and I think we can find that in most cases that maybe one, two, or three will be tied down sooner or later because of the prolonged nature of a stroke case.

Now, in the age group of 36 years, we had 1; 40 to 45, 6; 46 to 50, 7; 51 to 55, 11; 56 to 60, 10; 61 to 65, 9; and 66 and over, 40. And if you break this to a percentage, the ones up to 64 were 52 percent; and the ones above 65, 48 percent.

Although 52 percent of the affected were below 65 years of age, it stands to reason that they will be greatly dependent in all the phases of the demands of life by the turn of three score and five. By proper medical and rehabilitation care, the degree of incapacitation will be reduced.

Now, this report here was made in April 1961. The reason April 1961 is taken as the point is because that is when we consolidated the old Hilo Memorial with the Pumaile area, and when we consolidated with this area we were able to form better teamwork in rehabilitation or the concept of total patient care. Dr. Woo has explained some of this. And now we have a physical therapist; we have an occupational therapist; we have a social worker; we have Dr. Woo and a medical staff leading this program, and Dr. Shepard heading, developing, and guiding this program.

So today, if a patient comes in with a stroke, he is likely to have not only a complete but a higher percentage of return from disability because of our better setup.

To summarize this whole program, by far the greatest single affliction which demands rehabilitation is the stroke patient. In our own chronic hospital, 20 of the 31 bedridden cases are primarily due to CVA.

Recovery of function in the stroke cases takes place over an extended period of months to perhaps 1 to 2 years. The factor of length of recovery and the incapacitating nature of the disease make some form of financial assistance imperative if we are to gain maximum return in independence or face the consequences of incapacitation and dependency on the taxpayer.

A stroke patient, in many cases, has multiple afflictions; this factor augments his medical expense.

A stroke patient also needs bracing, wheelchair, cane, and possible home renovation. This further adds to his expenses.

The other afflictions that we have had in Hilo, insofar as rehabilitation is concerned, are arthritis, fractures of the hip, Parkinson's disease, and some other afflictions.

The elderly definitely need some form of financial aid in rehabilitation. In a roundabout way, it is a tax-saving program, since rehabilitation prevents total dependency; and if we could prevent dependency, then institutionalization could be prevented, and it will decrease the need for more nursing homes and decrease the bedridden who are now in the nursing homes.

The insurance companies are not covering—I don't know of any insurance company who is covering the comprehensive rehabilitation needs of the patient at the present time.

Senator LONG. Thank you very much for your interesting and comprehensive statement of this very important part of the health program.

Is Mrs. Martin Pence in the group now?

I think possibly this is a good place for a break for our lunch. For your information, we have six more names. We will reconvene at a quarter of 2, for those who are interested; and if anyone who has prepared a statement and for any reason cannot appear this afternoon, we will, of course, want that statement for the record.

I thank you for your presence and for your splendid attention. The program here ran just about as it did on each of the other three islands, although on two of them we did stay on until we finished. On one, we had the break for lunch. Thank you.

(The hearing was recessed at 12:20 p.m. and was reconvened at 1:58 p.m.)

AFTERNOON SESSION

Senator LONG. The hearing will reconvene at 2 minutes of 2.

This morning I mentioned certain members of the staff and expressed my appreciation to them. I wish this afternoon to mention three others to whom we are very deeply indebted and who are very necessary members of the group: Mrs. Jayne Cushing, committee clerk; Mrs. Ivy W. Parks, official court reporter. And then in connection with the overall planning we are deeply indebted to Mrs. Alexander Faye, executive secretary, Commission on Aging for the State of Hawaii. We are deeply indebted to them, as I said, and we thank them.

Our first witness this afternoon will be Mrs. Martin Pence representing the Rainbow Falls Home. Mrs. Pence?

**STATEMENT OF MRS. MARTIN PENCE, REPRESENTING THE
RAINBOW FALLS HOME**

Mrs. PENCE. Senator Long, this Rainbow Falls Home is proposed—unfortunately, it is still proposed as a private home for the elderly—I won't use the word "aged," but "elderly"—who are not in need of nursing care. It is purely a domiciliary facility.

The county of Hawaii has given us permission to lease the old Hilo Memorial Hospital for \$1 a year. In taking over that facility, which is already there, there were certain variances that had to be met. In the first place, a fire protection system. The county has already appropriated \$25,000 for an alarm system to be installed in the Rainbow Falls Home, which has been accepted by the State fire marshal.

Then it was a question of the board of health giving us the license. There were certain things that we had to do and there are certain things that they still do not approve of, but we, like every other home for the aged, as I understand it, in the whole State—there isn't one that meets the requirements of the board of health. We come very close to it. There are one or two things that have to be done like, for instance, stair rails on both sides of the stairs, which is very understandable. For this home, now, we have all of the variances; all of the requirements have been met.

There is a great need for this home. For one thing, just a survey of the plantations, the pensioners; I believe there are 88 people of 2 years ago whom the plantations were most interested in putting into the home. They were aged bachelors, most of them, who had no way of taking care of themselves. They are in no way medical patients. They need proper supervision, proper meals, and the fundamentals of a good life, which we hope to give them.

In this home there will be, naturally, ward patients. The board of health insists that a ward can consist of only four beds to a ward, but they agree that the partitions can be three-quarters of the way up; in other words, movable partitions. The sanitary facilities are all right.

And then we also expect in the private rooms, former private rooms of the hospital, that we will charge a greater proportion for that; that is, if somebody wants to move in with their own furniture and pay a higher fee, well, that's just fine. Our fees will be about \$65 a month.

Things have come to such a point that we are ready to go except for one great item. We feel that we need \$10,000 to start with. It is a mere detail, I know; it seems so in this day and age. But as it is a private home and it is going to be run on an absolutely nonprofit basis, the money has to be donated. It could be—it has been said that it is such a great saving to the county and to the State that maybe they would donate this \$10,000. That could be. We are exploring every possibility we can because we need the money for hired help and, oh, the bare necessities before we begin getting State and Federal funds, which will be forthcoming when we begin meeting our obligation.

The staff of the home has been worked out, but nobody has been hired as yet. We are in hopes of getting one person who is both a registered nurse and an administrator; and from then on, we would like, oh, maybe four or five practical nurses because we do not need and we will not have any nursing care.

There is a board of seven members that is in charge of the home. The seven members are not individuals. We are representatives of

various organizations. For instance, I represent the Hilo Woman's Club. Now, when I leave, it will be up to the Hilo Woman's Club to appoint my successor. Then there are the junior chamber of commerce, the Hongwanji, the council of ministers, the medical society—that is not seven, but those are some of the representatives of the group. Also there is the St. Francis Council. They are all groups of people who would be interested in the home, and we have been interested and we have worked hard. It has been kind of uphill work.

I don't know of anything more that I can add to this except that we are almost ready to go on with something that is greatly needed here on the island of Hawaii. And it will be islandwide. Thank you.

Senator LONG. Thank you. What did you say the capacity will be? How many will you be able to accommodate?

Mrs. PENCE. About 150. That would be taking in ward space, and then the private rooms on the other side. At the present moment, there are 88 from the plantations that have applied. How many would be from Hilo, I do not know. There has been no survey and it is practically impossible to determine. But there have been a great many inquiries from people who would like to move in as to when are we going to open up. And a great many of those inquiries have been from persons who could afford the private rooms.

Senator LONG. To whom do you look for the \$10,000? Are you part of the community chest?

Mrs. PENCE. No. We have looked to the McInerny Foundation and to Watamull's. And then we have a list of people who—I would rather not say who they are—whom we would like to see if they wouldn't be bighearted enough.

Senator LONG. You can nearly always find them for a good cause.

Mrs. PENCE. Thank you.

Senator LONG. There is an item here on housing that might be of interest to you. The program of direct Federal loans, administered by the Community Facilities Administration of the HHFA, provides low-interest rates—currently, 3 $\frac{3}{8}$ percent. A long-term—up to 50 years—loan to nonprofit organizations for the housing of elderly people.

Mrs. PENCE. That would be just exactly what we would need.

Senator LONG. We will give you this at the end of the meeting, or you can take it now, if you wish.

Mrs. PENCE. I would like to.

Senator LONG. It might be an answer to one of your problems. Now, you said it would be \$65—

Mrs. PENCE (interrupting). That is a rough figure because they figure this way, that \$1 a day is for food; and then the extra for the help and the lights. Now, a great many of our people who will come in will have maybe a \$30, \$35, or \$40 a month pension. That will be taken, less \$5. We decided a long time ago that, particularly a man, should have \$5 to spend for his cigarettes, chewing gum, or whatever he wants. Then we would apply, naturally, to the Federal and State agencies to make up the difference. But \$65 would be, as I say, right now a round figure. It might be more; it could be less.

Senator LONG. You can't include medical care, can you?

Mrs. PENCE. No. That is one thing—the people who are there in the home will have their own doctors.

Senator LONG. Yes. Thank you for a very interesting statement. The next witness, the county administrator, State employment service, Mr. Benedict Lui Kwan.

