NURSING HOMES

HEARINGS

BEFORE THE

SUBCOMMITTEE ON NURSING HOMES

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

EIGHTY-SEVENTH CONGRESS

FIRST SESSION

Part 5.—Minneapolis, Minn.

DECEMBER 4, 1961

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

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Part 2.—Walla Walla, Wash.
Part 3.—Hartford, Conn.
Part 4.—Boston, Mass.
Part 5.—Minneapolis, Minn.
Part 6.—Springfield, Mo.

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NURSING HOMES

MONDAY, DECEMBER 4, 1961

U.S. SENATE,
SUBCOMMITTEE ON NURSING HOMES,
SPECIAL COMMITTEE ON AGING,
Minneapolis, Minn.

The subcommittee met at 9:30 a.m., in the ballroom, Coffman Memorial Union Building, University of Minnesota, Senator Edward V. Long presiding.

Senator LONG. The subcommittee will come to order.

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

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

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

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

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

As you well understand, we are limited for time, as our committee can only be here today. This afternoon will be a town hall system of meeting for our elderly citizens where the citizens themselves, who are more interested in the problems of the aging than anyone else, will be here to discuss their problems with the committee.

The witnesses this morning have submitted written statements to the committee. We must of necessity, as you understand, limit our discussion somewhat for each witness. We want to give everyone proper time but we just don't have enough time during the day to go at length with every witness. We have asked the witnesses to submit statements, which they have done. We will ask the witnesses not to read their statements when they are making their presentations,

but if they could speak informally for just a few minutes from them and perhaps then make themselves available for questions and discussion from that time on.

The first witness this morning is Dr. Robert N. Barr, who is the secretary and executive officer of the Minnesota Department of Health.

Dr. Barr, if you are in the audience, we will appreciate it if you will come around.

STATEMENT OF DR. ROBERT N. BARR, SECRETARY AND EXECUTIVE OFFICER OF THE MINNESOTA DEPARTMENT OF HEALTH FOR MINNEAPOLIS

Dr. Barr. Senator Long and members of the committee, the State board of health is the official agency in Minnesota which administers the Hill-Burton program. It also licenses all hospitals and related facilities, including nursing homes, homes for the aged, boarding and care homes, and licenses hotels, lodging houses, camps, and resorts, et cetera. There are two exceptions. The foster homes which care for not more than two older people who are relatively well and do not need nursing care, operate under a permit from the local county welfare board. Some 20 nursing homes that are owned and operated by the county welfare board, are licensed by the Minnesota Department of Welfare using the standards of the Minnesota Department of Health and include 6 that are conversions of the small tuberculosis sanitoriums in the State.

I have available for the committee a packet of informational data on nursing homes and boarding care homes in Minnesota which indicates the number of beds, the quality of beds in the various categories of hospitals, and related facilities in Minnesota. It includes the facilities and beds that have been built in Minnesota during the past 12 years.

I also have a statement made by myself as a representative of the department of health relative to nursing homes and a fact sheet which summarizes the development of nursing homes in Minnesota. Both are available to the audience.

I believe there are one or two points that should be emphasized to the committee, Senator. One is that almost 70 percent of the nursing homes and homes for the aged beds under construction in Minnesota are being built by nonprofit and public organizations. This includes construction by local governments, community hospitals, church, and other nonprofit organizations. Some 60 percent of all long-term-care beds at the present time are actually owned and operated by these groups. Private enterprise, provides in Minnesota a smaller segment. This is rather unusual. As in most States private enterprise owns and operates for profit the vast majority of the nursing home beds.

There has been a tremendous upsurge in the construction of nursing homes and homes for the aged in Minnesota. Some 2,224 beds were completed or are under construction as of November of this year and there are some 6,000 beds or more in the planning stages. Our experiences indicated that about 30 to 50 percent of those in the planning stages go ahead to completion. As a result, there is a critical need in every area in Minnesota for a very careful study of needs so that we do not get overbuilding in one area and underbuilding in another.

The community services bill passed by the Congress during its last session I believe is one of its finest pieces of health legislation. It may, in the future, rank next to the Hill-Burton legislation in this field of health legislation. I am sure it will do a great deal in developing out-of-hospital facilities and services in the community, particularly in the forms of home nursing, homemaker services, and other kinds of community services to help people stay in their own home.

I think that eventually, nursing homes and homes for the aged are going to be provided by nonprofit organizations, as have hospitals in this and most States. I should add that the department does not exclude good private enterprise in Minnesota. This occurs for one reason only, namely that the present levels of pay that are provided by welfare in this State or in other States are such that if the individual nursing home provides all the services that the patient needs, the private operator would lose his shirt in the operation of the nursing home. So we have problems: One is the cost of the operation and the provisions of and the paying for needed services; another is the provision of good facilities and services for all who need such. This creates also a very severe shortage of trained personnel, particularly nursing, in spite of the fact that Minnesota has a rather remarkable program for training nurses. We train them for other States. Last year Minnesota nurse training schools graduated 1,053 registered nurses and 466 licensed practical nurses. A shortage of nurses still exists and women who have been nurses, are being reactivated in order to provide services in our hospitals, nursing homes and other facilities.

We must also be more realistic in the future and recognize that: (1) When we spend a dollar for nursing home care, home care, and homemaker service, we should get a dollar's worth of service. On the other hand, we must be willing to spend the necessary dollars in nursing home care and rehabilitation, to assure quality services. Many rehabilitation services have been developed in this State. Complete rehabilitation centers are located in Minneapolis, St. Paul, Rochester, and the university. About 120 other facilities which provide some rehabilitation are located throughout the State.

About 20 nursing homes in Minnesota are units of acute general hospitals. Here some of the most intensive nursing care is being provided. We are probably approximating the total need for nursing home beds in Minnesota. If this proves to be true, then we must improve the quality of services that are given in all of these institutions, hosiptals, nursing homes, rehabilitation centers, homes for the aged, and so forth, in order to make certain that these people who need services can be placed in the kind of facility that provides their needed services. This means integration of all activities to provide better service for the aged.

Senator LONG. I have a question I would like to ask you, but first, I recognize the great progress that the State of Minnesota has made. That's one reason that our committee wanted to be here and take testimony here to give the advantage to other States and our committee that can be gained from the experience that you have had here.

You mentioned in your statement and in your remarks a moment ago that a large percentage of your beds, 65 or 70 percent, that have been added since 1950 were nonprofit and Federal and you indicated that was a trend and I understood you think that in the course of time that privately owned nursing homes of that type will be passé.

Dr. BARR. I think so. Senator, years ago we had the same trend in hospitals and gradually the hospitals became nonprofit because of the recognition that the provision of hospital services is a public responsibility and should not be placed on a single individual or group of individuals. Nonprofit organizations being tax exempt, et cetera, have real advantages. If a third of the nursing home beds eventually become units of hospitals, again, these will be nonprofit because all hospitals in Minnesota are nonprofiit. Private enterprise has stepped in and filled a gap that was left by society which did not recognize its responsibility in the earlier years.

Senator LONG. Doctor, you indicate there would be a need of 1,600 beds per year in your statement until 1970. Are you optimistic that you will be able to achieve that growth? It is a double-barreled question. Do you think you will be able to achieve it, too, at the present levels of the Hill-Burton funds that you now have available?

Dr. BARR. Very little of the construction in nursing homes has come from Hill-Burton, even though we have transferred chronic hospital and diagnostic treatment funds to nursing homes construction. Only three or four projects could be assisted each year.

Under exhibit 7 in the tabulation provided is listed the nursing homes, et cetera, built each year from 1950 to November 1, 1961, and indicates those which received Hill-Burton aid. On page 8 it will be noted that 1,482 beds were completed in 1960, 1,453 beds were completed and 2,202 additional beds were under construction as of November 1, 1961. We have also reported that more than 6,000 beds are in the planning stages as of today. It is very likely that Minnesota may reach its goal before the 10-year period is up. There is one other figure which will be of interest, 840 nursing home beds in Minnesota were reclassified or closed during the period January 1, 1960, to October 31, 1961. This, I think, in part, is the result of competition and the providing higher quality service.

Senator LONG. I am not sure you covered this in your prepared statement or in your remarks, but can you tell me the number of square feet per bed and the average cost per square foot in nursing homes that are now being constructed?

Dr. BARR. The State standard is the same as appendix A of the Federal act. It is, single room, 100 square feet; room for two persons, 80 square feet per bed; and room for three or more persons, 70 square feet per bed. The cost per square foot is a very difficult thing to determine and is not included in the tabulations submitted. It is also quite variable. For example, there is a very splendid infirmary completed by the Wilder Charities, in St. Paul. It has 141 beds. Sixty beds are reserved for welfare patients. It is part of a complex which will have 500 beds which will also provide housing for the aged in the form of utility, 1-bedroom and 2-bedroom apartments, a dormitory kind of housing for the aged, and a day care center where you can leave grandpa off in the morning and pick him up at night.

It has both rehabilitation services and medical direction. The infirmary per diem costs are now pegged between \$8½ and \$10 a day, depending upon the kinds of service needed. Obviously, the foundation is underwriting part of the cost and is not charging off any of

the construction costs. Approximate construction costs per bed were $14,000.

Senator LONG. Thank you very much. Your testimony has been very helpful to the committee.

You are excused.

The next witness I would like to call is Dr. Karl R. Lundeberg, commissioner of health, Minneapolis Health Department.

STATEMENT OF DR. KARL R. LUNDEBERG, COMMISSIONER OF HEALTH, MINNEAPOLIS HEALTH DEPARTMENT

Dr. LUNDEBERG. Senator Long and members of the committee, our experience in Minneapolis, which is an average-size town with an average health department, has been quite interesting.

Ten years ago the work of the local health department in nursing home improvement and surveillance consisted of a periodic visit by a sanitarian, aimed principally at sanitation in the home. We have come quite a distance since that time due to the fact that Dr. Barr, the State health officer, has deputized me as the city commissioner of health, to do certain types of work for him in the nursing homes of Minneapolis. Ten years ago the local health department was essentially relieved of all responsibility by a law passed by the State legislature. It is possible, under these situations, sometimes to get around the difficulty. This was done locally by deputizing of the health department to do this work for the State; we report to the State and they execute our recommendations. Thus we can emphasize our educational effort here. We've learned several things in these last 10 years about surveillance of nursing homes, and this applies particularly to the privately operated nursing home. First, that there must be no dual licensing. To require both a State license and a local license is most undesirable.

Secondly, it is our firm conviction that on the level of the health department, it is possible to work much more closely with nursing home operators than it is from the level of the State. As an example in Minneapolis, we are able with the facilities and strength of the local health department to make about 18 visits per year per home, whereas upstate Dr. Barr's staff is so small that he is able to make only perhaps 10 percent of that number of visits. Improvements that are needed are much more easily effected on the local level. It can be done more quickly, it doesn't require State action, and the implementation is quicker.

Finally we have learned this, and this is no surprise and it shouldn't be to anyone, a surveillance program is not merely policing, there has to be an educational and cooperative effort if there is to be improvement in nursing homes. The two elements of enforcement and surveillance without education and persuasion are absolutely useless. We believe that if a flourishing nursing home business is to become a respected part of the medical care team, that this type of an approach must be used.

I mentioned that 10 years ago our work in nursing homes consisted of an annual or semiannual visit by a sanitarian. Today we have a

specially trained physician working halftime in this field. We have a full-time nurse educator and a half-time sanitarian. We believe that in a town of this size it is the minimum staff requirement. We have directed special attention to the education of nurses and nurses aids and also the administrators of nursing homes. We do this by on-the-spot instruction at the time inspection is made in the home. This is one approach. In addition to that, we have established a 16-hour training course for nurses aids. We try to teach the elements of nursing practice and ethics to the sometimes poorly trained aids who obtain employment in our nursing homes. These courses are held in the health center and are limited to about 25 women per class. In addition to that, we have a monthly assembly for all operators, administrators, and chief nurses, held at the public health center and addressed by medical leaders in the city. Finally, in this educational effort we have regularly recurring special demonstrations in rehabilitation nursing within the home itself.

A word about surveillance. One thing that is always important is the giving of a dollar's worth of nursing care and service for a dollar of compensation. This requires some type of scoring. It is a delicate subject. We have developed a scoring system in Minneapolis which I think is fair. It has been well accepted. It is not spectacular. We have three grades, excellent, average, and unsatisfactory. I think it is sufficient to say that in the last 3 years the trend has been from a very large number of completely unsatisfactory homes to the point where now the unsatisfactory homes can be counted on the fingers of one hand, and the excellent homes are about one-third of the total.

Senator LONG. Doctor, I am interested in that scoring system. Could you provide the committee with a copy of the scoring system that would be used?

Dr. LUNDEBERG. I am not sure that we have it available here, but I think it could be done.

Senator LONG. I would appreciate it if you would see that we have a copy.

Dr. LUNDEBERG. Yes, sir; we can take care of that.

Senator LONG. How long have you used such a system here in Minneapolis?

Dr. LUNDEBERG. It has only been in full operation less than 2 or 2½ years.

Senator LONG. Would it be possible for you to use that system, in your judgment, for an objective measuring of improvement over a period of years? Could you use it in that manner?

Dr. LUNDEBERG. Yes. This objectivity is one of the most difficult things. I believe what we have developed is about as objective a scoring system as it is possible to make, emphasizing nursing as the paramount consideration. We would be glad to make available a description of this system to the committee.

Senator LONG. Does the State of Minnesota inspect your homes here in Minneapolis or have they turned that over to the city?

Dr. LUNDEBERG. There are many joint inspections, but in general we do the work, we make recommendations, we tell Dr. Barr that a certain home is a topnotch home or a certain home should not be

licensed, in our opinion. Our opinion has carried great weight with him. He executes the law. We have no authority to do that, since he is the licensing power.

Senator LONG. In your judgment, based on your experience, are the inspections you have here sufficient or would you recommend closer inspections?

Dr. LUNDEBERG. No, sir; we are doing a great deal of work. I don't know if you caught that figure. We go into nursing homes at least 18 times a year. These are not policings. These are educational and training visits.

Senator LONG. At the time you make the inspections you do use an educational method of making improvements and suggestions to them at the time?

Dr. LUNDEBERG. Yes, that's the main purpose. These are not inspections, we don't like that term. It is visits made by technical experts, particularly nursing experts, who make on-the-spot corrections of what is wrong and combine this with extensive teaching at the same time.

Senator LONG. Do you know how your system, your schedule compares with the schedules of other cities and other States?

Dr. LUNDEBERG. I don't know. I would think that this is about as extensive surveillance and educational program as is going on. You might ask Dr. Park what his opinion on this is. I would doubt if many cities in America are concentrating on this to the extent that we are.

Senator LONG. Would you be able to point out any improvements that could be made in your present system?

Dr. LUNDEBERG. Well, of course, there must be improvements. I don't think I am prepared at the moment to point to any particular item.

Senator LONG. I am very much impressed with the system that you have used and it would be helpful to the committee if we could have that scorecard that you use.

Dr. LUNDEBERG. Yes, sir.

Senator LONG. Thank you. You are excused.

PREPARED STATEMENT OF KARL R. LUNDEBERG, M.D., COMMISSIONER OF HEALTH, MINNEAPOLIS HEALTH DEPARTMENT, MINNEAPOLIS, MINN.

THE ROLE OF THE LOCAL HEALTH DEPARTMENT IN MAINTENANCE OF HIGH STANDARDS OF CARE IN NURSING HOMES

The Minneapolis Health Department has had some 10 years of valuable experience in dealing with nursing homes. The first 5 were years of frustration because an act of the 1951 legislature, through removal of local licensing authority, prohibited the Minneapolis Health Department from having any effective influence or control. The last 5 years have been years of pioneering and progress through deputized authority from the State health department which, combined with financial support from the State, has made it possible for us to acquire a staff, with both vision and dedication, to work intensively in this field.

Through experience we have learned a number of things which I enumerate briefly:

(1) Dual licensing of nursing homes (i.e., by both State and city) is undesirable and is properly resented by nursing home owners.

(2) It is possible to work much more closely with nursing homes on the local level than on the State level. In Minneapolis, staff visits to nursing homes average 18 per year compared with about 2 visits per year per home by State officials in other parts of the State.

(3) Improvements in standards are likely to be developed and accepted on the local level much earlier than they can be written into State regulations and implemented.

(4) Nursing home administrators and nurses welcome and cooperate well with local enforcement officials when detection of deficiencies and shortcomings is combined with a genuine and sympathetic effort to show them how to improve.

We believe that enforcement and surveillance without education and persuasion is useless. These two elements of an improvement program must be combined, and in proper balance, if the flourishing new nursing home business is to become a respected, useful, and accepted partner in the medical care team.

Our nursing home surveillance and improvement program was developed as a separate program within the health department. It has been under the immediate part-time direction of a physician from my staff, with long experience in general practice, medical administration, and public relations. His principal assistant is a registered nurse with years of background experience in hospital ward-administration and in the teaching of undergraduate nurses and nurses' aids. An experienced sanitarian is assigned half time.

The emphasis in this program has been upon helping and teaching administrators, nurses-in-charge, and nurses' aids how to do their jobs well.

The educational program includes:

(1) On-the-spot instruction at the time an inspection is made. Such help may include suggestions for improvement of physical facilities, administration, or nursing techniques.

(2) An intensive 16-hour course for nurses' aids, conducted in a specially equipped room at the public health center. These courses are held once or twice a month and attendance limited to about 25 by preregistration.

(3) Monthly general sessions for all administrators and nurses, held at the public health center. Speakers are leading physicians and persons heading community programs related to nursing homes.

(4) Special demonstration classes held weekly in selected nursing homes to teach rehabilitation nursing until satisfactory proficiency is attained.

(5) Promotion of weekly in-service training classes in each nursing home conducted by the nurse-in-charge.

(6) Assistance with setting up kardex controls, nursing records, personnel policies, proficiency records, job descriptions, etc.

The Minneapolis scoring system

A positive advancement in the surveillance area was the development of a very useful grading system for nursing homes known as the Minneapolis scoring system. This scoring system evaluates 13 distinct functional and physical areas as "unsatisfactory," "average," or "excellent." A score of 1 is assigned to average, excellent a score of 2, and unsatisfactory a score of zero. Six of the areas are in the field of nursing, five relate to physical facilities, and two are concerned with administration. This system identifies nursing as the most important area. The Minneapolis scoring system is a measurement of performance. Scores may be converted into grades A, B, and C or used to identify homes unsuitable for further licensing. Grades are not made public but an operator is informed of his own score. This evaluation tool has been extremely valuable in measuring progress in individual homes and for statistical analyses on a citywide basis.

Future plans

Our future plans include further emphasis on rehabilitation nursing to meet the demands of increasing transfers of chronic disease patients from expensive hospital beds. Federal funds have recently been made available to the Minneapolis Health Department, under the Community Health Services and Facilities Act of 1961 for expansion of active nursing care at home, in nursing homes, and other institutions. We are looking forward to many interesting developments as project 101.11 unfolds here during the next 3 years.

Statistics on Nursing Homes and Boarding Care Homes in Minneapolis on Dec. 1, 1961

Homes licensed as nursing homes only	49
Homes licensed as nursing homes with boarding care beds as well	12
Homes licensed as boarding care only	15
Number of beds licensed for nursing care	2,474
Number of beds licensed for boarding care	1,724

Nursing homes in process of building extensions:

	Beds anticipated for nursing care
Cedar Pines	30
Central	25
Grand	4
Loring	8
Alliance No. 2[1]	41
Total	108

[1] Loss of 8 beds for boarding care.

CITY OF MINNEAPOLIS,
DIVISION OF PUBLIC HEALTH,
December 4, 1961.

SUBCOMMITTEE ON NURSING HOMES OF THE U.S. SPECIAL SENATE COMMITTEE ON AGING
Public Hearing, Minneapolis.

DEAR SIRS: In accordance with the request of Senator Long, the enclosed additional information is hereby submitted to clarify the use of the Minneapolis scoring system for the Subcommittee on Nursing Homes of the U.S. Special Senate Committee on Aging. It consists of two parts under the title, "Evaluation, the Measure of Progress." Tables 1 and 2 in this paper have been brought up to date and indicate the status of nursing homes and nursing home beds in Minneapolis on December 1, 1961, as scored by the Minneapolis scoring system.

Some additional copies of the Minneapolis scoring system are also enclosed for distribution as you wish.

Very truly yours,

KARL R. LUNDEBERG, M.D.