**STATEMENT OF BENEDICT LUI KWAN, COUNTY ADMINISTRATOR
OF THE STATE EMPLOYMENT SERVICE**

Mr. KWAN. Hon. Senator Long, members of the committee, ladies and gentlemen, my name is Benedict Lui Kwan, manager, Hilo local office, State Employment Service, Hilo Hotel Building, Hilo, Hawaii, and I would like to present a report covering the activities of the employment service on the island of Hawaii with respect to the aging and the pattern of this group in the labor market.

The material that you have was prepared from the records of the Hilo local office. I trust that the information contained therein includes items that may be used in the work of the committee, as well as the joint efforts of the island community toward the solution of problems confronting the aging.

I have prepared this report under three separate headings. The first heading is "Employment Service Definition of an Older Worker." The second phase is "Characteristics of the 153 Older Workers in the Employment Service File of the Hilo Local Office as of November 1961."

I would like, very briefly, to touch on the appendixes, which are three charts. The first one is the "Active File Inventory of the Hilo Local Office, State Employment Service." The second chart is the same inventory, broken down by occupational titles. And the third chart depicts the services rendered older worker applicants by the State employment service on this island between the years 1958 through October 1961.

With your permission, Hon. Senator Long, I would like to give you this report verbatim from the written material.

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

The difficulty depends on the occupation, labor market conditions, and other factors:

(1) Chemists, scientists, or other professional workers are not considered old until they reach 65 years of age.

(2) On the other hand, carpenters, painters, plumbers, and other skilled construction workers are considered older workers at about 45 years of age.

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

(4) Then the airline stewardesses or hostesses fall into a much younger age level and are called older workers at 27 years of age.

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

I will now go into phase II of this report—on the characteristics of the 153 older workers in our active file. The first item I would like to touch on is that of the people who are registered.

Approximately 21 percent of the unemployed registered with this office are 45 years of age or over. The greater number of these applicants have had many years of work experience and over one-third have held one job up to the present period of unemployment. A recap of the work experience factor by percentage follows:

Those with less than 10 years' work experience constitute 31 percent of this group; those with 10 to 20 years' work experience, 30 percent; 20 to 30 years' experience, 18 percent; and those with 30 to 40 years' work experience, 18 percent; and I would like you to take note of this—that 3 percent have had 40 to 50 years of work experience.

Females, mostly housewives, constitute about 50 percent of those with work experience of 10 years or less. Many of these women are housewives seeking employment for the first time or who have reentered the labor market in recent years due to family need. Some have become available as a result of their children attaining adulthood.

Item No. 2. The length of unemployment as of November for this group is disposed as follows—the length of unemployment and percentage:

Those with 6 months or over of unemployment constitute about 43 percent. Those who have been unemployed from 5 to 6 months, 7 percent; 3 to 4 months, 12 percent; 1 to 2 months, 15 percent; less than 1 month, 23 percent.

I hope you will bear with me, Senator Long, in my presentation. These things can get very boring. This is a statistical report, as you readily understand, and must be set forth.

Senator LONG. Well, of course, the value of this is for the record. I doubt if an audience, listening to these statistics, gets it all; so if you wish to refer just in a general way, I think it would—

Mr. KWAN (interrupting). Yes. And if you don't mind, I would like to—instead of listing these statistics and data, I would just like to touch on the items I have, generally.

Senator LONG. Yes, will you, please.

Mr. KWAN. On this item of "Length of Unemployment," 50 percent of the older workers have been unemployed 5 months or longer.

Again, of this group, 63 percent are drawing unemployment benefits from various unemployment insurance programs. Here, again, we have a listing of percentages of industries from which these claimants were laid off. You will note here that **immigrating claimants** (other than local residents returning from the Armed Forces or employment elsewhere) constitute 15 percent. I would say that half of that group are from the mainland.

The educational level of these applicants is as follows: 21 percent have up to 4th grade or less schooling; 58 percent—and this is an interesting figure—have at least an elementary education—up to the 9th grade; and 21 percent have either high school or better. And of that group 5 percent furthered their education by attending business schools, colleges, or technical schools, but only one has a college degree and that is a retired school teacher. Those who had at least an 8th grade education—or up through an 8th grade education, I should say—are scattered throughout every occupational group except the professional, clerical and sales categories. Those with a 4th grade education are mostly in the agricultural, unskilled, and entry groups. High school graduates and others who furthered their

education are mostly in the clerical, sales, and professional occupations.

About 69 percent of all of these applicants are males; 31 percent are females; 5 percent of the total are veterans. And here, again, 53 percent of the female applicants are registered for clerical, sales, or service occupations while male applicants are almost equally divided among all occupational groups except the professional and managerial.

On physical disability, there are about 21 percent who are physically disabled—a total of about 32. Now, there are other factors, besides age, which also contribute toward recent separation from work, as well as continued unemployment, and they are as follows: language barrier, 4—and these are numbers, not percentages; temporary lay-offs awaiting recall, 8—and in this group are mostly construction workers, and such; necessity for change of occupation due to age, including pensioners, 14; rigid demands on wages or type of work, 8; residents in areas that lack job opportunities, 23; and those with poor work records, attitude, et cetera, 17.

I also have a recap here of the job placements which were accomplished during the year. You will note there that the highest placement ratio were in the domestic and service occupations. That ties in quite closely to the service occupations—in the industrial pattern, that is, for industrial penetration—the domestic and service totals are quite close to the occupational bracket of service, at the bottom of the recap.

The next tabulation we have here are the areas in which these applicants reside. Although you will note that for Hilo and vicinity, which is between the Volcano—up to the Volcano area and north to Laupahoehoe—is about 77 percent, I would say that in the Hilo area alone there are about 50 percent of the people. And the people who reside outside of Hilo of the older age group prefer to work in the vicinity of their homes.

Now, the last phase, the "Analysis of Chart No. II"—this is a tabulation of services rendered the older workers by the Hilo local office from 1958 to October 1961. The work load of this group varies in all phases from year to year. You will note that work loads in 1958 and 1960 exceed those of 1959. In 1958, shortly after the sugar strike, which lasted from February to June, a work force cutback was initiated by these companies in which older workers were urged to take early retirement in order to reduce the potential losses of younger workers who lacked seniority. This, coupled with the unemployment insurance coverage of agricultural workers, which was instituted on October 1, 1957, were primary reasons for this trend. In 1960, normal attrition losses in all industries in which the older worker was affected, as well as coverage of State and county employees for unemployment insurance benefits, were significant contributions toward the increase. This year's traffic should average out slightly lower than that of last year.

The big island is supported primarily by one industry; namely, sugar. Within a span of 10 years, from 1950 to 1960, drastic changes have taken place in this industry whereby mechanical processing has replaced much of the manual work performed in the fields. As a direct result, the industry reduced their work force from over 8,000 in 1950 to slightly over 5,000 in 1960. Although a great percentage

of this cutback consisted of aliens who returned to their homelands, it also included families who were compelled to leave the Island because of loss of jobs in the sugar industry. The adverse economic effect within these plantation communities resulted in the curtailment of many service and retail businesses due to diminishing purchasing power. The Island's population was reduced by 12 percent from approximately 68,000 in 1950 to 61,000 in 1960. The lack of opportunities of this area in recent years was attributed to this loss factor and has had an adverse effect on all age groups, especially those in the older categories.

(The reports referred to previously follow :)

REPORT OF THE ACTIVITIES OF HAWAII STATE EMPLOYMENT SERVICE

I. EMPLOYMENT SERVICE DEFINITION OF AN OLDER WORKER

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

The difficulty depends on the occupation, labor market conditions, and other factors:

1. Chemists, scientists, or other professional workers are not considered old until they reach 65 years of age.
2. Carpenters, painters, plumbers, and other skilled construction workers are considered older workers at about 45 years of age.
3. Female secretaries, stenographers, and clerks fall into the older worker category somewhere around 35 to 38 years of age.
4. Yet the airline hostesses fall into a much younger age level and are called older workers at 27 years old.

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

II. CHARACTERISTICS OF THE 153 OLDER WORKERS IN THE EMPLOYMENT SERVICE FILE (HILO LOCAL OFFICE). NOVEMBER 1961 (SEE CHART I)

1. Approximately 21 percent of the unemployed registered with this office are 45 years of age or over. The greater number of these applicants have had many years of work experience and over one-third have held one job up to the present period of unemployment. A recap of the work experience factor by percentage follows:

| <i>Number of years</i> | <i>Work experience</i> | <i>Percentage</i> |
|-------------------------|------------------------|-------------------|
| Less than 10 years..... | | 31 |
| 10 to 20..... | | 30 |
| 20 to 30..... | | 18 |
| 30 to 40..... | | 18 |
| 40 to 50..... | | 3 |

Females, mostly housewives, constituted about 50 percent of those with work experience of 10 years or less. Many of these women are housewives seeking employment for the first time or who have reentered the labor market in recent years due to family need. Some have become available as a result of their children's attaining adulthood.