PART I.—EVALUATION, THE MEASURE OF PROGRESS

(By Wilford E. Park, M.D., chief, occupational health service, Minneapolis Health Department, Minneapolis, Minn.)

During the years 1958 through 1960, a remarkable improvement has taken place in the nursing homes in the city of Minneapolis. This improvement is the fruitful results of the efforts of dedicated health department staff in a helping and teaching program which has had the excellent support and cooperation of nursing home personnel.

Among the tools developed for measuring progress, and pinpointing the direction emphasis should take, is the Minneapolis scoring system. Its surprisingly accurate measurements and sensitivity to changes has made it an exceedingly valuable tool in work among nursing homes in Minneapolis.

The Minneapolis scoring system has been used since September 1, 1959. Between that date and January 1, 1961, the percentage of nursing homes in the higher grades has moved from 27.7 to 56.7 percent, and the number of beds in the same higher grades has moved from 40.3 to 73.7 percent. Part II of this paper will illustrate the value of the system for interpreting progress while part I will be devoted to explanation of the system.

THE MINNEAPOLIS SCORING SYSTEM

The Minneapolis scoring system is designed to evaluate only nursing homes. It should not be used for boarding care homes or retirement homes. It does, however, work perfectly well when applied to the infirmary only or nursing care area of a retirement home.

(See fig. I for a reproduction of the scoring sheets.) The scoring system provides for a general evaluation of 13 equally important areas. The 13 scoring areas have been chosen with care, so that there is, we believe, a proper balance between the 3 large general areas of nursing, physical plant, and administration. Nursing has a dominant position, with six areas scored. The physical plant is scored in five areas and administration in two.

Minneapolis Scoring System for Nursing Homes

Code:

No. of Points	Grade
23 - 26	A
18 - 22	B
11 - 17	C
11 - 17 limited	CL
Under 11	Unsuitable

Total Score __________ Grade __________

Name of Nursing Home __________

Address __________

Scored by __________ Date __________

Therapist Bonus Score [ ] Merit Bonus Score [ ]

Evaluation	Score
Poor, unsatisfactory, below average	0
Satisfactory, average, good	1
Very good, above average, excellent	2

Therapist Bonus Score Code:	No. Points
For each registered occ. or physical therapist working 20-39 hrs. per wk.	½
40 or more hours per week - - -	1

NURSING AREA

Nursing Supervision
Includes general quality and amount of nursing supervision on all shifts, appraisal of the nurse in charge, details of the nursing service for which the nursing supervisor can be held responsible, delegation of duties, informing management of nursing supplies needed, personal relationships of nurse in charge with her staff, attending physicians, the visiting public, etc. Supervisory nurses' attitudes to their patients and their responsibilities, personal appearance, qualifications, control of time schedule for nursing personnel, participation in hiring and discharging of nursing staff, nurses' job descriptions and proficiency records. [ ]

Routine Nursing Practices
Includes appraisal of routine nursing practices, the quality and quantity of work done by non-supervisory nursing staff, personal appearances of such staff, the nursing standards used, the attitudes of staff nurses and orderlies to their work and to their patients, methods of handling excretions, soiled linens, use of nursing equipment, use of Kardex. [ ]

Treatments
Includes efficiency with which treatments are carried out, adherence to doctors' orders, handling of medicines, control of narcotics, sterilization of syringes, needles and other nursing equipment, maintenance of first aid equipment and treatment trays, serving of special diets, handling of feeders, changing of dressings, care of bedsores, use of restraints, etc. [ ]

Records
Includes appraisal of the adequacy of nursing admission records, nurses' notes, doctors' diagnoses, doctors' notes, doctors' orders, narcotic records, narcotic permit where applicable, security of records, etc. [ ]

Rehabilitation Nursing
Includes appraisal of the attention given to rehabilitation nursing, the attitudes of the staff to keeping people active and restoring function, the understanding of rehabilitation nursing, the quality and quantity of rehabilitation nursing practiced, the psychological response of patients, emphasis on recreation, use of gadgets and equipment, handling of partially disabled patients, bowel and bladder training, stimulation of patients' interests and activity, etc. [ ]

In-service Training
Includes appraisal of the in-service training program being given by the nurse-in-charge, the curriculum, the participation of staff in any other nursing training programs, the frequency and freedom of staff meetings, the attitudes of supervisors and staff to the training programs, availability of nursing reference books, etc. [ ]

PHYSICAL PLANT AREA

Building
Includes the general suitability of the building, its general layout, maintenance, toilets and lavatories, tubs or showers, plumbing, general storage space, wheel chair storage, heating, lighting, ventilation, hand grips, hand rails, stairways, halls, dayrooms, janitor's closet, laundry equipment, incinerator, closets and clothing storage, stock linen storage, employees' quarters, dining room, recreational area, screen doors and windows, elevators, illegal occupancy, grounds and outbuildings, etc. ☐

Fire Safety
Includes the fire resistive character of the building, sprinkling system, fire doors, fire alarms, fire exits, safe stairways, fire extinguishers, emergency lights, fire drills, safety of patient restraints, unsafe occupancy of upper floors, unnecessary clutter of attics and basements, etc. ☐
(Only fire resistive structures can be rated excellent, sprinkling systems can be rated no higher than average, less well protected must be rated unsatisfactory.)

Furnishings
Includes beds, bedside tables, chairs, bed screens, mattresses, bed linen, side rails, wardrobes, walkers, wheel chairs, dayroom and diningroom furniture, radios, television sets, maintenance of furnishings and bedding, etc. ☐

Nursing Facilities and equipment
Includes utility rooms, bed pans, urinals, basins, catheters, nurses' supplies and equipment, nursing station, medicine cabinet, refrigeration for biologicals, sterilization equipment for nurses' use, bed pan sterilizer, facilities for handling soiled linen and contaminated waste, local clean linen storage, charting area, records file, Kardex, signalling system, nurses' lavatory, etc. ☐

Kitchen and Food Service
Includes the location of the kitchen, its physical layout, ventilation, lighting, facilities for tray service, food preparation, refrigeration, food storage, garbage disposal, storage for dishes and trays, dishwashing, hand washing, condition and adequacy of utensils, dishes, glasses and silverware, general cleanliness, vermin and rodent control, methods of serving and handling of foods, menus kept and followed, ability to prepare special diets, adequacy, appearance and quality of meals served, appearance, cleanliness and techniques of kitchen and food service staff, etc. ☐

ADMINISTRATION AREA

Attitudes of Operator or Corporation
Includes attitudes to and relationships with patients, nursing staff, other personnel, attending physicians, visiting public, volunteer workers, welfare workers, public health officials, etc. Interest in patient's health, comfort and welfare, interest in rehabilitation, occupational therapy, and patients' recreation, ability of operator to inspire confidence and loyalty, approachability, etc. ☐

Efficiency
Includes appraisal of the efficiency of management, familiarity with regulations, recognition of the responsibilities and limitations of management, ability of the operator to manage and work with his employees, delegation of authority, support of nurses and other personnel, control of housekeeping, control of waste materials, maintenance of supplies, food, equipment, grounds and buildings, personnel policies, personnel records, non-nursing staff work schedules, employment of adequate numbers of qualified staff, reaction to emergency situations, amount of time spent on duty, admission and discharge records, promotion of staff meetings, promptness in correcting deficiencies when brought to his attention, staff job descriptions and proficiency records. ☐

Minneapolis Health Department
Revised 1/11/61

Consolidated in each of the 13 areas are many related functions and conditions, which are evaluated as to whether or not the area under consideration is, in general, unsatisfactory, satisfactory, or excellent. The items which are considered together in each area are detailed on the scoring sheet, so that the person making the evaluation will always have them before him, and consider them in their proper places. In the point scoring, satisfactory, or average performance, is given a score of one; excellent is given a score of two, while unsatisfactory is given a zero.

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While the Minneapolis scoring system is a valuable evaluation tool, whether or not the total scores are converted into grades, it lends itself well to that purpose. For grading purposes a total score of from 23 to 26 points is used to designate a grade A nursing home, from 18 to 22 to designate a grade B home and from 11 to 17 to designate a grade C home. It should be noted that a total of 13 points represents an average of 1 point in each scoring area and at the same time 50 percent of the maximum of 26 points. On the basis of total points grade C represents the average nursing home while both grades B and A represent definitely superior nursing homes.

Grade CL, is used to designate a home falling into grade C, so far as scoring points are concerned, but which also has limitations on the type of patients which can be accepted. It is the practice to place all nursing homes not built of fire resistive materials, or equipped with a fire sprinkling system, into grade CL because in such homes only ambulatory patients are permitted above the ground floor, and we believe that no home of this type should be graded A or B.

Any home failing to score enough for grade C or CL is considered unsuitable for a nursing home but might qualify for some other license such as a boarding care home.

The range of points within the various grades is a feature which has definite value. It provides needed flexibility which lessens the possibility of error, reduces the necessity of comparing one nursing home with another, and makes possible scoring by different competent people without greatly affecting the final grade.

The range of points within grade A is sufficiently limited so that it is impossible to obtain grade A without an excellent nursing service, even with the maximum number of points in the general areas of physical plant and administration. It is also virtually impossible for an operator to establish a rating, in the upper half of grade C without a reasonably satisfactory nursing service. On the other hand it is possible for an administrator with the right attitudes and good nursing service to obtain a good score even with some deficiencies in the physical plant.

In scoring, the building is evaluated on the basis of whether or not it meets the requirements of the Minnesota Department of Health. Evaluation of the nursing service and administration is on the basis of whether or not the performance is what might be reasonably expected of an ordinary qualified person in any ordinary nursing home.

The scoring is done by the author in consultation with the sanitarian who makes the building inspections and with the nurse-adviser who is devoting full time to nursing homes, with emphasis on improvement in the quality of nursing services. The fact that each of the homes is visited by one or more of this trio many times each year, makes the maintenance of up-to-date scores possible.

The Minneapolis scoring system does not establish a separate appraisal of what might be described as social activity, or the area of human relations. It does, however, recognize the importance of this aspect and does give it weight in appraisals of the attitudes of the supervisory nurse, the regular nursing staff and particularly of the attitudes of the nursing home administrator. The significance of this area is also reflected in the layout and furnishings found in the dayrooms and recreational ares.

THERAPIST BONUS POINTS

The use of physiotherapists and occupational therapists in nursing homes is rapidly gaining momentum and is a development which needs encouragement. We believe that the Minneapolis scoring system does give sufficient emphasis to this activity when it remains a merely interest-stimulating activity, but when a therapist is employed more than half time, the activity gets beyond an educational and recreational function into the field of specific therapy. In such instances, credit should be given for this extra service.

In assigning points for the employment of registered physiotherapists and occupational therapists one point is given for each full time therapist and one-half point for a therapist serving from half time to full time. Points earned for therapists are placed in a special box on the score sheet called Therapist Bonus Score. It is felt that bonus points, for registered therapists, should not

be included in the regular score because development of this special area should not substitute for poor care, or poor conditions, in any 1 of the other 13 areas scored. Futhermore, when physiotherapy is provided, extra payment should be made for this service by, or on behalf of, the patient receiving it. In arriving at the final total which determines the grade, therapist bonus points are not counted but it is the practice to show their presence by adding a plus sign, to the regular total number of points, followed by the number of therapist bonus points. (Example: 24+1½.)

MERIT BONUS POINTS

Under the Minneapolis scoring system, it is possible for a nursing home, by excellence in other areas, to attain a point score higher than the top of grade CL in spite of the handicap of a non-fire-resistive and unsprinkled building. According to established criteria, such a building cannot qualify for grade B nor grade A and is not permitted to have nonambulatory patients above ground floor. In other words, the grade has to be CL in spite of more than 17 points. Such a situation is taken care of by placing all earned points above the top of grade CL into a special area called a bonus score for merit. The presence of such merit bonus points is indicated by adding a plus sign, to the grade CL followed by the number of earned bonus points. (Example: CL+2.)

It is our feeling that any grade CL nursing home obtaining any merit bonus score should qualify to care for ground floor patients on the same basis as grade B nursing homes providing, of course, that such patients are cared for on the ground floor. In the statistical analyses in part 2 the beds on ground floor of such homes are classified as grade B beds.

It is the practice to send the nursing home administrator a complete copy of his score when it is originally made and a new copy whenever a change in grade is warranted. The number of points may fluctuate as significant improvement or deterioration takes place in any of the 13 areas. So long as the fluctuations remain within the same grade range, the change is recorded only in the files of the Minneapolis Health Department. It is the practice to keep the Minnesota Department of Health, the county welfare agency, and the city relief department fully informed. Administrators are encouraged to come into the office and discuss their grades and point scores at their convenience and they often do so. The Minneapolis scoring system has been found most helpful in discussions with administrators and nurses in charge. It makes easy the pointing out of weaknesses and strengths in a nursing home and assists both nursing home operators and health department surveillance staff in maintaining a balance of program emphasis.

The Minneapolis scoring system differs distinctly from most other known methods of evaluating nursing homes, because it primarily measures performance, in contrast to other certifications which are based on numbers of staff, education, hours of work, meeting licensing standards, etc. To us, the matter we are most concerned about is whether or not the patient is actually getting the care he wants, needs, and is paying for.

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Part II.—Evaluation, the Measure of Progress

The strength of the Minneapolis scoring system lies in the fact that it measures performance. It reflects the quality of care the patients receive and the atmosphere of kindliness, or lack of it, which permeates the nursing home. To be sure, an element of personal feeling enters into any appraisal of people or their work performances. But this is a skill which is a characteristic of good personnel officers and interviewers, and one which can be effectively used in an evaluation of personnel and their work performance in a nursing home.

In Minneapolis the scoring of nursing homes is based on personal contacts with the homes and their staffs, which may be as frequent as 25 times a year.

The contacts are frequently of such a nature that it is possible to learn a great deal about the attitudes, understanding, and ability of the people involved. During 16 months of use, the Minneapolis scoring system has given a dependable measurement of the effectiveness of the nursing home improvement program as is shown by the following graphs and charts. In all of the following tables and graphs adjustments have been made for new homes opened up and old ones closed, so that the figures given represent the situation on the dates indicated.

The number of nursing homes by grades on five evaluation dates are shown in table I. The most notable change during the scoring period under review was in the grade A category. In 1 year and 4 months the number of grade A homes increased 4½ times. In the same period grade C homes decreased 45 percent.

Table I.—*Number of nursing homes in grades A, B, and C*

[Includes adjustments for homes closed, reclassified, and new homes opened in the interval between scoring dates]

Dates of scoring by Minneapolis scoring system	Grade A	Grade B includes CL homes with any merit bonus scores	Grade C includes CL homes without a merit bonus score and homes scored as unsuitable	Total number of homes in Minneapolis on dates of scoring
Sept. 1, 1959	2	16	47	65
Jan. 1, 1960	4	17	44	65
May 1, 1960	8	21	33	62
Sept. 1, 1960	10	18	33	61
Jan. 1, 1961	9	25	26	60
Dec. 1, 1961	10	27	24	61

On September 1, 1959, 13 nursing homes were scored unsuitable; on January 1, 1960, 11 nursing homes were scored unsuitable; on May 1, 1960, 5 nursing homes were scored unsuitable; on September 1, 1960, 4 nursing homes were scored unsuitable; on January 1, 1961, 1 nursing home was scored unsuitable.

Of the original 13 homes unsuitable, on September 1, 1959, 4 have closed, 2 have become boarding care homes, and 6 have improved. The one remaining unsuitable will become a boarding care home on January 1, 1962.

Table II shows the same changes which are recorded in table I but in terms of the number of beds in the same homes by grades. The most dramatic change was in the number of beds in grade A homes where the increase was 720 percent. When it is realized that every one of these beds is available to a patient in need of nursing care the value to the community is very considerable. The decrease in beds in grade C homes was less spectacular (53.2 percent) but the shift of 614 beds from the average care category into better than average care is nevertheless very significant.

Another significant change which took place between September 1, 1959, and January 1, 1961, was the reduction of 13 unsuitable nursing homes to 1. This was brought about by sufficient improvement in six to raise them to a score of 11 points or higher, by reclassification of two to boarding care homes and by closing of four. It is expected that the one remaining unsuitable nursing home will be reclassified at the end of 1961. The number of beds in the nursing homes listed as unsuitable on September 1, 1959, totaled 236. January 1, 1961, through the changes mentioned, this number of beds has been reduced to one digit.

TABLE II.—*Number of nursing home beds in Minneapolis by grades*

[Includes adjustments for homes closed and new homes opened in the interval between the specified scoring dates]

Dates of scoring by Minneapolis scoring system	Grade A	Grade B, includes 1st floor beds of CL homes with any merit bonus score	Grade C, includes CL homes without a bonus score and 2d floor beds of homes with a merit bonus score, also includes unsuitable homes	Total number of beds on dates of scoring
Sept. 1, 1959	74	705	1,155	1,934
Jan. 1, 1960	223	574	1,135	1,932
May 1, 1960	460	645	792	1,897
Sept. 1, 1960	482	774	764	2,020
Jan. 1, 1961	607	911	541	2,059
May 1, 1961	667	881	548	2,096
Dec. 1, 1961	672	1,286	516	2,474

(See fig. I in pt. I of this article for a reproduction of the scoring sheets.) When data obtained through the Minneapolis scoring system were tabulated so that all nursing homes in Minneapolis were included much useful statistical information was extracted. For instance an overall picture of the general attitudes and efficiency of administrators was obtained by adding separately all points scored in each of these areas. This was then converted into percentages by using the maximum of 2 points per home as 100 percent. Since on September 1, 1959, there were 65 nursing homes in the city, the highest possible aggregate score in each area on that date was 130, which was taken as 100 percent. Table III shows the aggregate scores in these two administration areas in percentages on the dates mentioned. This table shows that on a citywide basis the attitude of administrators improved from a score of 65 percent on September 1, 1959, to 81.7 percent on January 1, 1961, and efficiency of administrators shifted from 55 percent to 71.7 percent. This, on the whole, is a very satisfactory showing and speaks well for the quality of administrators who are managing nursing homes in Minneapolis. It also reflects the cooperation administrators are giving the Minneapolis Health Department in efforts being made to improve nursing homes in the city. It also indicates that administrators on the whole are making adjustments for the better.

By relating turnover of employees to attitudes and efficiency of administrators it should be possible to show the effect of good administration on turnover. On the basis of incomplete returns, enough information has been obtained in Minneapolis to suggest that turnover in nursing homes with poor administration may run on the average as much as three times as high as in nursing homes with good administration.

TABLE III.—*Aggregate scoring of attitudes and efficiency of administrators in all nursing homes in Minneapolis in percent of the maximum at 4-month intervals beginning Sept. 1, 1959*

[2 points multiplied by the total number of nursing homes operating on the dates of scoring gives the 100-percent aggregate]

[Percent]

	Attitudes	Efficiency
Sept. 1, 1959	65.0	55.0
Jan. 1, 1960	72.5	65.0
May 1, 1960	75.0	68.3
Sept. 1, 1960	76.2	66.5
Jan. 1, 1961	81.7	71.7

Figure II shows graphically the relationship of administration to grades. For this graph only the most recent evaluation was used. It depicts the relationship on January 1, 1961. For this graph the two areas of scoring of administration (attitudes and efficiency) were combined. By multiplying the number of nursing homes in each grade by 4 an aggregate figure is obtained which represents 100 percent. By adding together the number of points scored in administration in each grade separately, we obtain a figure which can be converted into a percentage of the maximum aggregate for the grade. For example, on January 1, 1961, there were 26 homes in grade C (see table I). A score of 4 each in administration makes a possible aggregate of 104. The total points actually scored in administration, in the 26 homes, was 63 which is 61 percent. Figure II clearly shows that good administration has a direct relationship to better grades. The fact that, even in grade C, the scoring of administration is better than the acceptable 50 percent indicated that administration is, on the whole, quite good.

FIGURE II.—RELATIONSHIP OF GRADES A, B, AND C, TO PERCENTAGE SCORES OF ADMINISTRATORS ON JANUARY 1, 1961

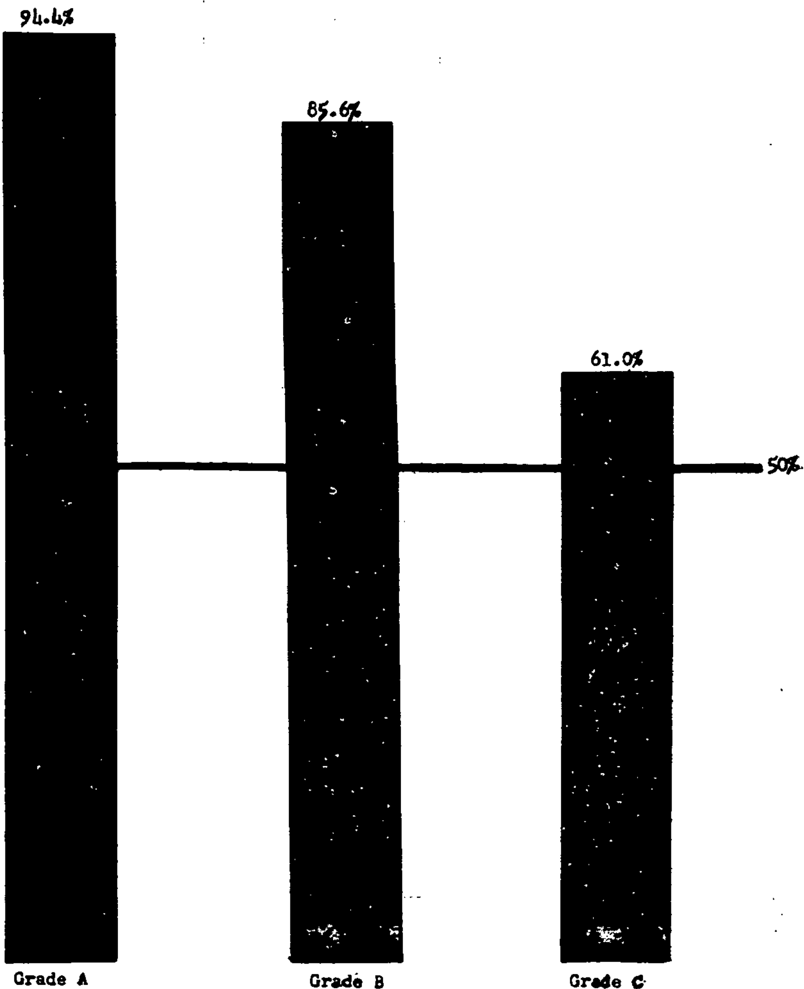


Figure III is a similar percentage graph showing the relationship between the one area of inservice training and grades A, B, and C on January 1, 1961. (For numbers in the various grades see table I.) It is obvious that the best job of inservice training is being done in grade A homes and the poorest in grade C homes. Since this graph shows that inservice training is generally unsatisfactory in grade C homes, and not much above 50 percent in grade B homes, the natural conclusion is that program emphasis needs to be turned in this direction.

FIGURE III.—RELATIONSHIP OF IN-SERVICE TRAINING TO GRADES A, B, AND C, ON JANUARY 1, 1961

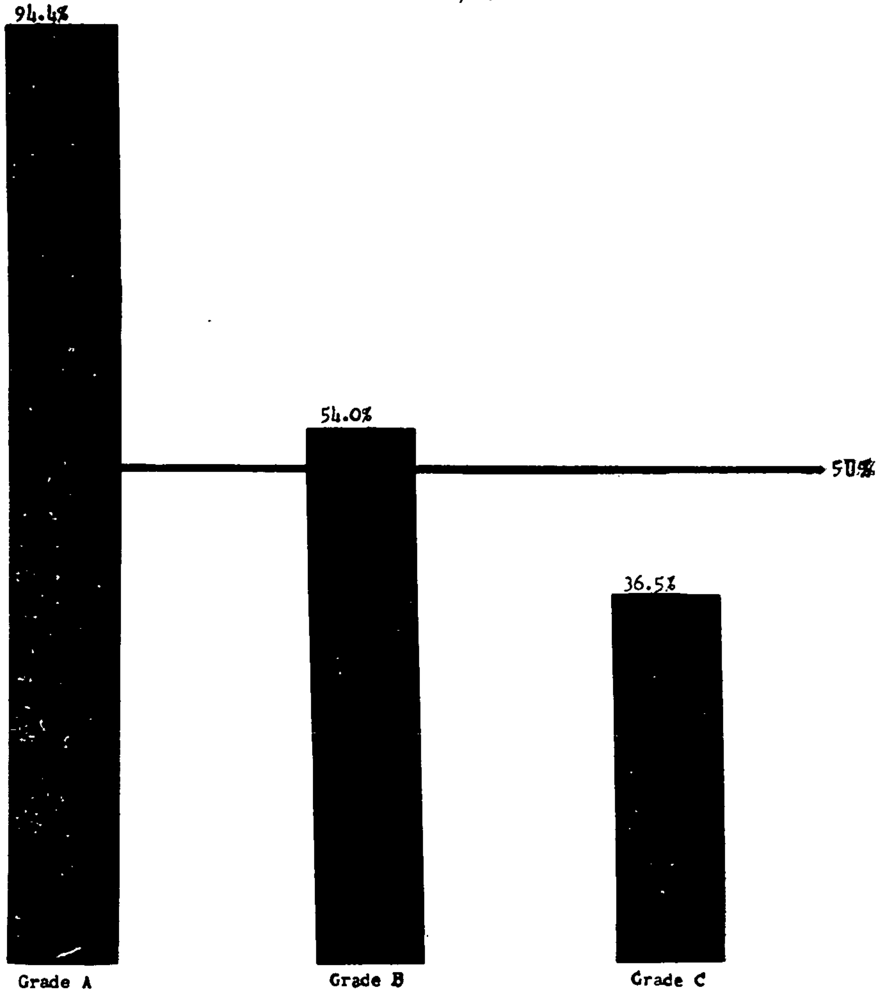


Figure IV is a similar percentage graph showing the relationship between the one area of rehabilitation nursing and grades A, B, and C on January 1, 1961. Grade A homes are doing a good job in this particular area of nursing, while grades B and C are not. Here again the need for program emphasis in this direction is well demonstrated.

FIGURE IV.—RELATIONSHIP OF REHABILITATION NURSING TO GRADES A, B, AND C ON JANUARY 1, 1961

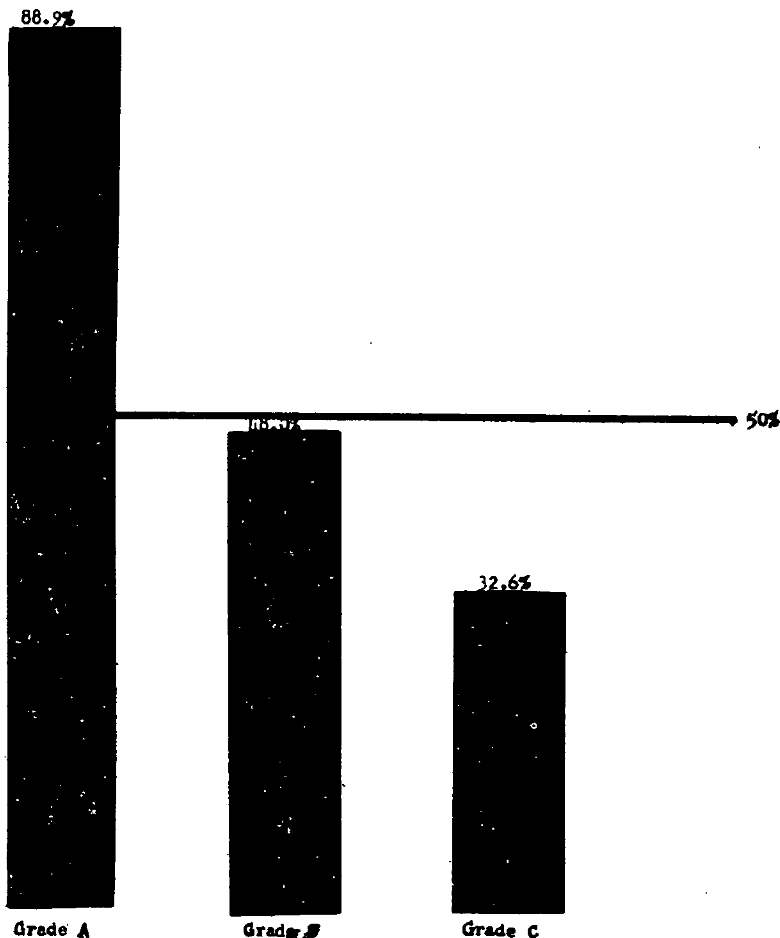
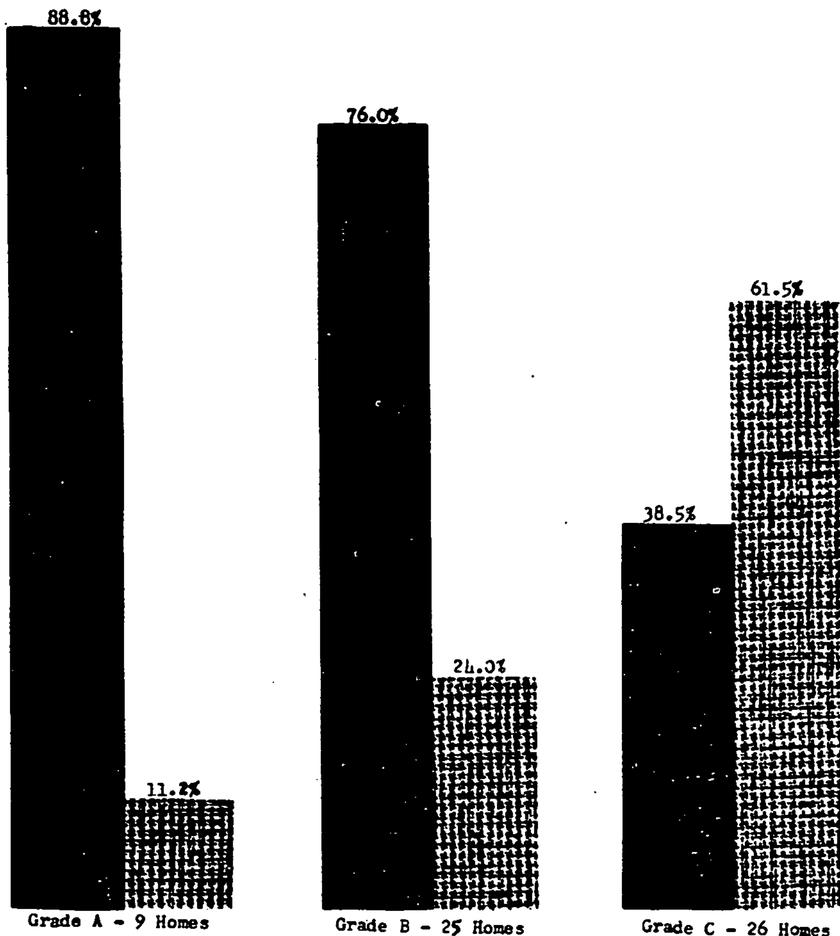


Figure V shows how the qualifications of the nurse in charge affect the grades. In this graph the percentage of homes served by registered nurses in charge is compared with the percentage served by licensed practical nurses in charge. Each of the grades A, B, and C is depicted separately. Figure V percentages represent the situation in Minneapolis on January 1, 1961. The percentage of registered nurses is shown in black and the percentage of licensed practical nurses in gray. In the evaluation of performance made through use of the Minneapolis scoring system no weight is given which would favor the registered nurse. Therefore, figure V simply shows that registered nurses do a better job of managing a nursing service than licensed practical nurses. Obviously their good work helps to raise the grade of nursing homes.

FIGURE V.—EFFECT OF THE SUPERVISOR'S TRAINING ON GRADES



Based on training of the nurses-in-charge and the grades on January 1, 1961. State law requires that the nurse-in-charge must be either a registered nurse or a licensed practical nurse. The percentage with registered nurse training is represented in solid black and licensed practice nurse training in grey.

SUMMARY

In part I the Minneapolis scoring system was described in some detail with an explanation of how scores may be converted into grades.

In part II several tables and graphs illustrate some of the valuable information which can be obtained by an anaysis of the scores. Such analyses serve to reveal the areas where greater emphasis is needed in program planning. Also when identical data are extracted at different times, an accurate measurement of progress is obtained.

The Minneapolis scoring system is particularly valuable as an evaluation method because it is designed to measure performance and as such it is sensitive to changes in the care being given. After all, actual results obtained and actual care given are of more importance to the elderly patient in a nursing home than any amount of potential which remains unused.

In our hands the evaluations made possible by the Minneapolis scoring system have proved invaluable and we still do not think that its usefulness has been entirely explored.

The next witness is Mrs. Irene H. Jacobson, president of the Minnesota Association of County Welfare Directors from Gaylord, Minn., I believe.

STATEMENT OF IRENE H. JACOBSON, PRESIDENT, MINNESOTA ASSOCIATION OF COUNTY WELFARE DIRECTORS

Mrs. JACOBSON. Senator Long and Members of the Senate who may be present, Minnesota is fortunate in having some skilled nursing homes and a larger number of homes for the aged which have some nursing care. Our aged patients needing nursing care have little choice as to what home they may enter, to say nothing of the quality of nursing care they wish, because of the lack of such homes in their respective communities.

Few nursing homes are staffed with qualified geriatric personnel. There is a real need of training of nursing staffs. It is recommended that the Congress give consideration to an appropriation of funds for scholarships earmarked for geriatrics nurses.

Licensing laws of nusing homes must be adequate to protect the public and must be vigorously enforced. The statutes relating to licensing should include the provision to insure staff to do the job adequately by State and local health departments.

Nursing homes should provide more than custodial and sanitary care. Nursing homes must give skilled nursing care, supervise needed medications and treatment as prescribed by qualified physicians, provide services for self-care and self-help in a homelike environment, protect patients' personal possessions and give personal care to maintain for the patient his respect, dignity, and independence. Emphasis here is on nursing service and on home.

This quality of nursing home care is costly but meets need.

A nursing home need not become a permanent home for the aged patient. The skilled nursing home would allow many a patient to return to his own home, enter a home for the aged, a boarding home, or a foster home for elderly.

There is far too much encouragement from relatives and nursing home operators to the aged to remain in a nursing home facility for the patient who pays his own care and for the patient who receives public assistance. Having the elderly person secure within the four walls of a nursing home facility gives his relatives "peace of mind"

regardless of cost or quality of care. This attitude seems widespread and must be changed. Public assistance recipients will increase as private patients expend their last dollars for longtime care. Aged persons have varying needs which require the attention of differing services and facilities and various degrees of intensity of nursing service. Private nursing home patients usually pay a rate not based on amount of nursing care required as the public assistant recipient patient does. The elderly private patient needs protection of such practice of overcharging. When the private nursing home patient runs out of money he applies to the county welfare department for old-age assistance. The county welfare department finds that the patient qualifies for old-age assistance but that he is often not in need of nursing based on a physicians recommendation. The public welfare social worker then plans with the patient to move to a boarding home facility, a foster care home, or home for the aged. This points up the need for a counseling service for the aged person before he enters a nursing home facility if he is going to conserve his financial resources and also conserve the tax dollar. It is evident that the aged person needs preventive, protective, and rehabilitative services before he enters a nursing home facility during the time that he is in this facility and when he leaves the facility. These services should be available, not only to the public assistance recipient, but also to the person who can afford to purchase these services. In rural areas these services are only given by public welfare departments.

The present arrangement of joint financing of public assistance by Federal, State, and county governments is sound and should be continued. There should be one program of public assistance for persons in need of financial assistance and/or social service. The categories of "old-age assistance," "aid to the blind," "aid to dependent children," and "aid to the disabled" should be eliminated. Standards of assistance should be uniform for all ages on a need basis. There are those who recommend that Congress should amend the Social Security Act to provide for Federal participation in general assistance program. In other words, this would be adding another category. If the Congress must continue public assistance on the categorical aid system, then general assistance should be added. County welfare directors and boards are generally agreed that Congress should amend the Social Security Act to provide for one public assistance program. Public welfare social workers are spending their major time with the yearning of and the meaning of the hodgepodge of legal requirements for eligibility for the various programs.

We commend you Senators as Members of Congress for your concern for the citizens of our fine country. Your first concern of human welfare was proven by the passage of the Social Security Act in 1935. This act created for the first time a nationwide public welfare policy, and created local public welfare agencies covering all counties in every State. In Minnesota, as our public welfare manual states, this resulted in a single comprehensive county welfare agency system within which basic public assistance and child welfare programs were combined, a step which made these agencies a central factor in the community's local social service network.

You are to be doubly commended for the 1956 amendments to the Social Security Act in which you charge the public welfare depart-

ments to develop services for recipients of public assistance. In your meaning from the 1956 amendments to the Social Security Act you specify self-care as the major aim for those recipients of advanced age, self-support and self-care as special goals for the blind and disabled and your major charge of strengthening family life. In order to carry out these goals in a meaningful, economical, and efficient manner, we need your leadership in making it possible for us to resolve the causes of dependency and family dissolution. We need your leadership in developing communitywide prevention and control programs.

By the elimination of the categories in the present public assistance program which would mean amending the Social Security Act to provide for one public assistance program on the same arrangement of joint financing by Federal and State Governments, you would help us accomplish your goals. By so doing, you will release the talent of the public welfare personnel in helping people. There will be time for us to focus on the family rather than on the extra paperwork by our present system of categories under different formulas and requirements. As someone said long ago, "The human family does not live in separate compartments." We must stop classifying people in these rigid categories and improve the capacity of the family as a whole. Many an aged person today is in the nursing home because his family fell to pieces long ago. He needed help as an aging person. Aging begins at birth.

In the rural areas of Minnesota our good nursing homes provide skilled nursing care and provide dietary services. Other required services to maintain a homelike atmosphere are social services, psychological services, medical services, housekeeping services, recreational and education services, rehabilitation services, occupational therapy, speech and hearing services, spiritual services, vacation services, day center services, and services for the blind. Few nursing homes in rural areas, or for that matter, anywhere in Minnesota, can provide all of these services, so rightfully needs to look to the community resources. In some of our communities there is some duplication of services but generally there is a lack of services. Many of these services could be provided and/or developed if the county public health, education, welfare, and agricultural extension agencies made a concerted effort with the medical societies, church, and community organizations to make their services available in an organized manner to meet need on a continuing basis.

By the elimination of categories in the present public assistance program, the county welfare departments would have time to assist the local communities to coordinate the local public and private resources and do some much needed community organization. You have charged us with the development of these services and since every county in the United States has a public welfare department, there the responsibility may well remain.

Training of volunteers to assist patients in nursing homes is one of the many services that could be developed locally. Volunteers can add life to the added years of our aged with no Federal dollars involved. There is a place for everyone who has a concern for his fellow man. A friendly visiting program ought to be available to every nursing home. Surveys made in Minnesota reveal that persons in nursing homes pre-

ferred the following services in this order: Friendly visiting programs, free or low-priced health clinics, movies, and social organization.

Services must be coordinated on the county or local level. It is fine for the consultant from St. Paul or Washington, D.C. to give technical assistance and inspiration at the local level, but it is the local machinery that keeps the community "on the ball" day by day. Thank you.

Senator LONG. Thank you. Is that a State position?

Mrs. JACOBSON. Yes, it is.

Senator LONG. Thank you very much. Dr. Frank H. Krusen.

STATEMENT OF DR. FRANK H. KRUSEN, DIRECTOR, SISTER KENNY INSTITUTE, MINNEAPOLIS

Dr. KRUSEN. Senator Long, I have presented you with four exhibits I have here for the committee as a whole, additional copies of which I can give to your committee.

I would like to call your attention first to exhibit A and just after the heading at the middle of the first paragraph of this item from the Congressional Record appears this statement by our senior Senator of this State (Senator Humphrey), that the voluntary health agency is needed more vitally than ever before and that is thanks to the wise decision of Congress to expand Federal teamwork in cooperation with health groups.

I happen to be the president of the Minnesota State Board of Health, of which Dr. Barr, who testified previously, is executive officer, and I happen also to have served as chairman of one of the work committees of the Rehabilitation Section of the White House Conference on Aging. In exhibit B, which I have presented to you, on page 8 I have made reference to nursing homes and some of the problems of the people in nursing homes. The American Medical Association, I have pointed out, has realized the need for rapid expansion of the number and quality of nursing homes in this country. It is estimated that we have, as you know, I am sure, better than I do, about 25,000 nursing homes containing 450,000 beds; 180,000 of these beds are in skilled nursing homes and 80,000 in personal care homes that provide some skilled nursing care. The point that I think is important is that the average age of the persons in these homes is 80 years and two-thirds of those are over 75 years of age. Only one-third are men, less than half can walk with assistance, and more than half have periods of disorientation.

One of the most important things, we think, in nursing homes is to provide training of nurses in rehabilitation nursing services and we believe this is extremely important.