2. The length of unemployment as of November for this group are disposed as follows:

| <i>Length of unemployment</i> | <i>Percentage</i> |
|-------------------------------|-------------------|
| 6 months or over..... | 43 |
| 5 to 6 months..... | 7 |
| 3 to 4 months..... | 12 |
| 1 to 2 months..... | 15 |
| Less than 1 month..... | 23 |

Fifty percent of the older workers have been unemployed 5 months or longer. 3. Of this group 63 percent are drawing benefits from various unemployment insurance programs. The following percentages show from what industries these claimants come:

| <i>Industries</i> | <i>Percentage</i> |
|----------------------------------|-------------------|
| Government..... | 18 |
| Wholesale and retail trades..... | 14 |
| Construction..... | 12 |
| Service..... | 10 |
| Agriculture..... | 9 |
| Manufacturing..... | 5 |

In-migrating claimants (other than local residents returning from the Armed Forces or employment elsewhere), 15 percent.

TEC claimants, 17 percent.

4. The educational level of these applicants are: 21 percent fourth grade or less schooling; 58 percent up to the ninth grade; 21 percent with high school or better education and of this group approximately 5 percent furthered their education by attending business schools, colleges, or technical schools, but only one has a college degree. Those who had up to ninth grade education are scattered throughout every occupational group except the professional, clerical, and sales categories. Those with fourth grade education are mostly in the agricultural, unskilled, and entry groups. High school graduates and others who furthered their education are mostly in the clerical, sales, and professional occupations.

5. Approximately 69 percent of all of these applicants are males (5 percent are veterans) and 31 percent are females. About 53 percent of the female applicants are registered for clerical, sales, or service occupations while male applicants are almost equally divided among all occupational groups except the professional and managerial.

6. Approximately 21 percent of these applicants have some physical disability. Of the 153 older workers who are unemployed 32 had some form of physical or mental disabilities. Other factors besides age which contributed toward recent separation from work as well as continued unemployment are as follows: language barrier, 4; temporary layoff awaiting recall, 8; necessity for change of occupation due to age (including pensioners), 14; rigid demands on wages or type of work, 8; residents in areas that lack job opportunities, 23; poor work record, attitude, appearance, and alcoholic, 17.

7. Of this older group a total of 77 job placements were accomplished during the year. The following is the breakdown of the job placements by industry and occupations:

| <i>Industries</i> | <i>Percentage</i> |
|----------------------------------|-------------------|
| Domestic..... | 34 |
| Construction..... | 23 |
| Wholesale-retail..... | 16 |
| Service..... | 10 |
| Manufacturing..... | 9 |
| Government..... | 6 |
| Public utilities..... | 1 |
| Forestry..... | 1 |
| <i>Occupations</i> | |
| Professional and managerial..... | 3 |
| Clerical and sales..... | 4 |
| Service..... | 49 |
| Skilled..... | 18 |
| Semiskilled..... | 9 |
| Unskilled..... | 17 |

S. Residence:

| <i>Districts</i> | <i>Percentage</i> |
|---|-------------------|
| Hilo and vicinity (volcano to Laupahoehoe)..... | 77 |
| Kona..... | 12 |
| Kamuela to Kohala..... | 8 |
| Kau..... | 2 |
| Laupahoehoe to Honokaa..... | 1 |

III. ANALYSIS OF CHART II

1. On chart II is a tabulation of services rendered the older workers by the Hilo local office from 1958 to October 1961. The workload of this group varies in all phases from year to year. Note that workloads in 1958 and 1960 exceed those of 1959. In 1958, shortly after the sugar strike from February to June, a work force cutback was initiated by these companies in which older workers were urged to take early retirement in order to reduce the potential losses of younger workers who lacked seniority. This coupled with the unemployment insurance coverage of agricultural workers, instituted on October 1, 1957, were primary reasons for this trend. In 1960 normal attrition losses in all industries in which the older worker was affected and coverage of State and county employees for unemployment insurance benefits were significant contributions toward the increase. The 1961 traffic should average out slightly lower than that of 1960.

2. The big island is supported primarily by one industry; namely, sugar. Within a span of 10 years (1950-60) drastic changes have taken place in this industry whereby mechanical processing has replaced much of the manual work performed in the field. As a direct result the industry reduced their work force from over 8,000 in 1950 to slightly over 5,000 in 1960. Although a great percentage of this cutback consisted of aliens (mostly Filipinos) who returned to their homelands, it also included families who were compelled to leave the island because of loss of jobs in the sugar industry. The adverse economic effect within these plantation communities resulted in the curtailment of many service and retail businesses due to diminishing purchasing power. The island's population was reduced by 12 percent from approximately 68,000 in 1950 to 61,000 in 1960. The lack of opportunities of this area in recent years was attributed to this loss factor and has had an adverse effect on all age groups, especially those in the older categories.

Hilo local employment office, active file inventory, applicants 45 years and older, November 1961

[CHART I]

| Occupational group | Total | | Female | | Veteran | | | Handicapped | | | | | | |
|--|-------|-------|--------|-------|---------|-------|---|-------------|-------|--------|-------|---------|-------|---|
| | | | | | | | F | Total | | Female | | Veteran | | |
| | 45-64 | 65 up | 45-64 | 65 up | 45-64 | 65 up | F | 45-64 | 65 up | 45-64 | 65 up | 45-64 | 65 up | |
| 0—Professional, semiprofessional and managerial..... | 9 | 1 | 6 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 1—Clerical and sales..... | 18 | 4 | 13 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 |
| 2—Service..... | 33 | 2 | 15 | 1 | 2 | 0 | 0 | 12 | 1 | 2 | 0 | 1 | 1 | 0 |
| 3—Agriculture, forestry, and fishing..... | 13 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 |
| 4 and 5—Skilled..... | 17 | 2 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| 6 and 7—Semi-skilled..... | 18 | 1 | 3 | 1 | 2 | 0 | 0 | 4 | 0 | 0 | 0 | 1 | 0 | 0 |
| 8 and 9—Unskilled..... | 14 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Entries..... | 18 | 2 | 4 | 0 | 1 | 0 | 0 | 10 | 0 | 0 | 0 | 1 | 0 | 0 |
| Grand total..... | 140 | 13 | 43 | 5 | 7 | 0 | 0 | 30 | 2 | 2 | 1 | 3 | 0 | 0 |

Hilo local employment office, active file inventory by occupational titles, applicants 45 years and older; November 1961

[CHART Ia]

| | |
|--|----|
| Professional, semiprofessional and managerial: | |
| Playground director..... | 1 |
| Teachers..... | 4 |
| Nurses..... | 2 |
| Instrumentman..... | 1 |
| Manager, retail and wholesale..... | 2 |
| Total..... | 10 |

Hilo local employment office, active file inventory by occupational titles, applicants 45 years and older; November 1961—Continued

| | |
|---|-----------|
| Clerical and sales: | |
| General office clerks, secretaries, stenographers, etc..... | 10 |
| Stock clerks | 2 |
| Salesclerks | 10 |
| Total | <u>22</u> |
| Service: | |
| Domestic workers..... | 10 |
| Concession attendant..... | 1 |
| Chambermaid..... | 3 |
| Cook | 2 |
| Waitress | 3 |
| Kitchen helper..... | 3 |
| Practical nurse..... | 2 |
| Watchman | 3 |
| Charwoman | 3 |
| Janitor..... | 5 |
| Total..... | <u>35</u> |
| Farmhand..... | <u>13</u> |
| Skilled: | |
| Structural steelworker..... | 1 |
| Welder | 1 |
| Carpenter | 2 |
| Cement finisher..... | 2 |
| Pipefitter..... | 1 |
| Asbestos worker..... | 1 |
| Crane operator..... | 1 |
| Blaster | 1 |
| Maintenance mechanic..... | 2 |
| Foreman | 7 |
| Total | <u>19</u> |
| Semiskilled: | |
| Sewing machine operator..... | 1 |
| Bulldozer operator..... | 1 |
| Reinforce ironworker..... | 1 |
| Truck driver..... | 9 |
| Water service supervisor..... | 1 |
| Laundry worker..... | 3 |
| Driller, machine..... | 2 |
| Steam cleaner..... | 1 |
| Total | <u>19</u> |
| Unskilled: | |
| Laborer, coffee..... | 1 |
| Laborer, sugar..... | 2 |
| Laborer, wallboard..... | 1 |
| Laborer, construction..... | 8 |
| Longshoreman | 1 |
| Florist helper..... | 1 |
| Packer | 1 |
| Total..... | <u>15</u> |
| Entries..... | <u>20</u> |

Services rendered older worker applicants by the State employment service on the island of Hawaii, 1958 through October 1961

[CHART II]

| | 1958 | 1959 | 1960 | 1961 ² |
|---|------|------|------|-------------------|
| 1. New applicants..... | 423 | 285 | 565 | 320 |
| (a) Handicapped..... | 40 | 39 | 43 | 38 |
| 2. Active file ¹ | 101 | 92 | 174 | 153 |
| (a) Handicapped ¹ | 19 | 20 | 38 | 32 |
| 3. Initial counseling interviews..... | 21 | 16 | 21 | 14 |
| (a) Handicapped..... | 14 | 10 | 15 | 10 |
| 4. Job placements..... | 26 | 121 | 136 | 77 |
| (a) Handicapped..... | 4 | 24 | 14 | 6 |
| 5. Total, all applicants in active file November each year..... | 630 | 513 | 650 | 719 |
| (a) Total, older worker active file..... | 101 | 92 | 174 | 153 |

¹ Includes only survey for November reports.