In exhibit C, on page 8, I point out that the opportunity to see and evaluate the number of chronically ill and handicapped persons will enable us to arrive at more accurate projections of our needs in the field of our aging and handicapped and the possibility of their needing services. I have felt particularly the need for a disability detection program and the need to do everything we can to lessen the number of beds in nursing homes by providing adequate rehabilitation services. There is a natural tendency to discuss this problem in terms of present and future needs for approved facilities for housing of the chronically ill. Requirements for nursing home beds are constantly

in our minds. Perhaps more attention should be given to the question of how to reduce these needs by keeping our aged citizens out of these beds. Perhaps, in brief, we should give less emphasis to habilitation and more emphasis to rehabilitation. How can we give our aging citizens the ability to live outside of the nursing home? And failing this, how can we give them the ability to live with greater dignity, independence, and hope inside the nursing home? One answer to both of these questions, I am certain, lies in developing fuller awareness and fuller application of present-day rehabilitation concepts and techniques. Initially rehabilitation is three to four times as costly as routine care, but in the long run it is considerably less expensive. Rehabilitation may take many months, but passive institutional care can go on and on indefinitely in nursing homes. In addition, rehabilitation offers benefits which cannot be measured in terms of dollars; among them, hope, a chance of obtaining some degree of independence, and the prospect of returning a disabled person to his own home rather than remaining in a nursing home.

The long ranges which can be effected through rehabilitation were well illustrated in a San Mateo, Calif., study reported last year. In this community a group of citizens were given thorough examination at the time they applied for welfare assistance and half of these people required rehabilitation services, and social retraining. The program was financed by welfare funds. The cost of supplying these services increased initially the welfare expenditures. However, 5 years later it was found that the total medical care bill for this group was 10 times lower than that group which did not receive rehabilitation. For those provided services the need for long-term nursing home care was much diminished.

In St. Louis, Steinberg has studied the ability of aging patients to live at home. In this program, out of 43 patients discharged, 30 were returned home.

In New York intensive economic evaluation of 95 chronic hospital patients showed that only 27 were in need of continuing hospital care, 11 were adjudged to have a better than 50–50 prospect of successful rehabilitation.

These studies suggest that rehabilitation can keep many patients out of the nursing home or defer the need for this care. It is also important and a largely unfulfilled function to perform inside the nursing home. At the Kenny Institute in conjunction with the State department of health here in Minnesota we are constantly conducting courses in rehabilitation nursing, especially to help the nurses in nursing homes to know how to train these people to live in the homes with as much dignity and with as much self-sufficiency as possible.

We have progressed a long way from the attitude of regarding the nursing home as a mere way station on the way to the grave. At the same time, rehabilitation has progressed past the stage where its exclusive object is reemployment of these people. To be sure, many nursing home occupants may never be returned to independent living, but rehabilitation can give greater dignity and emotional and physical well-being to those who are living dependent lives. The establishment of nursing homes and self-care facilities in proximity to comprehensive rehabilitation centers offers a very promising area for research.

Therefore to summarize, I would say that rehabilitation should be taken into account in any reckoning of our need for nursing homes or nursing home beds or other medical care facilities for our aging citizens. We must be constantly on guard against the easy answer to this problem which is to relegate these citizens to institutions which exist only to get them out of the way. Intead, let's ask the more difficult questions: How can we keep the aging citizen out of the nursing home? How can rehabilitation help gain greater dignity and independence and well-being inside the nursing home? If we have the courage to answer these questions, we may find that the need for expansion of our nursing facilities is not as great as we now believe, but most important we will prevent the waste of a rich reservoir of human resources and a waste of many precious years of life. Thank you very much.

Senator LONG. Thank you very much.

The rehabilitation program that you have here in Minnesota is perhaps one of the best in the Nation, I believe.

Dr. KRUSEN. We think it is a very good one, sir.

Senator LONG. I am sure you agree with me, it will result in great saving in cost and expense over the years to come, as you indicated a moment ago, if we can rehabilitate these people.

Dr. KRUSEN. Yes.

Senator LONG. There is quite a trend, I believe, in all health and mental work toward rehabilitation.

Dr. KRUSEN. Yes.

Senator LONG. When I introduced you a moment ago, I just indicated you were the director of the Sister Kenny Institute, and so for the record, that your statements may have proper attention, I want to say that you are president of the Sister Kenny Foundation, also a professor of physical medicine and rehabilitation at the University of Minnesota, the Mayo Foundation of Rochester, and the senior consultant in rehabilitation at Rochester. Also he has a national reputation for his work and writings in rehabilitation.

I hope I didn't embarrass you by giving that information.

There is one question I would like to ask you. The disability detection program that you mentioned in your statement that you gave, certainly, as you have further indicated in your statement to the committee here this morning, it is worthwhile and very forward looking, but I notice in the participants you mentioned you didn't mention private nursing homes or the Nursing Homes Association. Is there some reason that they shouldn't have a part in that program?

Dr. KRUSEN. They should have a part in it and, as we developed this program through our rehabilitation nursing consultant in the State board of health, Mrs. Laura Hagsted who is here today, we are in contact with nursing homes and we feel this is a very important part of this project of disability detection.

Senator LONG. Thank you very much. Your statement has been very helpful. The exhibits which you presented and your prepared statement will be made a part of the record.

(The materials referred to previously follows:)

PREPARED STATEMENT OF FRANK H. KRUSEN, M.D.

There is a natural tendency to discuss this problem exclusively in terms of present and future needs for approved facilities for housing our chronically ill

and disabled aging citizens. The requirements for nursing home beds are constantly in our minds. Perhaps more attention should be given to the question of how to reduce these needs by keeping our aging citizens out of these beds. Perhaps, in brief, we should give less emphasis to habitation and more to rehabilitation.

How can we give our aging citizens the ability to live outside the nursing home? And failing this, how can we give them the ability to live with greater dignity, independence, and hope inside the nursing home?

One answer to both these questions lies in developing fuller awareness and fuller application of present-day rehabilitation concepts and techniques.

Initially, rehabilitation is three to four times as costly as routine institutional care. In the long run, however, it is considerably less expensive. Rehabilitation may take weeks, or months; sometimes many months. But passive institutional care can go on and on. In addition, rehabilitation offers benefits which cannot be measured in terms of dollars; among them hope, a chance of attaining some degree of independence, and the prospect of returning home.

The long-range economies which can be effected through rehabilitation were well illustrated in the San Mateo, Calif., study reported last year. In this community, a group of aging citizens were given thorough physical examinations at the time they first applied for welfare assistance. Half of these applicants received rehabilitation—corrective surgery, artificial limbs, training, therapy, and other restorative services. The program was financed by welfare funds. Initially, the cost of supplying these services increased welfare expenditures. However, 5 years later it was found that the total medical care bill for this group was 10 times lower than that of the group which did not receive rehabilitation.

At the Jewish Hospital in St. Louis, Dr. Franz U. Steinberg is studying the ability of geriatric patients to live at home. In this program, intensive rehabilitation is carried on simultaneously with intensive medical care for acute conditions. Out of 43 patients discharged following this program, 30 were returned home.

In New York, intensive medical, psychological, social, and economic evaluation of 95 chronic hospital patients showed that only 7 were in need of continuing hospitalization; 11 were adjudged to have a better than 50-50 prospect of successful rehabilitation.

These studies suggest that rehabilitation can keep many patients out of the nursing home, or defer the need for this type of care.

Rehabilitation also has an important and largely unfulfilled function to perform inside the nursing home. The full utilization of rehabilitation concepts and techniques could do much to revitalize these institutions, transforming passive, custodial care into active and dynamic service.

We have progressed a long way from the attitude of regarding the nursing home as a mere way station on the road to the grave. At the same time, rehabilitation has progressed far beyond the stage where its exclusive object is reemployment of persons with vocational potential.

To be sure, many nursing home occupants may never return to independent or even semidependent living. But rehabilitation can help give greater dignity, and emotional and physical well-being to dependent living.

Let us never forget that there are varying degrees of dependence. The difference between custodial bed care and the ability to move about in a wheelchair may seem small to the so-called normal person, but to the patient it can make a world of difference. Dignity and self-reliance can be found in such seemingly simple things as the ability to feed oneself or to walk to the bathroom on crutches.

It should be the aim of the nursing home to help patients attain the fullest possible degree of independence within the limitations of their conditions.

It is essential, therefore, that nursing home personnel understand the philosophy, the concepts, and the promise of present-day rehabilitation services.

All those affiliated with the nursing home should know what is attainable through present-day rehabilitation services and where and how these services can be obtained. Insofar as possible, the concepts and techniques of rehabilitation should be integrated with the patient care these institutions provide.

This requires keeping nursing home personnel in close touch with the field of rehabilitation.

In this respect, a program currently being developed here in Minnesota deserves mention. Through this program, State and local health units, voluntary

health agencies, and the medical profession are blueprinting a cooperative plan for conducting what is termed a "disability detection" program. The purpose of this plan is to carry on a unified and intensive program of education and information aimed at heightening public and professional awareness of rehabilitation needs and the services which exist to meet these needs. It will be directed primarily to the key groups and individuals who are in a position to bring chronically ill and physically handicapped persons into touch with rehabilitation services either by direct referral or counseling. These include physicians, public health nurses, clergymen, local welfare officials, and employment counselors, as well as nursing home personnel. The program will be carried out through the coordinated efforts of the Sister Elizabeth Kenny Foundation, the Minnesota Division of Vocational Rehabilitation, the State department of health, the State division of welfare, the Minnesota Heart Association, the Minnesota TB Association, the Easter Seal Society, along with the academy of general practice, the University of Minnesota Department of Physical Medicine and Rehabilitation, the Minnesota State Medical Association, and the Hennepin County Medical Society.

This will be a sustaining effort to establish advanced and comprehensive rehabilitation services as an integral part of our State's scheme of social welfare and public health services. It is intended to stimulate a heightened awareness of the promise held out by present-day rehabilitation techniques among our professional people, our disabled population, and the general public.

These observations suggest a number of specific programs which could properly and fruitfully be sponsored by the Federal Government.

There is a great need for short courses in the general concepts and techniques of rehabilitation which can be applied by nursing home personnel. The course in rehabilitation nursing offered by Kenny Institute is an example.

There is also need for research and development in the area of intensive scientific evaluation of our aging citizens. Greater accuracy in identifying and classifying needs could help us better determine the type of care required.

The establishment of nursing homes and self-care facilities in proximity to comprehensive rehabilitation centers offers another highly promising area of research.

To summarize, rehabilitation should be taken into account in any reckoning of our needs for nursing home beds or other medical care facilities for our aging citizens. We must be constantly on guard against the easy answer to this problem, which is to relegate these citizens to institutions which exist only to get them out of the way. Instead, let us ask the more difficult questions: How can rehabilitation keep the aging citizen out of the nursing home? How can rehabilitation help gain greater dignity, independence, and well-being inside the nursing home?

If we have the courage to answer these questions, we may find that the need for expansion of nursing facilities is not as great as we now believe, but, most important, we will prevent the waste of a rich reservoir of human resources and the waste of many precious years.

EXHIBIT A.—SERVING AMERICA'S DISABLED: THE CREAT MISSION OF THE SISTER ELIZABETH KENNY FOUNDATION

[Speech of Hon. Hubert H. Humphrey, of Minnesota, in the Senate of the United States, Wednesday, Aug. 9, 1961]

Mr. HUMPHREY. Mr. President, on August 2, 1961, the Senate approved H.R. 7035, the 1962 fiscal year appropriation bill for the Department of Health, Education, and Welfare. This legislation includes funds for the U.S. Office of Vocational Rehabilitation and the National Institutes of Health, among other organizations.

Through this bill, the Senate took sound action to strengthen the Federal Government's health efforts. But this action does not for one moment lessen the parallel and more significant role of what the American people do for their own health through their private actions.

It is on citizen action and citizen organization that I speak today. I will refer specifically to one type of action—through the voluntary health agency.

PRIVATE ACTION NEEDED MORE THAN EVER BEFORE

The fact is that the voluntary health agency is needed more vitally than ever before. This is thanks to the wise decision of the Congress to expand Federal teamwork in cooperation with private health groups.

Mistakes and shortcomings of the past on the part of some private groups should not obscure the tremendous need for voluntary health agencies. Mistakes and shortcomings must be, and in a number of instances have already been, remedied. But the concept of enlightened voluntary action must not be impaired.

VOLUNTARYISM AND 20 MILLION HANDICAPPED

The voluntary health agency is widely recognized as unique and powerful force in American life. Next to the Federal Government, it is the most important single source of funds for medical research.

The preservation and the expansion of the activities of the voluntary health agency is essential if this country is to continue to make progress in its fight against disease and suffering.

Paradoxically, the success we have had in saving and prolonging life—for which our voluntary health agencies deserve much of the credit—has in turn created new medical problems—the problems of aging, chronic illness, and chronic physical disability. The number and percentage of persons 65 years of age and over in the United States is steadily increasing. By 1980, it is estimated that there will be an estimated 22 million U.S. citizens over age 65. This age group, of course, has the highest incidence of chronic illness and disability.

The number of physically handicapped persons of all ages in the United States is estimated at 20 million.

Unless more of our disabled citizens can be maintained at their maximum capacity for usefulness, it will not be long before we are overwhelmed by their need for care and by their economic dependency.

The rehabilitation of the chronically ill and handicapped * * * their restoration to the maximum degree of self-sufficiency represent a great challenge to the voluntary health agency.

DR. KRUSEN'S COMMENTS AT AWARD CEREMONY

The need for a voluntary health agency to carry on a massive assault on disability was eloquently expressed here in Washington in May. The speaker was Dr. Frank H. Krusen, who is on leave of absence from Mayo Clinic, to serve as president of the reorganized Sister Elizabeth Kenny Foundation. Dr. Krusen is a world leader in the field of physical medicine and rehabilitation.

Let me quote some of the remarks made by Dr. Krusen when he received the Goodwill Industries of America award here in Washington on May 5:

"In recent months, there has been a great deal of earnest soul searching going on over the definition of this country's national purpose.

"It seems to me that a national purpose, like a tradition, will emerge naturally. If it's there, you'll find it without looking.

"I believe that the United States has a national purpose and that we have progressed quietly and steadily toward its fulfillment. This national goal can be defined in the words—man's humanity to man.

"The American people have achieved an unequaled record of progress in caring for and about their fellow men. If Americans have any single distinguishing national trait, it is a spirit of open-hearted generosity and unhesitating readiness to help those in need.

"The overwhelming testimony of this spirit is to be found in the record of public support of voluntary health agencies.

"This spirit, combined with the American talent for organization and fund-raising on a grand scale, has created a system unparalleled anywhere on earth.

"Each year, Americans freely contribute nearly $1.1 billion to vountary health agencies. These funds have financed massive assaults on disease and human suffering.

"Everyone knows the results. Through the impetus created by the National Foundation, we have reached the point where killed virus, together with live virus, may soon be capable of virtually eradciating paralytic poliomyelitis.

"Not many years ago, tuberculosis was accepted as an inescapable curse of all mankind. Now our Nation's TB sanitariums stand nearly empty. Another voluntary health agency—the National Tuberculosis Association—was in the vanguard of this victory.

"In 1960, cancer detection campaigns, combined with improved medical skills, saved the lives of an estimated 40,000 Americans who would have died of cancer in 1945. In 1945, less than $1.5 million was devoted to cancer research in the United States. By 1960, this figure had risen to $130 million. The American Cancer Society has led the vast frontal attack on this disease.

"Other voluntary health agencies are receiving millions upon millions of dollars to combat heart disease, mental disease, neuromuscular diseases, blindness, leukemia, and mental retardation.

"The voluntary health agency system is one of the mightiest forces ever arrayed against human need and suffering.

"The voluntary health agency has become the channel for vast floods of public funds for use in combating specific diseases. However, in proportion to human need, rehabilitation has received only token support from this source.

"The field of rehabilitation would be transformed overnight if it were supported by public giving on the same scale as other fields.

"How can we marshal the American public's full capacity for giving behind the needs of the handicapped? This is the great question before the field of rehabilitation today.

"Only thus can we finance the truly massive effort required to bring timely and adequate help to all of our chronically ill and disabled.

"There is no lack of concern for the handicapped in our State and Federal Governments. But the public at large should share this concern. While Government aid is essential, the need is too great to be met by Government alone.

"There are more than 20 million persons in the United States who have difficulty in moving or who cannot move about without help. These are victims of multiple sclerosis, automobile accidents, and other injuries, hemiplegics, paraplegics, victims of cerebral palsy, muscular dystrophy, stroke, epilepsy, and poliomyelitis.

"Three million persons in the United States are feasible for rehabilitation to the point of remunerative employment. The State and Federal programs conducted by the Division of Vocational Rehabilitation rehabilitate less than 90,000 individuals per year. This is only one-third of the total number of persons who annually become disabled through accident and disease.

"Last August, Representative John E. Fogarty, speaking before the Third International Congress of Physical Medicine here in Washington, D.C., said:

" 'Rehabilitation services must be expanded to the point that the opportunity to benefit from these services is available to every person who needs them at the time needed.'

"If we accept this as our goal, it is painfully clear that our handicapped are now in the middle of a tragic rehabilitation gap.

"There is a tragic gap between the number of persons who need rehabilitation services and the personnel and facilities for providing these services. There is a tragic gap between the scientific advances in this field and the techniques which are now in general practice. We possess the knowledge to restore millions of handicapped persons to independent, productive living, but, alas, we lack the trained minds and hands, the facilities and equipment necessary to apply these skills to those who need their help.

"The shortage of professional personnel in the field is fantastic. The specialist in physical medicine and rehabilitation—the physiatrist—is, of course, the key man in any comprehensive rehabilitation program. How many of these specialists do we have? Less than 350—out of 241,000 physicians licensed to practice medicine in the United States. We could use 500 additional physiatrists tomorrow morning. Because of the shortage of qualified teaching personnel, physical medicine is taught in only one-third of our schools of medicine.

"In 1959, there was a need for 5,800 additional physical therapists; 1,000 occupational therapists; and 12,000 social workers in all fields. There is also an annual need for 600 additional counselors trained in rehabilitation techniques.

"These figures merely represent vacancies in existing rehabilitation facilities. If we had an adequate system of rehabilitation facilities, merely in terms of physical plant, the needs would be far greater.

"How can we marshal the support of the American public in closing this tragic rehabilitation gap?

"These remarks can be summed up by saying that only mass education and mass public giving can meet the massive proportions of the problem before us. The number of persons who annually become disabled or chronically ill through aging, accidents, and injuries is increasing each year. If we continue at the present

pace, we will not be able to keep up with the rehabilitation needs of those entering the ranks of the disabled each year, let alone care for the enormous backlog of patients now awaiting help.

"It is curious how our attitude toward the disabled differs from our attitude toward victims of acute illness and injury. Somehow, we feel that their conditions persist so long it makes them more bearable. We forget that the longer they endure these conditions, the greater is their suffering.

"Imagine our feelings if these millions of Americans had by some tragic disaster become disabled in a single day. Such an occurrence would be greeted as a national calamity, sending a wave of shock and horror into every home in the country. And from every home, funds and assistance of every kind would pour out in a merciful flood to aid these victims.

"Essentially, there is no great difference between such a national disaster and the plight of our chronically ill and disabled. This is a national calamity. And I appeal to the American people to respond to it as such. Winston Churchill once said: 'You can measure the civilization of a people by the way they treat their older folks.' It may be said just as truly that you can measure the civilization of a people by the way they treat their chronically ill and disabled. Measured by this yardstick, we can be proud of the degree of civilization we have attained. We have made truly astounding progress in caring for and about our chronically ill and handicapped. But the help we provide is still pitifully inadequate to the need that exists.

"We must also remember that our responsibilities to the handicapped are not circumscribed by national boundaries. Our concern must be worldwide.

"Our efforts to help the handicapped both at home and abroad can have a far-reaching influence on the attitudes of other nations toward the United States and our way of life. Rehabilitation is a triumphant affirmation of our belief in the intrinsic worth and dignity of the individual. According to this concept, eligibility for rehabilitation is not measured by an indvidual's potential usefulness to the state—his ability to bear arms, produce his production quota, or qualify as a useful member of society according to utilitarian standards.

"Rehabilitation may mean that an individual will merely be able to raise a fork to his lips, hoist himself from a bed to a chair, or clutch a pencil in a claw-like device. It may mean that he will need an intricate arrangement of pulleys, weights, and springs to perform some of the simple actions of everyday life. But the mere fact that he is a human being is sufficient reason to exert all of our efforts to help him use his remaining abilities, no matter how slight they may be.

"Imagine the impact of this philosophy on people living under other political systems. We are currently engaged in a war of ideologies, one which holds that man exists for the state and our own which holds that the state exists for man. We have sought to establish the superiority of our way of life in various ways: by pointing to our high material standard of living, by vaunting our industrial might, by competing feverishly to assert our military supremacy.

"But the American qualities which have a greater appeal to the minds and hearts of our neighbors can be found in our simple human concern for a handicapped child or a disabled older person.

"On the one hand the world is faced with a system under which one of its leaders—Mao Tse-tung—is capable of saying that he would readily sacrifice 100 million of his countrymen's lives to gain his military ends. On the other hand, the world sees a system which mobilizes all of the agencies of science and society to aid an individual with a damaged body return to life.

"If we can summon the full support of this country's resources of generosity, and compassion, we can close the rehabilitation gap quickly and dramatically. We can respond to the needs of our handicapped here and abroad on a scale which can win us lasting respect and understanding. And in so doing we will proclaim more eloquently than any technological breakthrough, the true meaning of our way of life."

PROFESSIONAL COMPETENCE OF KENNY INSTITUTE

Dr. Frank Krusen, whose remarks I have just quoted, is head of the Kenny Rehabilitation Institute, Minneapolis, Minn. The institute has attracted worldwide attention for its outstanding success in restoring the chronically ill and handicapped to a maximum degree of physical, social, and vocational independence.

The expansion of this institution's services to the point where it can realize its full potential would be an enormous step forward in the field of rehabilitation.

The institute is a subsidiary of the Sister Elizabeth Kenny Foundation. Last September, the foundation underwent a complete reorganization following an investigation of fundraising irregularities conducted by the Minnesota State attorney general's office.

The Kenny Rehabilitation Institute was in no way implicated in this investigation.

The reorganization resulted in the removal of the officers charged with misuse of funds, and placed the foundation in the hands of a group of outstanding citizens, representing the clergy, the medical profession, banking, and industry.

The integrity of the foundation is now beyond question. Remedial steps have been taken so as to assure the most unimpeachable procedures and personnel. The foundation will be a model for other voluntary groups.

The new foundation was extremely fortunate in securing the services of Dr. Krusen as president of the foundation and director of the Kenny Rehabilitation Institute.

Prior to accepting this appointment, Dr. Krusen was for 25 years associated with the section on physical medicine and rehabilitation at Mayo Clinic, Rochester, Minn., first as director of this department and later as senior consulant. He was granted an indefinite leave of absence from Mayo Clinic in order to accept this post.

Dr. Krusen is one of the world's foremost authorities in his field.

His pioneer work in the field of rehabilitating the handicapped has earned him the unofficial title of "Father of Physical Medicine."

Serving on the new Kenny Foundation board of directors is another outstanding leader in the field of rehabilitation, Dr. Frederic J. Kottke, director of the Department of Physical Medicine and Rehabilitation at the University of Minnesota.

Minnesota's leadership in the great humanitarian mission of helping the handicapped was evident last year when Dr. Krusen served as president of the International Congress of Physical Medicine held here in Washington, D.C., while Dr. Kottke served as president of the American Congress of Physical Medicine which sponsored this worldwide gathering.

Minnesota has made vast contributions to many areas of medical science through the University of Minnesota Medical School and Mayo Clinic. The Kenny Institute and the rehabilitation center, with the University of Minnesota, offers the potential for making an equally great contribution in the field of physical medicine and rehabilitation. If it receives the support it deserves the Kenny Rehabilitation Institute can make an enormous contribution to closing the rehabilitation gap.

REHABILITATION CENTERS IN THE MAKING

I am hopeful of further great achievement along these lines.

Part of this hope rests on the splendid decision of the Senate and House Appropriations Committees to provide in H.R. 7035 for regional rehabilitation centers in the United States. These centers would really be national "showcases"—national models of the greatest deeds of phyiscal medicine and rehabilitation.

The case for these centers had been made in eloquent testimony before both committees by both Drs. Krusen and Kottke. The American people will always be indebted to these two great individuals for their personal presentations at the crucial time of the hearings. I am delighted to say that, in heartwarming response, both committees, in their official reports, cited the opportunity for each such center to be established at a leading medical school with the close cooperation of a voluntary health agency and of State and local governments.

I know of no circumstances in the 50 States where there is closer professional and lay cooperation than that which exists between the Kenny Institute, the University of Minnesota, and State and local authorities.

I am hopeful, therefore, that an application for a center which will be made by these experts will receive favorable action by the Office of Vocational Rehabilitation.

If it does, as I believe will be the case, then the need for citizen support will be heightened.

This, I repeat, is not a local or regional matter; it is a national need. A great pilot program will be launched. The eyes of the Nation will be upon it.

A magnificent chapter in physical medicine and rehabilitation will thereby be written. And countless disabled will benefit—directly and indirectly.

Thus, the voluntary health agency will require and I believe receive a new mandate from the American people.

It is their instrument—their servant. The Kenny Institute will, I believe. establish bold new precedents in competent and unimpeachable leadership.

The next step is up to our citizens to give it the necessary support, as I believe they will.

Exhibit B.—Nursing Homes and Homes for the Aged

[Excerpt from Rehabilitation of the Aging by Frank H. Krusen, M.D., from the Southern Medical Journal of November 1960]

The American Medical Association has realized the need for rapid expansion of the number and quality of nursing homes in the United States. It is estimated that we have in this country about 25,000 nursing homes, containing 450,000 beds. One hundred eighty thousand of these beds are in what are called skilled nursing homes, and 80,000 in personal care homes that provide some skilled nursing care. The remainder of the beds are in personal care homes which do not have skilled nursing care.

The average age of persons in nursing homes is 80 years, and two-thirds of these are over 75 years of age. Only one-third are men. Less than half can walk with assistance, more than half have periods of disorientation. One-third are incontinent, and two-thirds have some type of circulatory disorder. In most instances the nursing home operators and nursing personnel require training for the provision of additional services to patients including rehabilitation services. There is need for rapid expansion of training in rehabilitation nursing in our nursing homes.

Exhibit C.—Disability Detection

[The following address by Frank H. Krusen, M.D., president of the Sister Elizabeth Kenny Foundation and director of Kenny Rehabilitation Institute, Minneapolis Minn., was presented on Monday, October 30, 1961, at a meeting held at Kenny Rehabilitation Institute, before a group which included representatives of the following organizations: Minnesota State Medical Association; Hennepin County Medical Association; Minnesota Division of the Academy of General Practice; the Minnesota State Division of Vocational Rehabilitation; the Minnesota Rehabilitation Association; the Minnesota Department of Health; the Minnesota Easter Seal Association; the Minnesota Tuberculosis Association; the Minnesota Heart Association; Minnesota State Services for the Blind; the Minneapolis Vocational Rehabilitation Center.]

A UNIFIED APPROACH TO EDUCATION AND INFORMATION IN THE REHABILITATION FIELD

I feel sure that all of us here today are proud of Minnesota's leadership in the field of rehabilitation. This area is endowed with rehabilitation personnel, facilities, and services of an exceptionally high order.

I am not referring solely to leadership in the purely medical aspects of rehabilitation, but to the total complex of services represented in this room—the health professions, the public health. social and welfare agencies, our educational institutions, and the voluntary health agencies.

Today, I would like to discuss with you a way in which Minnesota can once more assert its leadership in this field, and by so doing bring lasting rewards to the chronically ill and handicapped.

It concerns what I have frequently referred to in the recent months as the rehabilitation gap. All of you know the meaning of this phrase. It means that there is a wide gap between what we can do for the disabled and what is actually being done. It means that our scientific, technical, vocational, and social technics are years ahead of the service our handicapped actually receive. It means that the vast improvements in the science and technology of rehabilitation have not produced a corresponding improvement in the overall condition of our disabled population.

It means, too, that rehabilitation facilities and services in this area and elsewhere are not being utilized to the fullest by the maximal number of persons who could benefit by them.

The people of this area are offered every opportunity to obtain the finest rehabilitation services available. Yet, a large number remain locked in the grip of handicaps they could overcome. This is a tragic paradox.

I do not intend to minimize the great work which we have accomplished. To a greater degree than most States we have fulfilled the needs of our disabled population.

But we must do immeasurably more.

The State division of vocational rehabilitation estimates that there are 323,000 persons in Minnesota who need rehabilitation. If you include the disabled populations of North and South Dakota, Iowa and Wisconsin, the figure exceeds 1 million. In Minnesota, some 1,000 handicapped persons are returned to work each year through our vocational rehabilitation program; in the five-State area, about 3,000.

Nationally, the number of handicapped persons exceeds 20 million. These are persons who have difficulty in moving or cannot move about without help. Between 2½ and 3 million physically handicapped adults are in need of rehabilitation to return to remunerative employment. An additional 250,000 persons become disabled each year. But less than 100,000 are returned to work annually through the State and Federal programs of the Office of Vocational Rehabilitation.

In other words, we are rehabilitating less than one-fourth of the annual increment of cases, while doing nothing about the enormous backlog.

Many of you are familiar with these figures. I repeat them only to emphasize the point that I am trying to make; namely, that our rehabilitation services reach only a fraction of those who urgently need them.

I think everyone will agree that the demand upon our rehabilitation services is by no means commensurate with these figures.

While not concerned primarily with rehabilitation, the study of Minnesota's aging population conducted by Bernard Nash, special consultant to the Governor's Conference on Aging, provides an interesting parallel. I believe the findings of this extensive and carefully documented study show that a large percentage of those 65 and over are not utilizing the health services available to them. If this is true of health services in general, I daresay it is even more true of rehabilitation facilities which represent a newer and hence less well-known complex of services.

Many of us know from personal experience that this rehabilitation gap exists. I remember the case described by Dr. Howard Rusk concerning a girl of 17 paralyzed in an auto accident. After lying in bed for more than 19 years she finally learned of the existence of a modern rehabilitation center. Five months after admission, walking on crutches she went out and found a job and, at the age of 36, began a new life. Had she learned about rehabilitation earlier, the waste of 19 precious years might have been prevented. But despite these wasted years, this young woman was one of the lucky ones . How many others have wasted all the years following the onset of disability?

I think also of the case of Della Derein, who was discharged from Kenny Institute just a few weeks ago. Della was struck by spinal meningitis in April of 1955, shortly after graduating from high school. Her condition developed into encephalitis, resulting in total deafness, aphasia, and spastic paraplegia. She was told that nothing could be done for her. And for 5 long years nothing was done. Then, through a friend, she learned of Kenny Institute.

Here, in a period of 18 months, she progressed from a state requiring custodial bed care, and complicated by severe decubital ulcers, to complete independence in a wheelchair and gained some ability to walk with crutches. Through lipreading and speech therapy she regained the power to communicate with the world. Back home in Sheboygan, Wis., Della expects to work in a craft shop and is looking forward to going to art school.

Sitting down the table from me, I see my good friend and former patient, Judd Jacobson. Years ago, a spinal cord injury suffered in a diving accident left Judd a quadriplegic. Judd has built a fine career as a radio newscaster and leads a full and independent life. But while he is an example of highly successful rehabilitation, his case also illustrates the lack of contact between society and our rehabilitation resources. In the early days of his disability Judd received little encouragement in his attempts to make a comeback. But he kept trying and through his own courageous efforts finally received the help he needed to help himself.

What are the causes of the tragic situation we see illustrated in these cases?

It stems partly from certain deep-seated human and social attitudes. The handicapped individual and those around him often view disability as an immutable condition ordained by fate or providence and accept it with stoic resignation or despair.

Disability does not kill in the same sense as, say, heart disease or cancer. Nor does it imperil others in the same way as communicable diseases. Nor is disability amenable to the dramatic cures available through surgery and chemotherapy. Hence, it does not arouse the same urgent appeal for immediate attention.

Moreover, we cannot offer an ultimate weapon for the conquest of disability. We cannot promise a vaccine to eradicate it, nor an antibiotic to control it. The very weapons which save lives mean that more patients survive to become handicapped.

But perhaps the greatest single cause of the rehabilitation gap is lack of information and education. This is where the vital connection between rehabilitation and society breaks down. Our disabled people and the society in which they live are generally unaware of the advanced state of the art and science of rehabilitation. They simply do not know how dramatically rehabilitation has changed the outlook of the handicapped person.

In the world outside rehabilitation, the prevailing attitude toward disability is still expressed in the chilling term, "hopeless invalid," while for us it is personified in the inspiring lives of severely handicapped persons who are living full, productive lives.

My good friend and colleague, Dr. William Spencer, of Houston, Tex., Rehabilitation Center, has said that the first step in rehabilitating the bedridden patient is to "change his horizon from the ceiling to the world."

But society continues to feel that the outlook for the handicapped patient is the ceiling or the four walls at which he stares from his bed or wheelchair. It is up to us to widen this horizon to take in the new world of rehabilitation. The handicapped patient, his family and friends, and sometimes his physician are not aware of where and how these services can be obtained. There is a breakdown in the simple process of getting the patient into touch with our rehabilitation services.

Most of us here in this room share the conviction that the needs of the physically handicapped represent one of our Nation's most serious health problems. In fact, many of us could make a good case for the assertion that is now or soon will be our greatest health problem. But we must concede that we are a long way from convincing the general public and our legislative bodies of this fact. Compare the funds contributed and appropriated for research in the categorical diseases with those for rehabilitation. This is one indication that this field is not being supported on a scale corresponding with the need that exists.

Why is this true?

Primarily because chronic disability has not established the same clear claim to our society's compassion and concern as the specific conditions. And this is largely owing to the fact that the magnitude of this problem has not been brought home to the public in terms sufficiently dramatic and persuasive. We cannot expect the public and our legislative bodies to fully recognize the needs of the handicapped when the majority of the handicapped themselves do not seek rehabilitation.

I am convinced that we must shock our society into a new awareness of these needs. We must bring about a demand for rehabilitation which is truly commensurate with the amount of disability that exists. The purpose of this meeting today is to present the preliminary proposal for accomplishing this goal.

First and foremost, it is intended to bring the chronically ill and handicapped into touch with the services which exist to help them toward the end of restoring as many as possible to maximal function. At the same time, it would have the purpose of presenting to the public the living, indisputable evidence that disability is among the Nation's most pressing and serious health problems. This is perhaps the most effective way we can win the understanding and support necessary to meet the needs of the disabled now and in the future.

Secondly, it is hoped that each group will serve the active function of encouraging, each in its appropriate way, the demand for rehabilitation services by the handicapped.

This in broad outline is the program we propose.

But please remember that we are first of all seeking your reactions and recommendations. This is a momentous undertaking. We do not presume to have all of the answers and all the details assembled in a neat package at this time. The answers and many of the details must, to a large extent, come from the groups represented here. Only through your cooperation can we hope to succeed. This is a preliminary meeting, which we hope will lead to others where the specific program can be fully developed with the aid and participation of all of your groups.

I am not suggesting that this program represents a totally new concept. Many of the activities it would embody are already being carried on in one degree or another. I am suggesting, however, that this program would give a new urgency and a new dimension to the programs already underway. Through this program we can intensify our efforts by unifying them under the dynamic and dramatic theme of the disability detection campaign.

For obvious reasons, Minnesota provides an ideal proving grounds for such. First, because of the generally high level of rehabilitation services which exist here. Second, because we have already gone a long way toward coordinating and unifying the programs of the multiplicity of agencies involved in rehabilitation. This, of course, is an essential prerequisite to the success of such a program. The work being done through the Minnesota Rehabilitation Association gives us a head start. So does the overall view of our services which we are gaining from the survey of our rehabilitation resources being conducted by Bill Keenan. This survey has already resulted in a comprehensive directory of the services available in Minnesota.

In Minnesota and adjoining States, the Kenny Foundation has a strong and active volunteer organization which, I might add, is just completing a successful fund drive in the five-State area and which will represent an important element in the plan we propose. As the leading voluntary health organization in the field of comprehensive rehabilitation, the Kenny Foundation is well-known and well-established on the wide regional and national basis necessary to carry this program to other parts of the country.

The special OVR grant which we expect to receive will further enhance the stature of the institute as a center of national significance. I would like to comment on this grant since it represents an important turning point, not only for the Kenny Foundation, but for the entire field of rehabilitation.

This year, Congress added $1 million to the appropriation for the Office of Vocational Rehabilitation. This sum was especially earmarked for the establishment of two regional research and training programs.

Taking the lead in sponsoring this legislation were members of the Minnesota delegation, Senator Hubert H. Humphrey and Representative Fred Marshall. They were supported by Representatives Walter Judd, Ancher Nelsen, and by colleagues from other States, notably Senator Lister Hill and Representative John E. Fogarty.

From the beginning, these legislators had in mind two specific programs—one to be conducted jointly by the University of Minnesota and Kenny Rehabilitation Institute and the other by Dr. Howard Rusk at the New York University Rehabilitation Center.

Last week we completed applications to the Office of Vocational Rehabilitation, which will administer the grant.

This represents a highly significant breakthrough for the entire field of rehabilitation. The broad aims of the grant are to encourage research and development in the field of rehabilitation as comprehensive as that conducted by the National Institutes of Health in the categorical diseases. This marks an enormous step forward in gaining recognition of rehabilitation as a national health problem of equal magnitude to heart disease, cancer, and mental illness.

Against the background of this precedent-setting, regional program, the disability detection campaign can be expected to assume greater stature and arouse more widespread interest than it might otherwise.

On the purely practical level, the OVR grant will also provide at least partial financial support for the detection campaign. In addition, a substantial part of the Kenny Foundation's overall public relations efforts during the coming year will be devoted to this program. Our public relations facilities and the five-State-area volunteer organization will be brought into full play in support of this undertaking.

Nevertheless, we recognize that this undertaking cannot succeed without the interest and cooperation of all the groups represented here. Perhaps I am

optimistic in believing that all of these separate groups with their individual problems and goals can work together in this mutual endeavor. But I take heart from the many past experiences which have proved that we can work together for the welfare of the chronically ill and handicapped.

Such a program will mark an important step in the direction so strongly advocated by serious and farsighted students of the current health picture. I am thinking of the recent report on voluntary health agencies sponsored by the Rockefeller Foundation and of recent statements by Secretary Ribicoff urging greater cooperation by private and public health agencies as a means of avoiding duplication and promoting more efficient health services.

While primarily the aim of this program is to better serve the chronically ill and physically handicapped, I believe it will benefit all of the groups represented here.

It can bring the medical profession outside the field of rehabilitation into closer touch with the full range of services available to him in the management of his chronically ill and handicapped patients. The full utilization of rehabilitation by the physician in general practice will also highlight his humanitarian concern for the overall welfare of his patient, a quality which deserves emphasis as the medical profession seeks to preserve the physician's traditional relationship with his patient.

The success of this program could also help alleviate needs which the Federal Government might otherwise seek to fulfill. The Minnesota State Medical Association pointed out in its testimony before Congress on the King-Anderson bill, that full utilization of available local health services should be realized before Federal health programs are contemplated.

The benefits of this program will be immediately apparent to those of us who serve the handicapped through voluntary and Government rehabilitation agencies. For us, it will accomplish the all-important goal of bringing our statistics to life. Now we present our needs to the public in terms of abstract, inanimate statistics. The success of this program would rescue the handicapped from the shadowy limbo of statistics and bring them before the public as flesh and blood human being. It will, if successful, make known the true dimensions of disability, not in terms of numbers but through the overt appeal for help.

It will help bring our citizens to the full realization that they live in the midst of a disaster area, surrounded by victims, not of a single tragedy, but of countless isolated and individual tragedies which in the aggregate amount to a national calamity of devastating proportions. And this realization can hasten the day when we can bring timely and adequate aid to all these victims.

The demand for rehabilitation, indeed, the social pressure for rehabilitation. which could result would have a profound and far-reaching impact on this entire field.

I believe this program can have the further effect of giving us more reliable and comprehensive data for planning our programs. The opportunity to see and evaluate a representative number of chronically ill and handicapped persons will enable us to arrive at more accurate projections of our needs. We may discover, for example, that we are predicating our anticipated need for nursing homes and homes for incurables on a large group of patients who could be rehabilitated. We may discover that funds anticipated for these facilities may in part be better spent on rehabilitation and independent living programs, thus reducing the need for nursing and terminal beds.