² Includes only 10 months of year.

Senator LONG. Thank you, Mr. Kwan. That is a very comprehensive picture of the employment situation—or, rather, the unemployment situation on this island.

On the basis of the study which you have made and your familiarity with it, how do you feel as you look forward 1, 2, 3, 4, 5 years? Will the situation improve? Or will it likely become more serious?

Mr. KWAN. From reports presented at a recent meeting of the State Planning Commission, which took place here several weeks ago, they tell us that we are now on a plateau and that instead of a continuous decrease in population, we are now in a leveling-off period. From information which we have at the present time, indications are that the economy as a whole will improve due to a few factors which may materialize in the next 2 or 3 years, and some of these things, of course, are going to come about very quickly.

First of all, we have the developments on the north end of the island, for which preliminary reports indicate that a need, first of all, for construction people will come about—and I couldn't give you the number, but it would exceed a hundred. And then, subsequently, the staffing of these facilities in the areas—tourist destination areas—would require at least 200 people to begin with. Now, you understand that this has a sort of a snowball effect. With more people residing in the area, working, the wholesale-retail service industries will benefit, and, naturally, the tax base will, in turn, expand.

Senator Long, if you don't mind, I would like to make one observation before I leave.

Senator LONG. Please do so.

Mr. KWAN. First of all, I would like to express my appreciation for your committee being here; and in this I am sure I express the same sentiments as quite a number of people in Hilo. This morning I have learned more about the aging than I have ever learned in all the years I have lived in Hilo, and this is the only place I have lived.

I think that if positive efforts could be made by an organization spearheaded by, probably, the county government or the State government, or even a private organization, whereby much of the information such as has been disclosed this morning—and maybe many more other items—could be publicized and the public, itself, be made aware of the problems confronting the aging. I think that a good

nucleus to spearhead something like this would be, say, the retired teachers' group. I understand, from press releases I have seen in the past, that they have an organization. Now, I can think of no other group with finer resources and enough intelligent people that could spearhead a program of publicizing, as well as assisting wherever necessary in getting things "on the road." Now, this could relate to employment; it could relate to care of the aged; it could relate to very positive plans in getting these things going.

That's about the first step, I think, that should be taken, and I feel that it is positive, so that we could get people to understand and accept many things relative to the problems and possible solutions for the aging.

Senator LONG. Thank you very much. Your statement in relation to what the hearings so far today have meant to you really is related to the underlying purpose of all of these 30 conferences that are being held in various parts of the Nation. No one understands what the situation is nationally. This is an effort to bring together the findings of these 30 studies, plus other materials that have been gathered—to the end that members of the committee will not work in the dark, but that they will have a background. And in meeting here this morning, all of you people have made a contribution to this. Thank you.

The next speaker will be Mr. L. D. Rowlands, division of vocational rehabilitation of the State department of education.

STATEMENT OF L. D. ROWLANDS, HAWAII ADMINISTRATOR, DIVISION OF VOCATIONAL REHABILITATION OF THE STATE DEPARTMENT OF EDUCATION

Mr. ROWLANDS. Senator Long, members of your staff, and people of the audience, I am a State employee. Although my speech may not necessarily be controlled, my plans and my ideals are in line with the overall assistance to the person who may be down and out.

I am not afraid of that fearful bugaboo, "the welfare state" that may be approaching us, but I am not in favor of bureaucratic control of Federal moneys matched to State moneys in any ratio. Along with bureaucratic control—and I say out of Washington; that's where the money comes from—oftentimes those planners there have created a hat that does not cover the fringes. The problems are small to them, but are great to us here in Hilo and on this island.

The Hawaii County Vocational Rehabilitation Administration is responsible to the State director, division of vocational rehabilitation. It is this administrator's function to plan, develop, and administer the Division's programs of vocational rehabilitation, OASI disability determination, independent living program, and a work training center for the mentally retarded and other handicapped people.

This administrator coordinates the county's program with related programs with the county.

Vocational rehabilitation services must be improved and expanded to include the older disabled people so that they may maintain or regain their ability to work or to secure suitable employment.

To assure the older worker a chance to maintain his employment or to secure new employment if unemployed, the following recommendations are hereby presented—and they are not all my recommendations but they have been made by vocational rehabilitation counselors throughout the Nation:

(1) We always have the problem of staff increases. It will be necessary to have staff increases, a costly factor in the rehabilitation of physically handicapped people and the aging group. However, we want the experienced worker if we can get that type of person. We don't want the person who just passes a civil service exam because he has met the requirements, but we hope for experienced people in this work.

(2) Another factor, and it is a paramount one, is a greater public understanding of job opportunities for the aging worker and public effort to place the older worker on a job.

(3) Intensive study and research as to how the work skills of beneficiaries now receiving social security disability benefits can best utilize their present and former skills. I understand today that this will come under a new evaluation act known as the Rehabilitation Act of 1961, proposed by the National Rehabilitation Association. There is a great question as to how the skills of the older person can be revamped, how that person can be retrained to such a point that he can reenter occupational pursuit.

(4) Grant-in-aid legislation to help local communities establish work training centers and sheltered workshops for those older workers who cannot compete for regular jobs. And, as you know, many of the older workers cannot compete due to their forgotten skills or lack of skills or through their disabilities.

(5) Qualified teachers must be provided to teach personnel in rehabilitation work.

(6) Hospitals, rehabilitation centers, and geriatric institutions must provide minimum rehabilitation services for prospective disabled workers. As Mr. Vance told you this morning, and also Dr. Woo, that the Hilo Hospital is endeavoring to set up a rehabilitation center here on our own grounds, which would eliminate or partially eliminate this sending of the seriously handicapped people to Honolulu for rehabilitation services.

(7) Communities should develop home care programs, homemaker services, social clubs, and job finding committees. We do have these programs. Some are quite progressive, others in name only.

(8) A Federal grant-in-aid program should be established to provide the rehabilitation services needed to meet the needs of older people unable to function independently in meeting the demands of their own daily living. That will be in the Rehabilitation Act of 1961. This program is getting underway—the independent living program is getting underway pretty well in Honolulu and on Oahu. On the outside islands, we are not properly organized. There are many questions to be answered.

(9) State committees of representatives of public agencies concerned with services to older people must be established to coordinate the overall program designed to serve the aging population. And I would like to qualify and to add there "to all physically and mentally handicapped people."

Now, this statement here, I am quite concerned with it. I do not wish to be facetious, funny, or anything else. We have so many services on this island now that we are not receiving the full benefit. It's statewide and it is nationwide. The division of vocational rehabilitation can dispense medical services going into thousands of dollars, for medical, surgical treatment; and yet the division of social services can do the same thing, and the Board of Health. I think that there must be and should be a centralized control of the taxpayers' money, especially in medical treatment.

(10) The employer must be considered a major factor in programming for the older workers. Oftentimes, the employer is left out of the picture. The social worker or the employee draws up the plan and oftentimes the employer is left out. Certain concessions must be granted to the employer such as—don't jump on me, but we have to give some concession, as I have outlined here:

(a) That the employer be allowed to hire seriously handicapped persons and older people at hourly wages less than the minimum rate established by law. Now, we do have it on a national plan and a State plan for certain handicapped people. If it is a dollar minimum, well, maybe the fellow can work for 75 cents as a student learner for a period of 90 days. It has to be probably longer than a period of 90 days—and maybe a seriously handicapped person, not in full production but who would be willing and happy to work at a less wage—good for him and good for his aging wife.

(b) That the Government provide and underwrite industrial accident insurance for severely disabled applicants in cases where the employer is reluctant to hire, fearing that the job may aggravate the applicant's physical disability or that the applicant may endanger other workers on the job. Time and time again, the vocational rehabilitation counselor, when he tries to place a physically handicapped person on a job, is confronted with the employer's statement that he does not want to hire your man because "I'm afraid that his disability will be aggravated and I will be responsible for medical services and other charges."

Of the several recommendations listed above, it is this administrator's contention and feeling that recommendation No. 2, "Greater public understanding of job opportunities for the aging worker and public effort to place the older worker on a job," is one of the three most important recommendations. No. 4 is the next one: "Grant-in-aid from the Federal Government to establish work training centers and sheltered workshops for those older workers who cannot compete for jobs on the open market."

And the next recommendation that I most sincerely believe in is No. 9, all of these services must be controlled to better advantages. We, who are in the agency, must not be independent of other agencies in dispensing tax money for health services.

Now, the older handicapped worker, in searching for employment, is confronted with and confounded by preemployment medical examinations demanded by this island's major business and industrial employers. The older worker is also told by many employers that he will not fit into the company's medical and retirement plans. I don't blame the employer for setting up these regulations and policies. I don't blame the people who have a hard time in getting jobs because

of these line policies. I see their side of it. But there may be, there must be some modification that can fit in.

It is for these and other reasons that this administrator believes that the work-training centers and sheltered workshops can afford more valuable services to those workers who cannot compete for regular jobs.