To be sure, the success of this program could also mean that the demand for rehabilitation services will exceed our capacity for providing them. This thought has probably occurred to you. There is the possibility that cases could come to us in such numbers that many would be turned away and placed on waiting lists. Would we be guilty of holding out false hopes? This is a legitimate source of concern and we have given serious thought to this problem. We should, by all means, make it clear in all of our communications concerning the detection campaign that facilities may at times be limited, stressing that this is one of the situations which this program seeks to correct. We should honestly inform the rehabilitation candidate that his demand for services is intended to help bring about the needed expansion of facilities.

But I do not believe we should expect our chronically handicapped to continue to wait silently and patiently until we have trained sufficient personnel; until we have developed adequate facilities to accommodate them comfortably. Did we ask the victims of poliomyelitis to wait? Or the victims of tuberculosis?

No; they filled the wards and lined the corridors of our institutions presenting the living testimony of their need. And the public responded to their need, providing the funds and the facilities to care for them. No; I don't believe we are wrong to urge the chronically ill and physically handicapped to make their need known. To be sure, our waiting lists may grow longer, but remember, these people are already waiting—waiting without even the hope to sustain them of someday receiving help. Indeed, the very presence of these names on our waiting lists, documenting the overwhelming need for rehabilitation, can hasten the day that we can provide timely and adequate care for those who are waiting silently and invisibly in the dark back bedrooms of our land.

Senator LONG. We will take a 5-minute recess.

(A short recess was taken.)

Senator LONG. We will be in order, please.

The next witness will be Mr. Sidney S. Shields, president, Minnesota Nursing Home Association, St. Paul, Minn.

STATEMENT OF SIDNEY SHIELDS, PRESIDENT, MINNESOTA NURSING HOME ASSOCIATION

Mr. SHIELDS. Senator Long, the committee—I request that my prepared statement be made a part of the record as corrected.

Senator LONG. It is my understanding that all of the prepared statements will be a part of the record.

(The prepared statement of Mr. Shields follows:)

PREPARED STATEMENT OF SIDNEY S. SHIELDS, PRESIDENT, MINNESOTA NURSING HOME ASSOCIATION

My name is Sidney Shields. I am the president of the Minnesota Nursing Home Association, and I am representing both the Minnesota Nursing Home Association and the Twin City Nursing Home Association at this hearing. The Minnesota Nursing Home Association comprises in its membership both privately owned or proprietary nursing homes and nonprofit or religious and charitable homes. In this report, however, I will confine my remarks to the role of the proprietary nursing home. I do not intend to minimize in any way the very significant weight of religious and charitable organizations in their operation of nonprofit nursing homes. Many aspects of this report are applicable to both proprietary and nonprofit nursing homes, but the subject of this report is confined to privately owned or proprietary nursing homes.

The object of this statement is to show the present status of proprietary nursing homes in fulfilling the growing need for the care of nursing home patients, the place the proprietary nursing home must take in the nursing home picture, and the increased care and facilities required of proprietary nursing homes.

The object is also to show the fact that the proprietary nursing home can furnish its facilities at less cost than public or publically sponsored institutions, and consequently can provide good nursing home care at a substantial saving to private families and welfare agencies.

To the accomplishment of this end, private nursing home operators have through the auspices of strong and active State and Twin City nursing home organizations established an accreditation program designed to achieve the highest possible standards for nursing home care.

For the purpose of this statement, a nursing home is defined as a facility in which nursing care and medical services are performed under the general direction of a duly licensed physician, for persons who require nursing care and related medical services, but who are not so acutely ill as to require hospital care.

FACILITIES FOR NURSING HOME CARE PROVIDED BY PRIVATE OWNERS

The growth of the modern nursing home dates back to approximately 1945. At that time there first appeared a definite need for nursing home beds. There were no public facilities available for this purpose, and as a result many private individuals began to convert large mansion-type homes into nursing homes. The medical facilities provided in such homes were meager; however, they were

adequate to care for the type of patient who at that time sought nursing home care. There were not a great many bedridden patients, as these were cared for in hospitals. The patients mainly were ambulatory or semiambulatory, who needed some bedside care, administration of comfort medications, special diets, limited application of dressings or bandages, and a good deal of custodial care, such as help with bathing, dressing, personal care, and feeding.

As the need for nursing home beds increased, additions were made to these homes and new homes began to be built. Commencing with 1951 and 1952 private capital was induced to enter the nursing home field and a new type of modern, fireproof building appeared, providing many facilities found only in hospitals.

In 1951 the Minnesota Legislature for the first time passed a comprehensive law providing for the licensing and regulation of nursing homes in this State. Under this law the State board of health has put in force rules and regulations, for both the facility and the care of patients.

The State board of health has the power to propose regulations and does not require legislative approval. The normal procedure in instituting new regulations has been to call a public hearing at which time all parties concerned present their views, and new regulations have been promulgated from time to time.

In about 1950, when new proprietary homes began to be built, there were very few county homes and very few nonprofit homes or homes associated with religious institutions. From a few hundred beds in 1945, the number of nursing home beds in the State of Minnesota has increased to 11,196 as of April 15, 1961. Of this number 5,927, or 53 percent, were in proprietary ownership homes. Since April 15, 1961, the number of proprietary beds has increased by 139. The State board of health reports that since 1950, 8,921 new beds have been constructed, and a large percentage of these new beds have been constructed by private ownership.

Of the total number of individual homes in the State of Minnesota, 60 percent are proprietary.

So far in 1961 there has been a total of 588 new proprietary beds built, and 131 beds are under construction. The growth of new facilities is more than keeping pace with the potential needs, and the danger of overbuilding is becoming very real. The capacity of homes now being built is 2½ to 3 times that of homes formerly constructed.

The projected requirement for the State of Minnesota by the State board of health is 4 beds per 1,000 of population. In Hennepin County, the largest concentration of the elderly in the State of Minnesota, there now exist 4.46 beds per 1,000 of population over the age of 65.

Basically, throughout the State there has been adequate nursing home construction to meet the increasing needs. There are some remote areas in the State where the needs were not met by either proprietary or nonprofit associations, but this situation has now been corrected by the leasing of county facilities to private owners, who now operate these as private homes in county home facilities.

Approximately 10 percent of Minnesota's 3,413,864 citizens or 341,386 are 65 years of age or older. The majority of these individuals live in their homes with relatives, in roominghouses or hotels. Several thousand are in State institutions for the mentally ill and deficient. Many occupy beds in general hospitals intended for acutely ill. Some are receiving care in chronic disease units of general hospitals.

It should be noted that Minnesota was one of the first States to provide an adequate nursing home licensing statute and has shown probably the greatest growth in the building of both proprietary and nonprofit nursing homes. Minnesota has a total of 17,589 beds in licensed nursing homes and boarding care homes. Of these, 11,917 are nursing home beds and 5,672 boarding care beds, also licensed. As of last year, there were under construction 36 homes, proprietary and nonprofit, with a total of 1,742 beds, at an average estimated cost of $6,000 per bed, or $10,452,000. Of this number, 12 of the homes were proprietary with 452 beds, and 24 were nonprofit or public with 1,290 beds. This would indicate that nonprofit and public nursing homes are building more rapidly than proprietary nursing homes, but it must be pointed out that proprietary nursing homes have already undergone a big building program in previous years, whereas nonprofit and public homes have lagged behind. At the present time, 53 percent of the nursing home beds in Minnesota are proprietary.

The statistics cited in this report are taken from the official records of the Minnesota State Board of Health. However, it should be noted that these

statistics change from month to month, and if statistics vary from figures cited by others, it means only that other statistics may be as of a different date.

It is important to project Minnesota's nursing home construction program into at least the immediate future. Projecting these figures may be somewhat speculative but only because not all planned beds on record are finally constructed and some of the planned beds may wait a number of years before suitable arrangements are made to initiate construction.

The planned beds at present are as follows:

Proprietary nursing home beds, 34 percent	3,532
Nonprofit nursing home beds, 56 percent	5,512
Public beds	952
Total beds	9,996

Based upon past experience we can safely assume that at least 50 percent of the planned beds will be constructed. Because of the accelerated construction program in the nursing home field, we can safely state that there will be in the coming year or year and a half at least 5,100 new beds constructed in approximately 100 nursing homes at a cost of over $30 million. If this is true, there will be a surplus of nursing home beds in the State of Minnesota within the next year or so, based upon estimated needs of 4 beds for 1,000 population.

COST OF CONSTRUCTION AND OF CARE

It should be pointed out that all new construction is strictly governed by the State board of health's regulations. All plans must be approved by that department by the State fire marshal, and the local building and health authorities. Despite rigid requirements, private enterprise has been able to construct nursing homes for substantially less money than publicly sponsored or publicly financed institutions. For example, under the Hill-Burton Act the average cost of construction throughout the country has been $8,323 per bed. Under the FHA-approved financing, the average cost of construction has been $7,100 per bed. Private enterprise has been able to construct nursing homes at an average cost of $5,000 per bed. This has been done without sacrificing any of the basic needs for care and welfare of the patients.

Cost of construction is a definite factor in determining cost of care in proprietary homes. If, according to good accounting methods, the nonprofit and public homes were to consider cost of construction in the same manner as proprietary homes, the cost of care in the nonprofit homes would be considerably higher than they now are, as compared to costs in private homes. Despite the fact that nonprofit or public homes may not consider their construction costs in determining cost of care, it is a fact that costs in proprietary homes are considerably less than in publicly financed or sponsored nursing homes, and for this reason proprietary homes have been able to take care of a large percentage of welfare patients at a modest cost approved by welfare agencies. Homes constructed under the Hill-Burton Act must of necessity cater to private patients able to pay higher rates made necessary by high construction expenditures.

The cost of patient care depends not only on the cost of the facility, but also upon the ability of the owner to operate a nursing home efficiently and economically, and at the same time comply with all the requirements for care established by State boards of health, local health authorities and welfare departments, and by accreditation committees. Generally speaking, welfare patients occupy approximately 70 percent of available private nursing home beds. Hennepin County, which has the largest number of welfare nursing home patients in the State, has established a care rate ranging from $140 per month for ambulatory patients to $225 for heavy-care, bedridden patients. For exceptional special care cases, the welfare department will exceed the $225 limit. However, this occurs in extremely rare situations and requires special authority from the State welfare department.

The cost of nursing home care in facilities associated or connected physically with hospitals ranges from $8 per day per patient to $18 per day. (These are nonproprietary.) The cost for the average welfare patient in the proprietary nursing home is approximately $6 per day. It must be remembered, however, that in view of rising costs and also in view of stricter regulations adding to the cost of operating a nursing home and the increased care demanded by the patients, the figure of $6 per day should be considered as a basic figure which, of necessity, will have to be increased.

A recent study made by Hamilton Associates, known as the Hamilton Report, asserted that it would cost Hennepin County $8.80 per patient per day for nursing home care in the existing public supported and operated facility in Glen Lake, Minn. The privately owned homes have furnished a degree of care acceptable for accreditation and for recognition by local health and welfare authorities, and have proven their ability to operate at lower costs than public facilities.

PATIENT CARE IN PRIVATE FACILITIES

Whereas 10 years ago nursing home care was basically custodial and was confined primarily to ambulatory or semiambulatory patients, today the private homes serve an increased number of bedridden or semibedridden patients who require considerable nursing care and much more specialized nursing skills. Through joint efforts and cooperation with the local health authorities, State board of health, and University of Minnesota, training programs have been in effect for administrators, supervising nurses, and nurses' aids. There has been an influx of capable registered nurses and licensed practical nurses into the field, and this, together with the experience gained by the nurses who remain in this phase of nursing care, has made it possible to provide the more intensive type of care now demanded of nursing homes.

The concept, itself, of nursing home care has been changing. Where the emphasis formerly was on custodial care, the emphasis today is in restorative and rehabilitative care. In recognition of this concept, several large proprietary nursing homes have installed physical therapy departments. Training programs today stress getting the patient out of bed as much as is possible and training him to do as much for himself as is possible. Private enterprise has demonstrated its ability to provide the care indicated in these new concepts.

Recognition of the need to provide increased care facilities, together with special skills and special care required by the large number of "hard case" patients has prompted the American Nursing Home Association to establish an accreditation program. This program is designed to provide superior services, not merely the services required of them by law.

At the October 1961 convention of the American Nursing Home Association, delegates voted approval to the formal inauguration of an accreditation program to be adopted by the respective States and further developed for State application. Minnesota has adopted this program. As with hospitals, accreditation would be voluntary. It is believed that most homes would accredit themselves for the category of care of which they are capable and under which they would choose to render service.

INVESTMENT

It is difficult to estimate the amount of money actually invested by private enterprise in nursing home construction and facilities in Minnesota. A conservative estimate would be at least $18 million to $20 million. However, the new proprietary homes presently under construction are being built at a much higher average cost. It is estimated that the next 1,000 beds that will be built by private enterprise will involve a layout in excess of $5 million, exclusive of equipment.

It should be pointed out that the present nursing home profession has become a major industry in the economy of our State. Thousands of people are employed in nursing homes and, indirectly, thousands more find employment with firms who supply and service nursing homes. The tax outlay by nursing homes—real estate, personal property, income, employment, and other taxes—is considerable.

In financial problems, as well as operational problems, the nursing home owners need understanding and cooperation. There must be constant cooperation between the nursing home and the numerous State and local agencies which are concerned with its regulations, standards, and operation, and there must be cooperation also with the local welfare agencies which are concerned with care and the cost of care. The nursing home must adapt itself to the changing needs and the changing rules and regulations designed to improve, create, and maintain high standards for nursing homes without making the cost of that care prohibitive or burdensome on the public.

There must be a constant effort between the operators of nursing homes and the public regulatory agencies to see to it that their regulations are not made so stringent or oppressive so that cost of care does not exceed the limits made pos-

sible within the allocations available to the welfare departments who pay for the care. These regulations should not make it impossible to operate under present rates so as to require the public agency to raise their fee beyond their tax resources.

In Minnesota we are glad to report that such cooperation exists between the operators of private nursing homes and the various State and local agencies, both regulatory and welfare.

CONCLUSION

This report has attempted to convey that private nursing home owners first recognized and dealt with the very acute problem of caring for the ill and aged. The facilities were modest at the outset, the care required was also modest. Since the inception of the nursing home industry as we know it today, private nursing homes have contributed a significant share of excellent beds and have continued to advance in nursing skills to provide more specialized and intensive types of care.

Private nursing homes have provided good care at rates compatible with welfare allocations, and today are serving a disproportionate number of welfare recipients.

Private nursing home owners have recognized the need for achieving the highest possible standards and toward this end have participated in classes, institutes, and educational programs for staff and administrators. They have cooperated with interested public officials and the University of Minnesota, in programs designed to improve the skills of its personnel, as well as entering into a program of self-accreditation.

The statistics of the growth of nursing home beds in Minnesota would clearly indicate that the proprietary nursing homes can provide facilities for the average nursing home patient who requires normal nursing home care, whether ambulatory or bedridden. There are certain types of semiacute patients who require unusual care and who could be accommodated in nursing homes attached to hospitals that are generally designed as convalescent hospitals. Where public facilities are being considered, they should be considered to serve a category of patients who cannot be served adequately in private nursing homes, such as borderline mental patients or dischargees from mental hospitals. Recently a tuberculosis hospital, no longer needed for TB patients, was converted by the State into a nursing home, with the express understanding that its patients would be confined to dischargees from mental hospitals who are deemed to be unsuitable or undesirable for nursing homes. In this limited field public nursing home facilities might be justified.

Among the advantages in placing patients in non-county-home facilities there should be considered the psychological effect on the patient between that created by housing in a public facility and that produced by being housed in a private or nonprofit facility. At present welfare patients are mingled with private patients, and no one knows who is a welfare patient and who is not. In a publicly owned and operated facility, it would be evident to the public at large visiting such a facility that everyone receiving care there is a welfare recipient, which might reflect on the dignity of our senior citizens. In the nonpublic homes there is no distinction between welfare and private patients.

The private nursing home operators throughout this area are pledged to provide the best possible care to patients entrusted to their care, by requiring their personnel to attend clinics and classes provided by public facilities for the training of nurses' aids, to keep their equipment up to date at all times, to contribute to educational and research activities covering the field of the chronically ill, aged and convalescent patient, by respecting the social and religious practices and customs of their patients, cooperating with hospitals, health and welfare agencies interested in promoting the health and welfare of their patients, actively supporting and encouraging every effort which will ease the financial burdens of those who pay for nursing home care, and by giving factual and objective interpretations of accomplishments and objectives in the growth of nursing homes.

Mr. SHIELDS. There was a clerical error in the statement and I refer to the corrected statement.

The purpose of my report is to attempt to convey that private nursing home operators first dealt with the problem of caring for the ill and aged. While the facilities were modest the care required

was also modest. We note today that private nursing homes have contributed a significant share of excellent beds and have continued to advance in nursing skills to provide more specialized and intensive type of care. They have rates compatible with welfare allocations and today are serving a disproportionate number of welfare recipients.

Private nursing home operators have recognized the need for achieving the highest possible standards and toward this end have participated in classes, institutes, and educational programs for staff and administrators. They have cooperated with interested public officials and the University of Minnesota in programs designed to improve the skills of its personnel, as well as entering into a program of self-accreditation.

In this record I do not intend to minimize the very significant role of religious and charitable organizations. Many aspects of this report are applicable to both proprietary and nonprofit homes, but the subject of the report is confined primarily to private licensed or proprietary nursing homes.

I would like to point out that there may be some differences indicated in some of the figures which I have used and some of which we have heard a little earlier, but this is due, perhaps, to the fact that the statistics were taken from a different time period. In 1951 the Minnesota Legislature passed a law providing for the licensing and regulation of nursing homes in the State. Under this law the State board of health has put into force, rules and regulations for both the facilities and the care of the patients. The State board of health has the power to propose regulations and does not require legislative approval. Dr. Barr pointed out that private nursing homes comprise approximately 30-some percent of nursing homes. Now, according to the State board statistics, which appear in their directory of 1961, we now have 6,066 proprietary beds out of approximately 12,000.

My information is that proprietary nursing homes comprise 53 percent of the existing nursing home beds in the State. So far, in 1961, 588 new proprietary beds were built and there are 131 under construction nearing completion so far this year. The total number of beds built in the State, both proprietary and nonprofit associations, is 1,992. Again the State board of health has testified that 1,600 new beds per year would liquidate the existing shortage by 1970, and this is based on the assumption that the rate of growth, would continue as it has in the past.

Regarding this rate of growth, at the moment there are on record requests for 9,996 beds, of which 34 percent are proprietary, 56 percent nonprofit associations, and 10 percent public. In addition to this there are 100 different groups who have expressed interest in building new facilities. Of these approximately 10,000 beds that are now in planning stage, we can safely assume, based on previous performance, that 50 percent of these beds will materialize. This would indicate that we can look to see approximately 5,100 new beds constructed in the very near future, and this would be at a cost in excess of $30 million. Should these beds materialize we predict that there will be a surplus of nursing home beds in the State of Minnesota within the next 2 years, and this assumption is based on the State's estimated needs of four beds per thousand.

I would like to briefly discuss the subject of construction costs: Under Hill-Burton, the average cost per bed is $8,323. Under FHA approved financing the average cost of construction was $7,100 per bed. Private enterprise has been able to construct nursing home beds at $5,000 per bed, and this has been done without sacrificing any of the basic needs for the care and welfare of the patients. Again I point out that all new construction must receive approval of the State board of health, local zoning regulations and local health regulations. These beds must comply and conform to the State board of health requirements which we discussed previously.

Senator LONG. Where is the difference, where is the saving made?

Mr. SHIELDS. Hill-Burton requires one costly difference, which proprietary homes do not have to conform to, the size of recreational areas. I think that under Hill-Burton about twice as much day room space per patient is required. In Minnesota we are required to have 20 square feet of dayroom space per patient, while under Hill-Burton the requirement is approximately 38 square feet per patient. In Hill-Burton construction there are more refinements. I think we get down more to the practical aspect of construction. We are more interested in the functional rather than the decorative. I think private enterprise would like to have elaborate facilities, but I do not believe that the new construction of proprietary nursing homes would have to take a back seat insofar as meeting the basic requirements is concerned.

Senator LONG. Do private nursing homes provide some type of recreational program for the people who live in them?

Mr. SHIELDS. Some of the larger homes have gone into the field of occupational therapy. Again, this service depends a great deal on the type of patients they cater to, for instance, in the intensive care nursing home——

Senator LONG (interrupting). I noticed in reports I read that the only type of recreation they had was a community television that was used.