Now, I will give you the list of services that the division of vocational rehabilitation can give at the present time; and yet, we are unable to meet the full problem of these handicapped workers and the older workers in search of employment.

(1) Our division can provide the best medical diagnostic services obtainable in the State, free to the individual, himself.

(2) Counseling to help the disabled person select and obtain the right job. We can help that worker, that seeker for a job to the best of our ability, free of charge to him.

(3) Medical services to help bring back and improve the person's ability to work. We can provide that if he has no money. If he has money, he pays a certain ratio.

(4) Prostheses to fulfill need for physical aids.

(5) Training to develop skills to do the right job. That's a hard one to carry out while we are limited in job opportunities. Our island is not an industrial island as far as sitdown assembly jobs go. Many of our employers cannot set a worker at a single occupation. He will be pulled off his job to attend to other jobs within the factory, within his area, when demanded.

(6) We can provide training and transportation to people if they cannot afford it.

(7) After training—and we send many of the younger people to vocational schools, universities, on-the-job training, to technical schools, to commercial schools. We pay their tuition and can buy them their tools upon graduation, if they cannot afford them.

Now, with all these services that we have at our disposal—it may be my fault; it may be the Division's fault; I don't know—when it comes down to the actual placing of the physically handicapped person on the job, that is where we fall down. There is a lack of job opportunities for handicapped people, older people, and for many people who are in good health.

A few of the problems encountered in providing the services that I have listed are:

(1) Discriminatory hiring practices exercised by some employers. We say it is discriminatory. We say it on our side. On their side, they say it is not discriminatory; it's for our protection. But nevertheless age comes into this. Physical disability comes into it. The racial question comes into it. Those are probably a few of the outstanding ones.

(2) Then another problem is the preemployment medical examinations which eliminate a great number of handicapped people for employment. Preemployment physical examinations, exercised by the employer, just to eliminate that prospective employee. Now, the new trend, the new philosophy—and a philosophy breathed in by American labor organizations—is that a preemployment physical examination should determine what the man has left, what are his good qualities for the job; not the negative qualities.

(3) And the employers' resistance toward hiring and retaining the older worker. Many an employee can work beyond 65 years of age to 70, maybe 72. I don't say all of them can; I don't say all of them will be efficient; but many of them can.

(4) We have on this island a lack of suitable jobs to fit workers' capacities and capabilities in the small urban and rural areas.

(5) Then we have this, to a small degree, probably, the failure of many physicians and medical institutions to recognize the value of an overall comprehensive vocational rehabilitation adjustment for the disabled patient. If a man comes into the doctor's office with a disease that may be reduced or retarded or eliminated, I think there are institutions and medical men—and many of them do—will look at this patient and, more than just curing him, will try to get him back on the job.

(6) Another problem is community apathy toward and its failure to recognize that many disabled older people want to work and are capable of doing so if given a chance.

I have no statistics. I don't like statistics. I will say this: of 126 referrals, 21 percent of the referrals were 41 years of age and over. Fifty-nine percent of the referrals were 40 years of age and under. I would judge that the older worker, the considerably older worker makes up about 24 or 25 percent of our caseload; and most of these older workers are referred to the division of vocational rehabilitation by the OASI, old-age and survivors insurance. Even though a person has qualified for his social security pension because of the disability and can't work, these people are still referred to me to do a better job. It is quite a question, Senator Long.

Thank you very much.

Senator LONG. Thank you. I want to raise a question which I know you are competent to answer, in view of your longtime experience with the vocational program, where part of the support is from Federal funds. I couldn't agree with you more on anything than I agree with you on the idea that there should not be control from Washington.

How do you feel about the federally supported vocational program? Have Federal regulations hindered to any great extent? Have they helped, or what?

Mr. ROWLANDS. Yes. I think Mr. Sugara, the director of our division, mentioned that in Honolulu at your hearing there. And here is the thing: this man comes in here to me, referred to me as a physically handicapped person. I cannot look at that man because I want to. I've got to say, "Is he eligible? Why is he eligible?" And after I accept him for services, I've got to put him in status 1; I've got to put him in status 2; I've got to put him in status 3; status 4; status 5; status 6, 12, 13, and so forth. Statuses. And I am looking at a disabled man for a job, with statuses set up by some boys in Washington. You see what I mean, Senator Long? I want to look my client right in the face. Give us some money. We are honest. We will use it to the best of our ability.

Senator LONG. I was interested in your statement that you are not particularly fearful of what you referred to as "the welfare state." Of course, that's an old story.

Mr. ROWLANDS. Yes.

Senator LONG. You and I know that up until about 1830, perhaps, 1840 or 1842, education, a field we have been interested in, was entirely in relation to the private schools. And under the leadership of Horace Mann of Massachusetts, we moved over to State control; and there were people who made the same statement then, that it was getting away from good, sound government and would lead to radical controls, socialism, they called it, not "creeping socialism."

The same is true of the roads. I read a book on the history of the public highways of America and I was surprised to find that up until about 125 years ago every bridge in America and every mile of road was promoted by private enterprise.

Now, we changed that. It makes no difference what you call it—the change was a good change.

There are a number of areas where government can step in and make a service more effective at a lower cost to those who use it. We should be very much concerned about it.

Thank you for a good statement.

Mr. Laurence DeMello, retired railroad employee, is our next witness. Is Mr. DeMello in the group?

Senator LONG. Mr. Doro Takeda, director of recreation, county of Hawaii is our next speaker. Mr. Takeda?

STATEMENT OF DORO TAKEDA, DIRECTOR OF RECREATION FOR THE COUNTY OF HAWAII

Mr. TAKEDA. Senator Long, members of the Committee on Aging, and ladies and gentlemen, we in the field of recreation are aware of the fact that by the advancement in medical science the life expectancy of our citizens has lengthened and, as a result, we are finding more and more among us retired people whose waking hours are all leisure time. American workers have striven for better working hours and conditions, more pay and shorter workweek. Today, we have more leisure time than ever before.

This is true in this county. How this leisure time is used is important. These workers, too, will retire in the future. Therefore, we must learn to do something that interests us now and in the future in order not to be bored with life.

The last statement is true with our youth and younger children. The area of interests is picked up at home from parents; at school where they are exposed to dramatics, athletics, music, art, literature, et cetera; and at play centers and youth centers. They acquire these interests from their recreation and youth leaders. Therefore, carry-over activities are important—activities like golf, bowling, arts and crafts, music, dances, et cetera, while the citizens are young.

In this area, the county government is playing its role—the role to prepare for the proper use of leisure when they retire through our program of our parks and recreation.

The general recreation program of the department deals directly with youth and working people, but not with the aged except that it provides some of the facilities and areas which the aged can use and are now using. Some of them are our parks, pavilions, beaches, golf courses, and swimming pools. The county also provides music concerts through the county band.

The State provides State parks and libraries; and the National Park, their park, right here in our county for all, including the aged.

Frankly speaking, we in the recreation department have made no study of the recreational needs of the aged and we have no organized program for senior citizens. With more money and qualified personnel, we believe we can do something and I think we should do something.

I believe that we need a county committee on aging if there is none. We have the county committee on children and youth; therefore, I don't see why we can't have one on the aged.

Through my observations, I have seen people who have retired volunteering their services for the Red Cross and other organizations, and I think that is one of the highest forms of recreation. And here, we have with us Mrs. Beers, who is always helping with Red Cross; and Mr. Capellas, who is always trying to lead the youth to become better American citizens through his news articles and speeches. They all want to do something and they want to function as individuals. They do not wish to rust away their lives. Some of the people who have no interests whatsoever are bored with life, and they are lonely. Some of them deteriorate mentally and they are referred to psychologists and psychiatrists, and they are sent to mental hospitals where they do not belong.

Are there any questions?

Senator LONG. Thank you very much for your statement. I have no questions. I commend you for the study that you have made and the program you are promoting.

We have only one more speaker listed—Dr. John Musser, Chief, Hawaii Mental Health Service. Dr. Musser?

STATEMENT OF DR. JOHN MUSSER, CHIEF, HAWAII MENTAL HEALTH SERVICE

Dr. MUSSER. Honorable Senator Oren E. Long, Senator Wayne Morse, and committee members, Special Committee on Aging, U.S. Senate, my name is Dr. John Musser, psychiatrist with the Hawaii Mental Health Service, State department of health, Hilo, Hawaii. I welcome the opportunity of presenting to you some of our thinking on the problem and current trends relating to the mental health aspects of the aged.

Aging, as it relates to the need for special mental health services, presents current problems and treatment trends that must be viewed from the perspective of community needs.

The extent of the problem as it pertains to Hawaii County is not known at the present time. Up until now there has been no known study or survey made to assess the extent of the problem of the aged and their needs for community mental health services. Some of the traditional and cultural factors that have been a part of Hawaii appear to have minimized the problem. For example, the Orientals have, to a large degree, maintained the tradition of families caring for their own. Also, the sugar companies have encouraged the early retirement and return to the Philippines for some of their Filipino plantation workers. But changing trends in the cultural, economic, and social factors, plus the possible increase in the geriatric population, may pre-

sent new and different problems for these people and the communities in which they live. Therefore it is essential that the problem be determined and the needs assessed by the local community.

It may be of interest to you to know some of the nationwide trends in the promotion of sound mental health for the aged. Mental health services are designed to provide for better adjustment through programs of prevention and early treatment. Coordination of all community resources, such as the cooperation of physicians, nutritionists, nurses, public health agencies, social agencies, clinics, general hospitals, nursing homes, et cetera, is necessary to meet the individual needs of the aged. The promotion and support of mental health as it applies to this age group is a community responsibility. The local community, with all the help it can get from the Federal, State, and local governments as well as private and voluntary efforts, must strive to achieve these goals.

Out of this trend has developed such specific programs and facilities as homemaker services, foster homes, nursing homes, and day care centers.

As far as the Hawaii Mental Health Service is concerned, a total of 26 patients, 65 years and over, from this island were committed to the State hospital on Oahu in the last 6 years. During the last 2 years, when for the first time Hawaii has had a full-time psychiatrist, there have been only three geriatric patients committed to the State hospital. The drop in the incidence of commitments of the aged is undoubtedly due to the availability of a psychiatrist for consultation and direct services.

Serious consideration should be given to the development of a State grant-in-aid program for financial assistance in establishing and operating community-based facilities. Such a program would encourage local communities to accept the responsibility of providing needed facilities and services and would decrease the demands on the State institutions. This will enable the aged to not only remain in their own familiar surroundings, but also keep them in close touch with their families and friends. I know that a lot can be done to help the elderly in their emotional, physical, social, and spiritual adjustments because I have, in fact, worked with the first pilot research geriatric rehabilitation unit in New York State where these goals were achieved.

Senator LONG. Thank you, Doctor. Your reference to different groups in relation to the care of the aging—and you applied it, I believe, particularly to our people of Japanese ancestry—prompts a question. Do you think under American conditions, American education, American social practices that that will remain as a trait with their descendants?

Dr. MUSSER. No; I do not think it will remain as a trait. I think that up until now it has played a role in perhaps minimizing somewhat the problem of caring for the aged. I mean that public agencies have not had contact with a lot of elderly people who have been cared for by their own cultural groups; but that, I think, is going to change so that there will be more and more of a trend toward the mental health services and other related agencies having more and more contact as this gradually dies out.

Senator LONG. In the melting pot, it is unfortunate that more of the admirable traits of the people who have thrown in their lot with America—just like my ancestors did at one time and your ancestors did—are not retained. A great many of them are. And that counts in part for the strength of America.

I note in your statement—

The promotion and support of mental health as it applies to this age group is a community responsibility.

Then this statement—

The local community, with all the help it can get from the Federal, State, and local governments—

should go ahead. You have no fear of an interest, an active interest, a financial interest, in this area.

Dr. MUSSER. No; I don't believe so.

Senator LONG. Many people feel that it will inevitably lead to control by the bureaucrats.

Dr. MUSSER. No; I think it has to be a combined effort of all the forms of government.

Senator LONG. Yes.

Dr. MUSSER. From the Federal on down to the local.

Senator LONG. Working together.

Dr. MUSSER. Yes.

Senator LONG. I think that is entirely right.

Dr. MUSSER. I would like to add, Senator, that your comments about the misfortune that it is to have some of these traits dying out, such as the Japanese and Chinese ways of handling for and caring for their older people—that probably to most of them caring for the aged was not a problem. I don't think that they have thought that it is a problem, as such.

Senator LONG. It's an accepted pattern in their thinking—their emotional feeling.

Dr. MUSSER. That's right.

Senator LONG. One other thought—your emphasis upon mental health. What percentage of the inmates of our American hospitals today are there as a result of mental disturbances, roughly, do you recall?

Dr. MUSSER. What percentage of, say, 65 and over, you mean?

Senator LONG. Yes; or of any group, for that matter, but 65 and over, particularly.

Dr. MUSSER. The percentage of patients, I know, at the State hospital in Kaneohe, 65 and over, as of June 30 of this year was 18 percent. And a rather surprising finding is the fact that those from the ages of 19 to 34 also comprises about the same percentage, I think 19 percent; so that the vast majority are between 35 and 64. I think most of the hospitals on the mainland have approximately 15 to 20 percent of their patients being 65 and over.

Senator LONG. It's a great problem, isn't it, when you consider that the insurance companies just don't give one ray of light on that or one iota of assistance. I wrote a letter about 3 weeks ago to one of the outstanding insurance companies, specializing in health policies most widely advertised in Hawaii, as is the company the most widely advertised on the mainland. I made the statement that Mrs. Long

and I were interested in getting complete coverage, and underscored it. I said, "We want complete coverage," and that we were willing to pay for it, if we could. And I underscored the things that we were interested in and one of them was any mental illness that might befall either of us; and I sent it off, after commenting to my secretary and a member of my staff, "It's going to be interesting to see what I get."

I have the letter with me, the reply—a splendid letter. And they have such a policy, and there is a good sales pitch that they make in this letter, but right at the end of it in the fine print they said, "None of the provisions in this policy apply to mental disturbances."

Now, here we have one-fifth, almost—roughly 20 percent of all cases of illness, for which you just can't buy protection on. It's something to think about. But we will have to leave it to you medical men to point the way to us as to how it can ultimately be handled.

Thank you, Doctor.

That brings us to the end of the list. I thought, however, that after lunch and thinking things over there might still be someone who would have a statement that he would like to make.

If not, of course, the invitation to participate by submitting a statement for the record still stands. We are very anxious to have it.

I was impressed by Mr. Kwan's statement a few minutes ago that he had learned more during the morning session about our senior citizens and their problems than he had learned during all the other years of his life.

It indicates two things: the greatness of the problem and the need of conferences such as we have been having here today.

This record, which will be a part of a national record, is, I think, going to be of great value; and I hope that a number of you will write to me and ask for a copy of it. And out of that, of course, we hope that we will get something that will give the Members of Congress the wisdom to do the right thing.

Again, thank you for being present and all of you who have contributed.

I especially want to express again my great satisfaction that U.S. Senator Wayne Morse could be here with us. I have had the privilege of watching this membership of the "world's most exclusive club," and it is my opinion that through the some 172 years, or whatever it is, that there have been very few minds in the Senate that are as superior and better disciplined than Wayne Morse's. I thank you for being here and aloha nui loa. The meeting is adjourned.

(Whereupon, at approximately 3:15 p.m. Friday, December 1, 1961, at Hilo, Hawaii, State of Hawaii, the subcommittee hearing was adjourned.)

APPENDIX

PREPARED STATEMENT OF SAMUEL M. HARAGUCHI, PRESIDENT, HAWAII COUNTY MEDICAL SOCIETY

The members of the medical profession in Hawaii County makes this statement of policy. We believe that there exists a definite need for aid to help the aged in obtaining medical care. The aged are entitled to the best available medical care and we assure you that they will receive it. No aged individual will suffer from lack of medical attention.

We admittedly are not experts in this field of endeavor. It is obvious that the practice of medicine denies the majority of us the time to devote to matters other than the care of our patients. But we do stress this fact, what we say here is simply an opinion but an honest opinion.

We believe that the Federal Government should take a big part in the efforts necessary to furnish medical care to all aged patients who need medical attention. But we feel that the effort exerted by the Federal Government should be in the provision of financial aid. In this, we oppose the King-Anderson bill which compels compliance of all persons under social security, regardless of need. Under social security there will remain millions who are not presently covered but who will need medical aid. On the other extreme, there will be many who will be covered but who will need no aid in obtaining medical care. We cannot agree to a program that will compel all, regardless of need, to participate simply because he is covered by social security.

The Kerr-Mills Act has been in effect in Hawaii only since July 1, 1961. It has not been given a chance to demonstrate whether or not it is a successful program. We feel that time will prove this measure successful.

Matching fund requirements should be reasonable. It should be such that the State can afford to meet it. Further studies in methods of financing programs should be carried out so that no worthwhile program will be forced to bog down simply because the State was unable to afford it. Matching funds requirements should be such that the State budget can meet it.

In the matter of nursing homes for the aged, we would welcome greater participation by the Federal Government with local agencies running it.

Federal funds should be made available for homes for the aged. No strings should be attached to these funds and the State should be given the right to determine just how much of the moneys should be spent for what and how.

Criteria relative to (1) nursing homes for the aged and (2) homes for the aged should not be Federal criteria with its rigid requirements. Rather these criteria should be determined by the State. If the county or State believes that more should be spent on the one program, it should be able to do so and not be forced to follow Federal criteria. This will entail less red tape and the moneys available will be assured usage that will be most efficient and most equitable. Local agencies understand local situations better than some agency situated away from the State. We feel that they should be given a big say in deciding just how any program should be run.

Rather than funds being made available from the Social Security System, we believe that these funds should be made available from general taxation funds. This would be a more equitable source of funds since this source of revenue comes from people who can afford to pay.

Careful study should be made for the providing of outpatient care to the aged. This would actually result in savings since it would do away with uneconomical use of hospital beds.

To recapitulate, we offer the following :

1. The States should be allowed to continue to operate under the Kerr-Mills Act until the full potential of that act is realized.