Mr. SHIELDS. Well, in many instances that is sufficient. I wish to point out that the conception of the nursing home patient, or the public image of the average nursing home patient is not correct, because the average nursing home patient has deteriorated beyond popular understanding. From my own experience I would say that it is all a matter of a point of view; for example, a worm judging the animal kingdom refers to the duck, chicken, and goose as ferocious animals and the lion and leopard as kindly ones. Many of my patients are bedridden. The average age in my nursing home is 82. I am building an addition to my home and will have 150 beds. I expect that my patients will be on the intensive care side, although there may be some lighter care patients. Many of my patients are senile and, frankly speaking, there is a fine line between being senile and being a mental case. Many patients cannot tell whether it is day or night. We have had an occupational therapist in the past who spent 2 or 3 days per week. I have had two of them, both university trained, and the greater part of their time was spent in trying to induce some of my patients to participate in their programs. We had a very small percentage who actively engaged in the program as designed by the occupational therapist. Frankly, their effectiveness or beneficial value

was questionable with a large number of typical nursing home patients.

Senator LONG. Is there much use being made by the private homes here of the provisions of the Housing Act of 1959; FHA coverage for that type of home?

Mr. SHIELDS. Would you repeat that?

Senator LONG. You mentioned there were some private homes being built or planned now under the provisions of the Housing Act of 1959 which provide, I believe, 5½-percent rate of interest and under a 40-year loan under the FHA plan.

Mr. SHIELDS. Speaking from my own experience—when I attempted to get FHA financing, I found that as a practical matter I could not get 5½-percent financing, so the Government gesture in the practical application for FHA financing did not work too well. I think that the fact that very few FHA loans have been made in this area and throughout the State generally would testify to the effectiveness of this program.

Getting back to the Hill-Burton home, because of the higher construction costs and the much higher operational expense, their homes cater largely to the private patients who can afford to pay the higher fees that are required. As a matter of fact, proprietary homes would very much like to see the Hill-Burton homes take in a minimum of 33 percent welfare patients inasmuch as they are getting up to 33 percent Federal funds. To date they have left the responsibility of taking care of the welfare patients mainly to charitable and private homes. Generally speaking, welfare patients occupy approximately 70 percent of the available private nursing home beds. In Hennepin County, where the largest number of nursing home patients in the State are concentrated, a care rate of $140 a month for ambulatory cases to $225 for heavy, bedridden patients, has been established. There are some exceptions, however. For these, special authority must be gotten from the State welfare department to qualify above the $225 rate per month. The cost of nursing home care in facilities associated or connected physically with hospitals range from $8 per day per patient to $18. These facilities are nonproprietary. The cost for the average welfare patient in proprietary nursing homes throughout the State is approximately $6 a day; however, I want to qualify this. In view of rising cost and stricter regulations which have added to the cost of operating a nursing home, plus the increased care demanded by patients, $6 should be considered minimum cost, and of necessity should be increased.

Senator LONG. I understand that $6 or $7 per day is the cost per patient in private homes.

Mr. SHIELDS. The average payment by the welfare department, which pays for 70 percent of our patients, is $6 through the State. However, I repeat that we feel that it is low. I say it is too low based on my own figures which show that I have a direct labor cost, exclusive of other costs, which exceeds $130 per month per patient. The patient that is cared for in my nursing home at $170 is actually being subsidized. A recent study, known as the Hamilton report, asserted that it would cost Hennepin County from $8.80 to $9.10 per day for nursing home care in the existing public supported and operated facility at Glenn Lake, and this is exclusive of taxes and amortization of the facilities themselves.

Senator LONG. I am about to run out of time on you, but there is one question I would like to ask you before we go on. You mentioned in your prepared statement about the plan of accrediting your nursing home. Are there written standards and regular inspections provided for this?

Mr. SHIELDS. Yes. This program has been established by the American Nursing Home Association in concert and cooperation with the AMA, ADA, American Nursing Association, and other health care associations. It is a voluntary program. The program has been accepted by the association of Minnesota with certain adaptations or certain revisions that would be applicable to our own State. I point out with a certain amount of pride that the welfare program of the State of Minnesota is, we feel, among the top, and I would like to digress a moment. In your television interview yesterday you mentioned that Minnesota has only 2,000 nonacceptable beds, which is lower than the national average, and you said you were interested in finding out why—may I supply an answer?

Senator LONG. If it doesn't take too long.

Mr. SHIELDS. I think, first, it is because in the State of Minnesota the legislators and the welfare department have shown a practical attitude as to what constitutes a fair and equitable fee and to digress—you don't find a homely Cadillac—when you pay a good price, you are bound to get better quality. Conversely, in States which have low welfare rates, you find few good homes.

I think a second point is the desire of the owners themselves—again I speak of private—to improve their homes for competitive reasons and also for the opportunity to qualify for higher rates. Better homes command higher rates.

A third point, I believe, is the result of high standards established by the State board of health in 1951 and also the enforcement of those standards by local welfare authorities——

Senator LONG (interrupting). You understand I have been complimenting your people here. I was complimenting them because of the larger percentage——

Mr. SHIELDS (interrupting). I won't continue with my prepared address, however, I feel strongly that the private nursing homes have made a significant contribution to the nursing home picture. They first recognized the need and did something about it. There are substantial investments being made in private nursing homes, and a very large program for further expansion exists. I feel that private nursing homes have been a good stabilizing factor in establishing a fair rate for patients. Private nursing homes can provide good service and operate under the limited allocations established by the legislature and welfare department. I maintain that private nursing homes are meeting care problems at a standard that is basically good as attested to by a report made by Dr. Park of the Minneapolis Health Department which states that 70 percent of the nursing homes in Minneapolis now are classified C grade or better, judged by his own standards, the number of nonacceptable homes can be counted on one hand. The big building boom, up until last year, has been proprietary, but now nonprofit and charitable homes have entered into the picture and as they have more funds available they are building faster. However, 60 percent of existing nursing homes are still proprietary; and 53 per-

cent of all beds are proprietary. In new construction, however, only 34 percent will be proprietary, and I feel that this ratio may continue for some time.

Senator LONG. Thank you, Mr. Shields.

The next witness is Mrs. Campbell Keith, administrator of Walker Methodist Home, in Minneapolis.

STATEMENT OF MRS. CAMPBELL KEITH, ADMINISTRATOR, WALKER METHODIST HOME

Mrs. KEITH. Senator Long, members of the subcommittee, I was asked to speak to the relative role or importance of the infirmary facility within the retirement home. The concept, originally, of a retirement home, I feel, was one of a place to which some discarded person might go. The picture has changed entirely. We feel now that the retirement home has a very important part to play in the lives of our entire citizenry and that for the work of a retirement home to meet its commitment it must serve a total program.

We have observed in the past 16 years at the Walker Methodist Home a very definite change in the attitude of people seeking our care. Originally they came, perhaps, looking for an escape from a responsibility, perhaps the idea of a new home was novel to them, however, now the question asked is, "Would you take care of me when I am sick? Will you take care of me if I should lose my mind? What will I do if I can no longer take care of myself in a general way but just need partial support?" The trend is a very healthy one, I feel, toward keeping older people in their own homes, just as long as it can be accomplished, but when the move is made to a retirement home that there should be a five-point program there to completely satisfy the desire of the resident. He is entitled to feel that when he moves to a retirement home that he will remain there so long as he is able to participate in the program of the home and then should he need nursing care, partial or total, it would be provided, and should his mental capacities deteriorate to the point where he needs further support that so long as he is not a menace to those about him, that is the role of the home to meet these needs.

One of the greatest difficulties of any older person, I feel, is the acceptance of change, and should illness become a challenge to us, for the patient to go out for care, very often his convalescence, his general condition, his improvement, is deterred by the fact that he is adjusting to the change of the hospital facility. If he were able to continue in the home, in the infirmary or health center—and the term "health center" is far more acceptable to the old folk than is the term "infirmary"—his recovery will be expedited and there will be far less cost to him or to the agency taking care of his costs.

Another very important advantage of an infirmary or health center within a retirement home is the relationship to the rehabilitation program. The emphasis placed on rehabilitation in the geriatric field is well taken and Dr. Krusen certainly spoke to that. We have witnessed in our home tremendous gains and restoration of self-confidence, physical capacity, and emotional adjustment through our rehabilitation program. It is encouraging to the older patient in the rehabilitation program to be able to measure his progress against that of his neigh-

bors. We feel that the nursing staff is better able to evaluate his progress because he knows his patient better. He is an inspiration to others, to his neighbors who are loath to accept a rehabilitation service, and in every way we recommend strongly, from our point of view, the rehabilitation program in a retirement home.

The cost of a rehabilitation program is high at first, but when one considers what it means to the ultimate cost of patient care, it is much lower. It is our considered judgment that an infirmary is an integral part of a good retirement home. It gives security to every resident that knows should he become ill, he will be given care in familiar surroundings. The costs are less than those in acute hospitals and nurshomes. The infirmary is available at all times and the fearful, discouraged older person will find the support he needs.

I do not presume to hold a brief for a retirement home to compete with the acute hospital by way of having facilities for surgical intervention, et cetera, but where the resident is well oriented in the services his home provides, he will realize that possibly for diagnostic study and surgical treatment he will need to go out to an acute hospital, but with the assurance that for the convalescence he will return to his home. He will accept the change and will not rebel against it.

(The prepared statement of Mrs. Keith follows:)

PREPARED STATEMENT OF MRS. CAMPBELL KEITH, ADMINISTRATOR, WALKER METHODIST HOME, MINNEAPOLIS, 9, MINN.

To evaluate infirmary facilities within a retirement home, one must first clarify his concept of a retirement home. Should a retirement home be all embracive of services required by those older people within it or should it be limited to the policies and practices of the home in question, be they restricted to domiciliary care or limited nursing care. It would appear that there has emerged from the various conclaves and convocations within the field of geriatrics a picture of the ideal retirement home as the facility with the total program. This means that many of our fellow citizens needs must revise their thinking and redefine their conception of a retirement home.

The term, "total services," covers a broad area, and which should be paramount in order of value is problematical. Briefly and historically speaking, a retirement home was a place, not necessarily a haven for those within it, and perhaps was well described when it was designated as the poor house. Among the possible facets, however, that they might have had in common with the ideal retirement home as I would interpret it is that terminal care is given in both.

It has been an interesting experience throughout the past 16 years to have observed how inquiries relative to admission to the Walker Methodist Home have changed. The Walker Methodist Home opened its doors in 1945. At that time and for several years later many of the inquiries seemed to be based on the applicants' desire to be relieved from responsibility. He wanted to escape, or so it seemed in many instances, from the many demands made upon him—the male applicant perhaps wishing to be relieved of the storm window project, and the woman from the dishwashing or what have you. There has been a gradual and increasing emphasis, however, placed on the need for care. One of the first questions has become, "Do you take care of me when I am sick?"; another "What happens to me if I get queer or lose my mind?" followed by the comment, "I am just fine now, of course, and I would like to stay where I am until I need to move." It might well be that this change of attitude on the part of the applicant should be an important factor in our determination of what the services of a retirement home should include. Emphasis at the Walker Methodist Home has now come to be placed on what we would term a five-point program: domiciliary, limited nursing care, total care, custodial supervision, and outpatient services.

With the increased longevity of our people and the toll that time takes mentally from some, we feel that a retirement home can do a great deal to give care for the so-termed senile in the atmosphere to which he has become ac-

customed. I do not suggest that the senile patient be admitted directly to the home, but I strongly recommend that the one who becomes in need of special love and care, as we so describe it, for his sake and that of his family and friends, that they be provided for him at the home. It has been our observation that to have a special area for this type of patient does not serve as a reminder to the resident body that senility is a threat, but rather does it give the assurance that should it come, his home is still where he had chosen to live when he was in possession of his faculties. Further we have noted in some instances what appears to be a stabilization of the retrogression process.

We would like to use the term "health center" as an all-embracive one, to cover every service provided other than the domiciliary, although we are qualifying, of course, that those in the domiciliary section are eligible for health center services. Terminology is very important, and we have found a rejection of the term "infirmary" as such, but an acceptance of the health center.

Going back to our original premise that infirmary facilities within a retirement home are not only to be recommended but are essential, we accept as fact the concept that by far the greater number of residents within a retirement home have outlived most of their friends and relatives. Then too we must recognize that friendly visitation has therapeutic value at any age level. If the resident with the home requires acute nursing care, chronic or otherwise, and is moved to facilities beyond the campus of the retirement home, he in many instances is going to be denied the encouragement and strength that comes from contact with the new friends he has made since he entered the retirement home.

To accept change is a very difficult part of the lives of older folk, and it would then follow that ground would be lost in adjusting to an acute facility in lieu of a health center if a resident is transferred out for nursing care. During his residency in the home he has come to look upon the nursing staff as part of his own neighborhood. They are not creatures in white uniforms, but rather personal friends from whom concern and affection radiate, not to mention professional skills. We know and the patient will know, should he be transferred to an acute hospital (and there are times when this is indicated) and his associates within the home who may be older and less able than is he will be unable to make the journey to see him, perhaps due to physical limitations or maybe financial, and there will be a resultant lag in his convalescence.

Another advantage of having an infirmary or health center within a retirement home is its relationship to the rehabilitation program. The emphasis placed on rehabilitation in this geriatric field is well taken. We have witnessed tremendous gains and restoration of self-confidence, physical capacity, and emotional adjustment through our emphasis on rehabilitation. Among the advantages is that of being able to measure progress. The nursing staff within the home has a more accurate picture of the patient and his needs, as well as his capacities, than can the nurse with whom he comes in contact for a very limited time within the acute facility. His friends and neighbors within the home are a means of encouragement to him, as he in turn is an inspiration to others, and his true progress can be measured far more satisfactorily here than elsewhere.

The support of an infirmary program within a retirement facility can, in part, be absorbed by that portion of the budget allocated to administrative expense. A well-trained, experienced administrator of a retirement home is in a position to evaluate her nursing staff and to work intelligently and constructively with her supervisor of health services.

It is our considered judgment that an infirmary is an integral part of a good retirement home. It gives security to every resident who knows that should he become ill he will be given care in familiar surroundings and by people in whom he has confidence. The costs are less than those in acute hospitals and nursing homes. The infirmary is available at all times, and the fearful, discouraged older person will find in his familiar area the support he needs. I would indeed be a hostile witness (with all apologies to Perry Mason) if I were to designate as a good retirement home one that was not equipped to give general care to the ill. I do not presume to hold a brief for a retirement home to compete with the acute hospital by way of having facilities for surgical intervention, etc., but where the resident is well oriented in the services his home provides, he will realize that possibly for diagnostic study and surgical treatment he will need to go out to an acute hospital, but with the assurance that for his convalescence he returns to his home.

Senator LONG. Thank you. Dr. Leo Nash.

STATEMENT OF DR. LEO NASH, CHAIRMAN, COMMITTEE ON AGING, MINNESOTA STATE MEDICAL ASSOCIATION, ST. PAUL

Dr. Nash. Senator Long and members of the subcommittee, I am Dr. Leo Nash, of St. Paul, Minn., representing the Minnesota State Medical Association's Committee on Aging. I am a radiologist and one of the 3,650 Minnesota doctors who comprise the State Medical Association. One statement I have submitted to your committee outlines in detail many of the pertinent facts concerning our Minnesota nursing homes, the cost of caring for persons in these homes, and the obvious need for additional facilities within these homes.

But first, on behalf of the association, I wish to take this opportunity to welcome you to Minnesota. We appreciate the valuable time you are taking to consider our recommendations to help all of us who are, or will soon be, senior citizens. We are proud that you have chosen to hold hearings on our Minnesota nursing home program, a program which has been developed by the Minnesota Department of Health, the Minnesota Nursing Home Association, the Minnesota Hospital Association, churches and fraternal organizations, and the Minnesota State Medical Association.

As we physicians care for our aging population, we soon become aware of the fact that the only thing these people have in common is that they are over 65. They are not a homogeneous group. Hence, as doctors, we treat each person individually. We feel, also, that any programs instituted to help those over 65 must also be geared to the individual.

In Minnesota we know that 3.5 percent of our population over age 65 resides in licensed nursing homes. This does not include boarding homes. The average age of these people is 80 years, and they spend an average of 2 years in the homes. According to a recent study of persons living in congregated housing in the State, 90 percent were widows, widowers, or persons who never married. Of the approximate 12,000 nursing home beds in Minnesota, about 52 percent are occupied by recipients of old-age assistance. This study also pointed up the fact that people living in congregated housing have a much smaller net worth, and more of them spend their time just sitting and thinking, than those who live in noncongregated housing. It was noted that those in congregated homes regard their health problems as more serious than others.

These, and many other statistics contained in my statements lend emphasis to the fact that we should help elderly people remain in their own homes as long as they are able. Hence, we support the Federal Housing Act of 1956 and its 1959 amendments, and we urge that this act be strengthened to: (1) Facilitate the purchase of housing by older persons; (2) facilitate the financing of rental housing projects—both profit and nonprofit—designed specifically for the elderly; (3) facilitate the financing of proprietary nursing homes; (4) make public, low-rent housing more readily available to older persons; and (5) make direct loans to sponsors of nonprofit rental housing projects who are otherwise unable to obtain financing.

We have always supported, and will continue to support, the use of the Hill-Burton Construction Act for building new nursing homes. Builders, whether public or private, must be encouraged to take into

consideration the wishes of the elderly. Such homes, we recommend, should be homey. They should be located near medical, recreational, and shopping areas. Furthermore, they should be built in areas free of blight and near public transportation.

As physicians, we work under strict standards and a code of ethics. We know and appreciate the reason for such standards. We urge that volunteer organizations, such as the American Nursing Home Association, also prepare a model set of minimum standards which can be implemented in every State. We call upon the Governors' conference to appoint a committee which will prepare model legislation for the enforcement of minimum standards. It is our sincere belief that, working through these volunteer groups, minimum standards can be established and maintained in each State.

The problem of financing nursing home care cannot be solved by giving all persons eligible for social security 180 days of free care. As stated earlier, national statistics point out that the average stay in a nursing home is 2 years.

We are firmly convinced that providing complete nursing home care for those who need it is the answer for those persons who are financially unable to pay for their care. The Kerr-Mills bill provides all the necessary Federal legislation to do just that. Our Minnesota Medical Association tried to explain the need for the necessary State legislation to implement the Kerr-Mills bill; but some persons, both in and out of our State government, blocked these efforts. We will continue to work for the passage of the near medically indigent portion of the Kerr-Mills bill in Minnesota.

In addition to the State legislation which is needed for the local enactment of the Kerr-Mills bill, we recommend:

(1) Stopping or reducing all types of inflationary programs by the Federal Government. Instead of increasing Federal spending, we should tighten the Federal purse, which will, in turn, help the people on fixed or retirement income plans to take care of themselves.

(2) That the State Governors' Councils on Aging should encourage employees and State boards of education to prepare educational material for preretirement counseling.

(3) That the State governments encourage private insurance companies operating in their State to sell prepaid insurance which would also include nursing home care for the elderly.

We urge that the committee members take a few minutes of their busy schedule to read the other progressive recommendations that are presented in our statement. As doctors, we are dedicated to a continuing effort to improve the care of patients in and out of nursing homes. We will work for greater use of rehabilitation techniques, better nursing home environments producing a more effective readjustment of the patient, higher uniform standards, and a more aggressive enforcement of those standards.

We urge that the problem be approached from a scientific viewpoint and that emotionalism be disregarded. Only by studying the nursing home problem on an objective basis can we arrive at progressive, intelligent, mature solutions.

Our modern plans for rehabilitation of the disabled and the aging call for self-help and self-discipline. They are designed to help men to work so that they can maintain their independence and self-regard.

We urge your committee to apply the modern plans for rehabilitation to this problem. We urge that you help, not destroy, the possibility of the nursing home patient to help himself.

Thank you.

Senator LONG. As no one has a higher respect for the medical profession than I do, and I am sure that is true of the committee, I don't want to go into your statement in too much detail.

In your prepared statement you mentioned that people 65 and over, the only thing they have in common is their age. It seems to me that two other things they have in common that are vital to us and in particular concern to this committee is their illness, and they have very reduced financial resources. That is nearly as common a factor with them as their age. I am sure you are familiar with that.

I would like to ask you about the Kerr-Mills bill. There are only 21 States that have passed it. You commented that it was not passed here in Minnesota. What type of opposition did you have to it? We haven't passed it in Missouri, either.