2. Matching fund requirements should be reasonable.
3. Federal funds should be made available from general taxation funds and not from the Social Security System.

DECEMBER 18, 1961.

DEAR SENATOR LONG: Here is what I would have said at the hearing of your Subcommittee of the Special Committee on Aging if there had been time for everyone to speak:

1. Has any one considered building a housing unit for aged in Waimea?
2. Meals served cafeteria style.
3. Single units and bath.

Or in Hilo where we have many who would make use of it. A bus transportation for shopping or theater, lectures, or church, on certain days. Must have units with reasonable rates. Some of us have a rather slim pension.

JETTIE JACOBSON, 1685 KILAUEA AVENUE, *Hilo, Hawaii.*

PENSION PLAN FOR BARGAINING UNIT EMPLOYEES, HILO SUGAR CO., LTD.

PART I

The pension plan described in this booklet has been established in accordance with the pension agreement between your company and the union. To provide for payment of the benefits of the plan, your company has arranged to be included as a unit under a group annuity contract between C. Brewer & Co., Ltd., and the Prudential Insurance Co. of America.

The information contained in this booklet is intended only to explain the principal features of the plan. The booklet is not to be considered the contract. The complete terms of the plan are set forth in the group annuity contract. The terms of the pension agreement are in part II of this booklet.

The plan became effective January 1, 1954. Changes in the original plan were made in 1958 under the terms of an agreement between the union and your company signed at that time.

Who is eligible?

You are eligible to participate in the plan if you are a regular, full-time, bargaining unit employee and have completed 1 year of continuous service. Part-time, temporary, and intermittent employees are not eligible.

How do I join?

If you are eligible, you must sign a form making application to become a member. On this form you (1) state whom you want to be your beneficiary and (2) authorize the company to make payroll deductions of the contributions, which may be required from you.

When can I retire?

Your normal retirement date will be on the first day of the month following your 65th birthday. If your birthday is on the first day of the month, then your normal retirement date will be on your 65th birthday.

You may elect to retire on the first day of any month after your 55th birthday. If you do, your payments will be smaller because you could expect to get them for a longer period of time.

If the company permits you to continue working after you are 65, you continue to earn retirement benefits, and you will not begin receiving payments until you actually retire. These payments would start no later than on your 68th birthday.

What does it cost me?

You will contribute 3 percent of your total earnings after you become a member of the plan.

Your contributions will pay for only a part of the cost of your retirement benefits. The company will pay the entire additional cost.

Your contributions will be deducted from your earnings each month. That money plus the company's contributions will be held by the Prudential Insur-

ance Co. of America. When you become eligible to receive retirement benefits, amounts will then be withdrawn from the fund to purchase annuities for you.

How much pension will I get?

If you retire at age 65 you will get an annual pension equal to the greater of—

(1) One percent of your total earnings from the company for credited service after January 1, 1954; or

(2) \$24 multiplied by your years of credited service¹ up to 37.5 years.

Assuming you become covered under the plan on January 1, 1954, here's how to estimate your pension if you retire when you are 65 years old.

Step 1: Compute 1 percent of your gross earnings from the company since January 1, 1954.

For example:

| | |
|-----------|----------|
| 1954..... | \$2, 500 |
| 1955..... | 2, 700 |
| 1956..... | 3, 000 |
| 1957..... | 3, 200 |
| 1958..... | 2, 400 |

13, 800 × .01 = \$138

Step 2: Compute 1 percent of your expected earnings from now until you retire at age 65.

For example: You are now age 35. You estimate your 1959 earnings to be \$3,500. Assuming your earnings remain at \$3,500, you will earn $3,500 \times 30 \text{ years} = \$105,000$. $\$105,000 \times .01 = \$1,050$.

Step 3:

| | |
|---------------------------------------|--------|
| Credits from Step 1..... | \$138 |
| Add credits for expected service..... | 1, 050 |
| Normal annual benefit..... | 1, 188 |
| Normal monthly benefit..... | 99 |

Step 4: Compute your minimum benefit.

For example: You were employed on January 1, 1950, at age 29. If you have earnings in every month until age 65, you will have 65 minus 29 or 36 years of service, and after deducting the first year, 35 years of credited service. Your minimum benefit is 35 years × \$2 = \$70 per month.

Step 5: Compare your normal benefit to your minimum benefit; you get whichever is larger.

In the example above, the normal benefit is \$99 per month.

The minimum benefit is \$70 per month.

You get \$99 per month.

Step 6: Social security should be added to the above benefit. The estimated monthly primary benefit under the Federal Social Security Act as amended in 1958 would be \$104 based on average annual earnings of \$3,500 and this, plus \$99 would give a total monthly income at retirement of \$203.

If your minimum benefit is greater than your normal benefit you would receive the minimum benefit.

Your normal retirement benefit after purchase is guaranteed by the Prudential to be paid to you for the rest of your life.

If your minimum benefit is greater than your normal benefit, the Prudential will still guarantee, after purchase, to pay you your normal retirement benefit for life. The excess will be paid you by either the Prudential or your company.

Statistics indicate that the average man of 65 may expect to live about 15 years more.

If the employee in our example lives for these 15 years, he will receive under the plan a total of \$17,820 in retirement income—and this is in addition to social security.

Don't forget social security

In addition to the benefits provided under this plan, you are also entitled to social security benefits.

¹ Credited service means the years and months (both before and after Jan. 1, 1954) of your last period of continuous employment with the company, minus the 1st year and all months in which you had no earnings.

These benefits are determined by law; when you retire at age 65, be sure to apply for benefits at your social security office. Illustrations of social security primary insurance amounts at age 65 (based on Federal Social Security Act as amended in 1958) :

| Average monthly wage : | Primary benefit monthly |
|------------------------|-------------------------|
| \$50----- | \$33 |
| 100----- | 59 |
| 150----- | 73 |
| 200----- | 84 |
| 250----- | 95 |
| 300----- | 105 |
| 350----- | 116 |
| 400----- | 127 |

May my wife receive my pension income after I die?

Yes—if you arrange to have a monthly benefit paid to your wife after your death by taking a smaller retirement benefit for yourself. You may do this by electing what is called a contingent annuity option.

What if I am unable to work?

If you become totally and permanently disabled before your retirement, you may receive a disability benefit instead of any other benefits under the plan. Your disability benefit will be based upon the retirement benefits earned by you to the date of your disability.

The amount of disability benefit you receive will be at least \$50 per month, and these payments will continue until the total amount due you is exhausted or until your death, whichever occurs first.

What if I die before I'm 65?

If you die prior to retirement your beneficiary will receive the sum of all your contributions, plus compound interest. If you die after you start getting payments, your beneficiary will get all your contributions plus compound interest less the payments which you had already received.

Your beneficiary may be your wife, your children, or anyone else you may choose to name. You may change your beneficiary at any time by completing a form which will be furnished you by the company.

What if I leave the company before I retire?

If you leave the company's employment at any time before you commence receiving any benefits under the plan, you may elect to receive a refund of your own contributions, plus compound interest.

If your own contribution would purchase an annuity of \$40 or more per year, you can leave your contributions with the insurance company and receive such an annuity.

Also, if you leave the company with 16 or more years of service and fulfill certain requirements contained in the pension agreement, you may leave your contributions with the Prudential and upon reaching normal retirement age receive as a monthly pension the greater of your normal retirement benefit or your minimum retirement benefit.

Suppose I move to a foreign country?

If you go to live permanently in any foreign country :

(1) And you are 55 or older, you may elect to receive your regular monthly pension or a lump-sum cash settlement in the amount of the value of your annuity; or

(2) And you are between 45 and 55 years old and have completed at least 15 years of employment, you will receive in cash your own contributions plus interest and one-tenth of the value of your company annuity credit times the number of years (up to 10) since the plan began on January 1, 1954.

However, a lump-sum settlement will not be made if it will make the retirement income of others of the same age or older less secure, and only 1 percent of the plan members may receive lump-sum settlements in any year.

Anything else I should know?

The purpose of the plan is to provide security for your old age. To guarantee that security, all money paid in must remain. Accordingly, the plan cannot provide for withdrawing your contributions while you remain with the com-

pany or borrowing against them at any time. However, the money you have paid in is still your money, and must come back to you as retirement income or as a refund after you leave the company or to your beneficiary as a death benefit.

The complete text of the pension agreement is set forth in part II of this booklet and may be referred to for additional information.

PART II

PENSION AGREEMENT

This Pension Agreement made and entered into this 29th day of April, 1954 by and between Hilo Sugar Co., Ltd., hereinafter referred to as the "Company," and the ILWU, Local 142, hereinafter referred to as the "Union," and amended the 19th day of June, 1958.

Section I. Pension plan

The parties hereby agree to the establishment of a Pension Plan, hereinafter called the "Plan," in accordance with the following terms and conditions of this Agreement. For any portion of the benefits of the Plan that is funded hereafter, the Deposit Administration method will be used. The Underwriter will be an insurance company selected by the Company. Except as expressly provided in this Agreement, all features of the Plan, including all matters relating to funding, shall be within the sole discretion of the Company.

Section II. Eligibility

Employees eligible to participate in the Plan shall be only those regular full-time employees of the Company covered by the current collective bargaining agreement on wages, hours and working conditions between the Company and the Union, as it now exists or as it may be amended from time to time. Part-time, temporary and intermittent employees shall not be eligible to participate in the Plan.

Employees on the effective date of the Plan who are eligible to participate in the Plan, and any person who became or becomes such an employee after that date, shall become Participants in the Plan after completion of one year of service with the Company.

"Service" means the period of an employee's continuous employment with the Company as an eligible employee and shall not include service as a part-time, temporary or intermittent employee. "Credited" service under the Plan shall commence on January 1, 1954, or on the first of the month following the date on which an eligible employee completes one year of continuous service with the Company, whichever occurs later.

Section III. Scope of agreement

The terms and conditions of this Agreement shall be separate, independent and exclusive of any collective bargaining agreement on wages, hours and working conditions between the Company and the Union.

Section IV. Employee contributions

Each eligible employee shall contribute to the Plan at the rate of 3 percent of his total earnings as determined by the records of the Company. Such contributions shall begin as of the date a Participant's credited service commences and shall be deducted by the Company from the earnings of the Participant and paid over to the Underwriter.

Section V. Company obligation

The Company shall be obligated to provide such amounts as shall be necessary, together with employee contributions, to provide for the benefits described in Section IX and X below.

Section VI. Retirement age

A Participant shall retire at the age of 65 years, unless an early retirement option is elected or unless his retirement is postponed by the Company as provided in Section VIII.

Section VII. Early retirement

A Participant may elect to retire prior to his normal retirement date, provided that he may not elect to retire prior to age 55. In the event a Participant elects

early retirement, his retirement benefit shall be determined by reducing the greater of the normal or minimum benefit earned by him as of the date of his early retirement by a factor to make his early retirement benefit the actuarial equivalent of his normal or minimum retirement benefit.

Section VIII. Postponed retirement

The Company, in its sole discretion, may continue the employment of a Participant after the age of 65, but no later than attainment of age 68, under benefit conditions established by the contract with the Underwriter.

In the event a Participant's pension on retirement at age 65 would be less than \$50 per month, the Company and the Union shall meet prior to his retirement date and consider whether or not his retirement will work a hardship upon him.

In such cases, the Company will consider either supplementing his pension benefit or permitting him to continue in employment but in no event beyond age 68.

The Company's determination as to whether such a Participant's pension shall be supplemented, or whether he is permitted to continue work, or whether he is retired at age 65 without supplementary benefits shall be final.

Section IX. Retirement benefit

A Participant's normal annual retirement benefit shall be equal to 1 percent of his total earnings during his period of credited service.

Section X. Minimum retirement benefit

If a Participant's normal monthly retirement benefit is less than \$2 multiplied by the number of his years of service with the Company, less one year, he shall be entitled to a Minimum Retirement Benefit in lieu of his normal retirement benefit. The monthly amount of such Participant's Minimum Retirement Benefit shall be equal to \$2 multiplied by the number of his years of service with the Company, less one year, or \$75 whichever is the lesser amount. For purpose of determining the Participant's years of service, each completed month of service shall be counted as one-twelfth of a year of service.

"Years of Service," for the purpose of this Section, shall be continuous service with the Company since the Participant's last date of hire, deducting every calendar month during which the Participant had no earnings from the Company. Absence on leave will not be considered as breaking continuity of service for purposes of determining date of hire.

Section XI. Disability

The Plan shall contain a provision for payments to Participants in the event of total and permanent disability of the Participant, provided, however, that such provision shall not increase the cost of the Plan above the cost used as the basis of computation by the Company under its contract with the Underwriter, which cost is not to include any cost for disability benefits. The cost of a disabled Participant's disability benefit shall be provided by discounting the value of the retirement benefits earned by him under the Plan to the date of his disability.

Total and permanent disability shall mean a disability by bodily injury or a disease which in the opinion of a qualified physician appointed by the Company prevents the Participant from engaging in any occupation or employment offered by the Company and which in the physician's opinion will be permanent and continuous during the remainder of the Participant's lifetime.

Such disability shall not be considered established unless it has continued for a period of not less than 6 consecutive months. The Company, however, may, in its discretion, waive this 6 months' requirement.

If such total and permanent disability is compensable under any workmen's compensation law or by reason of military service, the disability payments under the Plan shall not commence until after such compensation ceases, except that, in individual cases, by mutual agreement between the Company and the Union, disability payments under the Plan may be used to augment compensation payments.

The Plan will provide that, during such disability, payments thereunder will not be in excess of \$600 in any one year and will continue until the total sum determined to be payable to the Participant is exhausted or until his death, whichever occurs first.

A disabled Participant may elect, instead of a disability benefit, to receive at age 65 an annuity based on the retirement benefits earned by him under the Plan prior to the date of his disability.

The provisions of this Section shall not apply to a Participant whose employment terminated prior to his becoming disabled nor in any case where the disability resulted from habitual drunkenness or addiction to narcotics, commission of a felony or willful intention to injure himself.

Section XII. Residence in foreign country

(a) A Participant who has retired or who is eligible to retire under the retirement provisions of the Plan and who leaves the United States for permanent residence in a foreign country other than Canada shall be entitled to receive a cash lump-sum settlement which is the actuarial equivalent of the annuity to which he would otherwise be entitled.

(b) If a Participant, who has completed 15 years of service with the Company and who is between the ages of 45 and 55 years, leaves the United States for permanent residence in a foreign country other than Canada, he shall, in lieu of receiving any retirement benefit under the Plan, be given a lump-sum settlement in the amount of his own contributions plus interest as provided in the contract between the Company and the Underwriter. Such Participants shall be entitled to receive such lump-sum settlements of their own contributions notwithstanding the provisions of Subsection (c).

In addition, such Participant shall receive a lump-sum settlement of one-tenth of the amount of the Company's obligation necessary to provide the retirement benefit under the Plan for such Participant for each year the Plan has been in effect, not to exceed 10 years.

(c) It is expressly provided, however, that the number of Participants entitled to receive lump-sum settlements under this Section in any one year shall be limited to one percent (1%) of the number of Participants under the Plan. In the event that more than 1 percent of such Participants apply for such settlements in any one year, preference shall be given to Participants with the longest service with the Company. Settlements under this Section in excess of such 1 percent of the Participants in any one year shall be made only with the approval of the Company.

Section XIII. Limitation on lump-sum settlements

No lump-sum settlements otherwise payable under the Plan shall be made if the result would be to impair the Deposit Administration Fund. In such event, such lump-sum settlements shall be deferred until such time as the Company and the Underwriter may determine that such settlements can be made without so impairing the Fund.

Section XIV. Termination of service

A Participant whose service with the Company is terminated prior to his retirement shall cease to be a Participant and his contributions to the Plan shall be returned to him by the Underwriter with interest as provided in the contract between the Company and the Underwriter, if he receives no benefits under the Plan.

However, if the termination of a Participant who has completed 16 years of service as defined in Section II is after June 8, 1958, and is because the Company is reducing the work force and is not voluntary on the part of the Participant, and is not within the control of the Participant, and does not arise out of any fault or incapacity of the Participant, then such a Participant may choose to leave his contributions in the Plan, subject to the provisions of Section XV, and if his contributions shall remain in the Plan until he reaches age 65 he shall be entitled at that time to receive the greater of his Normal Retirement Benefit or his Minimum Retirement Benefit. He shall not be entitled to any other benefits.

Section XV. Discontinuance of the plan

The provisions of the contract with the Underwriter relating to discontinuance of the Plan shall include a provision that in the event the Plan is discontinued Participants who have not been retired may elect to receive their contributions to the Plan with interest as provided for in cases of termination of service prior to retirement or a paid up deferred annuity purchased with their contributions.

Section XVI. Leaves of absence for union business

Participants granted leaves of absence for Union business, in accordance with the terms of the collective bargaining agreement between the Union and the Company, may continue in the Plan on the condition that the Participants' contributions are continued and payment of the Company's share of the cost of

purchase of benefits for such Participants will be paid by either the Union or the Participants.

Section XVII. Brokerage fees

Any brokerage fees will be paid in part to a broker selected by the Company and in part to a broker selected by the Union. That portion of the brokerage fee paid to a broker selected by the Union shall be limited to a fee on account of contributions of Participants only.

Section XVIII. Dividends

Dividends from the Deposit Administration Fund will be divided by the Underwriter between the Company and the Participants as their respective interests may appear. The Participants' portion of the dividends will be applied individually and will be used to reduce the Participants' contributions.

Section XIX. Duration and effective date

This Agreement shall become effective as of January 1, 1954 and shall remain in effect to and including December 31, 1963. The effective date of the Pension Plan shall be January 1, 1954.

Section XX. Government approval

The Plan shall become effective as of January 1, 1954 when it is approved by all governmental authorities whose approval is required in order that the Company may obtain deductions in full for tax purposes on account of payments made by it under the Plan.

If the Plan shall at any time fail to qualify for such deductions under any tax law, the Company's obligation to make such payments shall be suspended until such qualifications can be obtained.