Dr. NASH. I feel myself that there are individuals in high places in our State government who were able, perhaps, by predicting extensive usage of such a bill, to discourage the legislature from passing the Kerr-Mills bill. Now, the extent of this usage is only predicted. I don't know if there is any experience from other areas to warrant the prediction. I think that was one of the reasons. Another reason was that we have a good welfare program. The argument used was that a great majority of the county welfare directors would have two sets of individuals to deal with under the Kerr-Mills bill, those who are near medically indigent and those who are old-age assistance recipients. This would create additional cost. I think in consideration of the ultimate costs, these were not as important as they were made to appear. This is my own opinion. I think that progress of any sort is accompanied by a certain number of labor pains, and I think that the individuals in places of responsibility didn't wish to undergo these pains.

Senator LONG. Doctor, the Kerr-Mills bill, did that place the costs of this back on your local tax structure? Would that have something to do with the passage of that? The committee has had that feeling from other testimony.

Dr. NASH. It is a Federal-State matching grant-in-aid program. I think in Minnesota, we will receive about 50 percent Federal money. The rest will be matched by the State and county governments.

Senator LONG. You think approximately 50 percent?

Dr. NASH. Yes. But we felt that the gain from Federal funds would help our existing welfare program and that with modest expenditure we could implement the Kerr-Mills program.

This is my own opinion.

Senator LONG. Hasn't one of the big objections to medical care in the early days been the placing of it, charging it to the local tax structure rather than permitting it to be paid for in part by the individuals themselves?

Dr. NASH. I don't follow you, Senator.

Senator LONG. In the Kerr-Mills bill, 50 percent that would have to be paid by the State of Minnesota would come out of your local tax funds, would it not?

Dr. NASH. It would, yes.

Senator LONG. Do you think that would be a factor in opposition to it here as in other States?

Dr. NASH. It was a factor, probably. I also feel that we could have augmented our current welfare program by the 50 percent that the Government would allow.

Senator LONG. There is one other—I am not trying to unduly press you about this, but I am seriously wanting your comment—one of the things that has concerned me about the physicians' health program, as I understand, one of the objections is, you are apprehensive in the overall picture that there would not be the freedom of choice of your doctor. But under the Kerr-Mills bill, would it be necessary that the patient wouldn't have the choice of his doctor, that he would be treated by the public physician of the county, that he would be required to go to a county hospital in the States that had them, and would be required to be treated by the county doctor?

Dr. NASH. In our present welfare program, that is not the case. Private physicians——

Senator LONG. Would it not be true, under the Kerr-Mills bill, that he would be required to be treated by a doctor in the employment of the State, if there is a county hospital in that town?

Dr. NASH. I don't believe so.

Senator LONG. We have heard some testimony that that was the case in other States.

Dr. NASH. With the possible exception of Ramsey County, the county where St. Paul is located, all welfare cases have complete free choice of physician, hospital, and nursing home. In Ramsey County, welfare cases are treated at the city, county hospital, although they do have free choice of physician and nursing home.

Senator LONG. They don't have county physicians; each county doesn't have a county physician?

Dr. NASH. No.

Senator LONG. What about county hospitals?

Dr. NASH. In three major cities, we do have county hospitals, of course, but not for the old-age group. I think I am correct when I say that we have county or municipal hospitals in many counties in Minnesota. Welfare cases are not compelled to go to these hospitals for care.

Senator LONG. There was one other point that I wanted to ask you about and I don't have any figures on it. You suggested that the private insurance companies be encouraged to sell prepaid insurance to include nursing care for the elderly. Do you have any figures—have there been figures compiled as to the cost of that?

Dr. NASH. To my knowledge, no; but I feel that an insurance company can write anything that the people want them to write. I have no information as to this.

Senator LONG. It would seem to me that it would be rather expensive for a person in a low-income bracket to carry that type of insurance. I don't know whether your association has any figures on that or not.

Dr. NASH. I have no figures here.

Senator LONG. I agree with you that the insurance companies will write anything that there is enough business to write. That is the

point that is involved here. There is a possibility that they fail to do the job that the doctors want done and the citizens want done in care for the aged.

At this point we will insert in the record the prepared statement of Dr. Nash. Thank you so much.

(The prepared statement of Dr. Nash follows:)

PREPARED STATEMENT OF DR. LEO NASH, MINNESOTA STATE MEDICAL ASSOCIATION

GENERAL STATEMENT

The Minnesota State Medical Association, representing 3,650 members, is pleased to be able to submit a statement concerning nursing homes to the Senate subcommittee. The association, which represents the vast majority of Minnesota physicians, has as one of its purposes the promotion of high standards of medical and health service for the people of the State.

In the promotion of this purpose, the association has worked industriously with the Minnesota State Board of Health to establish high standards of care for all persons in nursing homes. Many hours have been spent perfecting current standards. The association also has cooperated with the Department of Welfare of the State of Minnesota to foster higher standards of care for all persons, wether or not they could afford such care. The result is that Minnesota's program for the needy is one of the best in the Nation.

Finally, the association has united its energies with those of such volunteer groups as the Minnesota Nursing Home Association and the Minnesota Hospital Association to improve methods of care for the elderly patient. We are pleased with the excellent results in Minnesota.

BACKGROUND

We physicians know that the health problems of the aged involve much more than hospitals or doctors' care. The older person requires housing, including nursing homes; recreation, community understanding, and acceptance; the chance to be useful; and the opportunity to be a respected member of society. We know that the lack of these things can affect the body's health as disastrously as a virus infection. To cite an example, suppose we diagnose an illness in an older person, put him in a hospital, and in due course, release him as cured.

If that person cannot find an opportunity to use his skills, talent, and capabilities upon returning to society and if he cannot win acceptance with his family, his friends or in his community, it is probable that he will seek the only shelter available. That means the artificial haven of a hospital, a nursing home, or a mental institution.

MINNESOTA'S NURSING HOME PROGRAM

According to 1960 population figures, there are 3,413,864 persons in Minnesota. About 10 percent of the population, or 340,000 are over age 65. The Minnesota Department of Health has stated that Minnesota should have four nursing home beds per thousand population. In other words, they suggest that Minnesota needs 13,655 beds. There are presently 10,549 suitable or replaceable licensed facilities. This leaves 1,992 nursing home beds under construction in the State. It is important to note that since 1950, there have been 10,478 new nursing home and home for the aged beds completed or under construction, according to the State health department.

On April 15, 1961, Minnesota had 321 licensed nursing homes with 11,196 beds. They were owned by the following groups:

(a) Nonprofit associations, 88 homes (27 percent) with 3,579 beds (32 percent).

(b) Public, 24 homes (8 percent) with 1,690 beds (15 percent).

(c) Proprietary, 209 homes (65 percent) with 5,927 beds (53 percent).

We also have 19 nursing home units in hospitals (licensed as convalescent and nursing care units) with 751 beds as follows:

	Units	*Beds*
Nonprofit association	12	425
Public	7	326
Total	19	751

There are no accurate figures as to the number of persons wanting to enter a nursing home, but the State department of health has said that most homes are operating at a high occupancy rate. Many of the newer homes, especially those which are church sponsored, have long waiting lists.

The Minnesota State Legislature has established a licensing law relating to the standards and inspection of nursing homes. The State board of health, according to the statute (144.56) shall "adopt and enforce reasonable rules, regulations, and standards. * * *"

Minnesota's minimum standards are high. They establish the minimum number of personnel needed, the minimum standard for stairings, moisture, heating, ventilation, lighting, telephones, water supply, sewage disposal, plumbing, screens, toilets, bathtubs, waste and refuse disposal, location of beds, floor size, spacing of beds, furnishings, laundry facilities, food service and sanitation, and reports and records. Disturbed mental patients cannot be received or retained in a nursing home. There are some special minimum requirements such as a supervising nurse, a night attendant, a designated medical doctor, provision for an isolation area, proper equipment for nursing care, and nursing records.

Finally, all Minnesota licensed nursing homes must meet all requirements of the State fire marshal.

Every effort is made in Minnesota to uphold the standards described above. Health officers in Minneapolis, St. Paul, Bloomington, and St. Louis Park have been designated by the State board of health for the surveillance of nursing homes in Hennepin and Ramsey Counties. This permits more frequent visits to all homes. Many of the older homes under proprietary ownership are converted dwellings which are rapidly being reclassified and replaced according to a plan established by the board. No dwelling has been converted to a nursing home during the last 4 years.

Unlicensed homes are much less a problem in Minnesota than formerly, as a result of a policy established by the department of public welfare which denies payments for nursing home patients except when the care is rendered in a licensed nursing home. When an unlicensed home is brought to the attention of the board of health, an investigation is immediately made and the patients requiring nursing care are removed to licensed facilities.

All nursing home are encouraged to provide nursing rehabilitation services as well as diversional and recreational activities. There is considerable variation among the homes as to the amount of equipment and trained personnel provided, however, and this variation still constitutes a problem. Some nursing homes are providing for the services of a physical and/or occupational therapist on a full- or part-time basis themselves, but there are many advantages afforded by a nursing home unit in a hospital because the specialized services and personnel can be used in both places.

Of the 340,000 persons over 65, about 46,000 are indigent and are entered on old-age assistance rolls. This group constitutes about 1.3 percent of Minnesota's total population. In a year's period, approximately 24,000 persons over 65 who are old-age assistance recipients receive medical care. This program includes comprehensive medical care including complete nursing home care. The overall program, which provides free choice of physician and is administered in the local community by the local county welfare director, costs $23,481,891 each year. Of this total, the Federal Government paid about 52.8 percent; the State about 25.6 percent and the counties about 21.6 percent.

During the 1961 fiscal year, Minnesota paid $7,204,434 for nursing home care. In other words, about 32 cents of every medical welfare dollar was spent for such care.

The department of public welfare has informed us that in any one month there are 6,200 persons receiving old-age assistance who are residents in nursing homes. This means that about 52 percent of the Minnesota licensed nursing home beds are occupied by recipients of old-age assistance. The old-age assistance program pays from $115 to $225 a month for nursing home care of their clients. A representative from the department estimated that most nursing homes in metropolitan areas charge about $200 a month; whereas, in outstate Minnesota, the cost is approximately $155 to $160 a month. If a nursing home has outstanding rehabilitation facilities, the cost per month is generally $280. Boarding-care homes charge around $103 a month.

WHO IS THE NURSING HOME PATIENT AND WHAT ARE HIS ATTITUDES?

The department of public welfare made a study of old-age assistance recipients in August 1960. It pointed out that the average age for those who live in foster homes is 80 and that most of the persons on old-age assistance had lived in nursing homes for an average of 22 months.

A self-appraisal study by Minnesota's senior citizens was completed in 1960 by Dr. Marvin J. Taves, associate professor of sociology and supervisor of rural sociology at the University of Minnesota. The sample included 300 social security beneficiaries whose eligibility was determined on the basis of income from farming; persons living in small towns; and those living in metropolitan areas. The study pointed up the following characteristics of our nursing home or boarding home population:

(1) Ninety percent of those who live in congregated housing (not living by themselves or with members of the family) were widows, widowers, or persons who never married.

(2) The amount of education was generally lower in the congregated group.

(3) While net worth of $10,000 or more was reported by one-half of both the congregated and noncongregated groups together, only 10 percent of the congregated group reported more than $10,000 net worth.

(4) Old-age assistance listed by 39 percent of the congregated group as their source of income; whereas, the noncongregated group listed social security as their major source. (Please note that the rural sample was weighted toward social security recipients.)

(5) Most persons in both the congregated and noncongregated housing wanted their living quarters on the first floor and all facilities on the same floor.

(6) Most wanted to be near public transportation.

(7) One-fourth of the congregated group and one-third of the noncongregated group wanted a garden plot.

(8) More residents of congregated housing report problems in adjusting to retirement.

(9) The congregated group reported more time was spent just sitting and thinking as compared to the noncongregated group.

(10) As expected, the number of persons confined to a chair, bed or home was higher in the congregated group than the noncongregated group. This seemed to affect their health status because a considerably lower level of morale involving health needs was reported in the congregated group.

(11) About 65 percent of the congregated residents scored low on personal adjustment as compared to 33 percent of the noncongregated residents.

The study, referring to item 11 above stated, "These findings raise serious questions about whether our current policies are directed to provide those situations which contribute to adjustment. May it not be that the emphasis upon financial adjustment at a certain point becomes less rewarding than would efforts in other areas such as increased emphasis on policies which would allow the senior citizen to continue living in his own home, to extend his education, to participate in social and community organizations, to be assured of availability of health services, and to be provided with employment arrangements, commensurate with the older person's interests and abilities.

NEEDS AND OUR RECOMMENDATIONS

The above-mentioned study asked each person to name the group or persons who, in his opinion, should have the major responsibility for providing what the older person cannot provide for himself.

One-third listed their children, another one-third assigned the responsibility to pension plans, but three-fourths made some mention of at least one level of government.

This is important, because the Government can help in many ways.

Item No. 11, above, pointed out that people want to live in their own homes. We wholeheartedly agree. Also, other comments described in the study showed that those who live in nursing homes want a more homelike atmosphere. These things can be accomplished by improving the Federal Housing Act of 1956. We urge that this act be strengthened to:

(*a*) Facilitate the purchase of housing by older people;

(*b*) Facilitate the financing of rental housing projects, both profit and nonprofit, designed specifically for the elderly;

(*c*) Facilitate the financing of proprietary nursing homes;

(*d*) Make low-rent housing more readily available to older persons, and

(*e*) Make direct loans to sponsors of nonprofit rental housing projects otherwise unable to obtain fianancing.

Our State board of health's study made in 1959 showed that approximately 1,600 long-term care beds will be needed in Minnesota each year through 1970 to liquidate the existing deficit and to provide for population growth as well as the replaceable and absolescent beds. Minnesota has received Hill-Burton Construction Act funds to build 866 nursing home beds plus 50 boarding care home beds. We feel that the Hill-Burton program has been a real stimulus in encouraging total planning for meeting the needs in all categories of care facilities. We favor the expansion of the Hill-Burton program.

The State Government can also provide a stimulus for the construction of new nursing home beds. A nursing home construction bill which did not pass the 1957 legislature would have provided $2 million in State funds to assist local communities in providing public or other nonprofit nursing homes and homes for the aged with infirmary units, on a matching basis.

It must always be kept in mind, however, that since 1950, 8,921 new beds have been provided in Minnesota. Seventy percent were sponsored by nonprofit association and public ownership and 30 percent by private ownership.

As physicians, we are well aware of the fact that people can become ill from environmental causes. The wishes and attitudes of the aged must be taken into consideration when providing new housing. Nursing homes should be built near public transportation, near shopping centers, near medical and other facilities, near recreational centers. They should be removed from blighted areas, they should be homelike, and they should have recreational, occupational, and physical therapists on the staff.

It is our belief that Minnesota's standards for nursing homes are high and, in the main, satisfactory. We feel also that minimum standards for all States are important and model standards should be prepared for passage by every State legislature in the country.

It is the duty and the responsibility of every State Governor and legislature to see that such standards are adopted. We recommend that the Governors' conference appoint a committee to prepare and work for the passage of model legislation for this purpose.

Once the standards are approved, enforcement is a necessity. We urge all State legislatures to place enforcement in the hands of the State public health officials and to provide them with funds to enforce the law.

We also call upon the welfare department in each state to release the senile patients from mental hospitals wherever possible and provide care for such persons in appropriate halfway houses; that is, institutions which do not remove them from all normal life and normal responsibilities.

As physicians, we realize the importance of proper management of patients who are in nursing homes, and we will continue to urge constant followup and frequent evaluation of these patients.

One of the underlying problems of nursing home care is, of course, its expense. In many cases, however, current costs can be cut by:

(1) Progressive patient care which will improve the patient's condition and enable him to return to boarding care home or to his own home.

(2) Increasing voluntary and governmental stimulation for programs designed to provide home care, homemaker service, and in-the-home rehabilitation.

The Governor's Citizens Council on Aging of Minnesota prepared "Minnesota's Recommendations for Action in the Field of Aging" for the 1961 White House Conference on Aging. In chapter II, the council said, "While maintenance of health and securing of medical care are primarily the responsibility of the individual, this responsibility must necessarily be assumed by the group when the individual becomes unable to meet the need." This, we believe, is an accurate statement. The paragraph points out, further, "that we need to discover and use newer ways of financing the health care of the aged." Again, we agree.

This is the reason why the Minnesota State Medical Association worked for passage of legislation to implement the Kerr-Mills Act in Minnesota. In conjunction with members of the department of public welfare and the legislature, we drafted a bill to provide complete medical, surgical, nursing home, dental, drug, etc., care for all persons over 65 who are not indigent but who need

help to care for their medical needs. The bill failed to pass in our 1961 legislature, but we will continue to work for its adoption in 1963.

As physicians, we know that all indigent persons over 65 receive complete, first-class medical care under our OAA program. We are convinced that a near-medical indigent over 65 who cannot pay for the first 180 days of nursing home care, cannot pay for the 181st or the 245th or the 365th day either. This is one of the major disadvantages of the King-Anderson bill. It is not flexible enough to give complete help to those who need aid. The Kerr-Mills program has flexibility.

We feel it is nonsense for the taxpayer to pay an increased social security tax in exchange for only partial institutional care, and for the prosperous as well as the needy; whereas the Kerr-Mills program could provide complete care for those who really need aid. Furthermore, one need not be a social security recipient to receive aid under the Kerr-Mills program. In Minnesota, 34.1 percent of the aged population does not receive social security benefits at all, and would not qualify for the limited institutional care available under the King-Anderson bill.

The question that must be answered is: Do we need an expensive, compulsory, limited-care program such as the King-Anderson bill would establish in the United States? The answer is "No."

In Dr. Marvin J. Taves' study in Minnesota, it was found that 49 percent of the group interviewed had sufficient income to live comfortably; 35 percent reported income enough for subsistence only, but no more; while 16 percent could not live on their means.

One's financial well-being, after age 65, according to the Taves report, is often more dependent upon previous accumulations of wealth than on personal earnings. One-half of the persons interviewed during their survey had a net worth of $10,000 or more. By their own admission, 87 percent of them had no uncared-for medical need. Only 5 percent said that they had medical needs which had not been met because medical care was too expensive. Yet, we know that of the 46,000 persons on OAA, only 24,000 in a given year need and receive medical care. Or, in other words, about 7 percent of the population over 65 receives complete medical care which is free, and we know that this is 0.7 percent of our entire population; and this is a major reason why we feel that we do not need a King-Anderson bill in Minnesota.

Another question we have asked ourselves is this: Is there any reason why a person who feels that he needs medical attention should go uncared for in Minnesota? Again, the answer is "No."

Among other facts pointed up in Doctor Taves' study were the following: Only 55 percent of the noncongregated elderly were aware of the fact that a public health nurse was available to help them meet their medical needs. It is apparent that better communications are needed with our senior citizens.

Also, it was revealed that 59 percent of our Minnesota aged who are not living in congregated housing spent between $10 and $200 for medical care during 1960, while 95 percent of them spent less than $500 during the year.

Finally, the study showed that 60 percent of the noncongregated aged are now covered by hospital insurance and 50 percent carry medical and surgical insurance. Most of these people had purchased their insurance within the last 15 years. This finding shows again the nationwide trend toward health insurance coverage for the aged.

One last point must be made regarding the financial situation of the aged population. Today, most persons over 65 were in their peak production years in the 1930's.

Many of today's elderly were not able to accumulate wealth during the depression years. In fact, most persons spent what savings they had in order to exist. This means that our aged population today had to accumulate its wealth in the later years of their lives and this is difficult to do.

As today's generation grows older, this will probably not be a problem, since there is no depression now. Also, today's generation will have pension plans, paid-up health insurance at age 65, and retirement programs.

If there is a limited need today, then we should adopt a limited program for the needy only to meet that need, rather than a compulsory program which wil not be necessary tomorrow.

Minnesota physicians support and encourage the implementation of the Kerr-Mills Act in Minnesota. We recognize that some of the aging have health-care problems, including especially the financing of nursing home care, but we do not believe that Government aid under the social security system will solve them.

We do believe in a generous, well-administered program of medical care for all who are not self-sustaining, and who need financial help in the settling of their medical and nursing home bills. We have a solid basis for such a program now in Minnesota.

When a physician diagnoses a bleeding ulcer, he does everything humanly possible to treat it medically before recommending radical surgery; and it turns out, actually, that surgery is not necessary in the great majority of cases.

The same principle applies to medical care for the aged. We know that we now provide complete nursing home care for those who are indigent; we know that implementation of the Kerr-Mills Act will make it possible to provide complete care for all persons who are near medically indigent, and we know that more and more of today's workers will have paid-up health insurance, retirement plans, and pensions when they become 65. It is our feeling that a compulsory health insurance program tied to social security, like radical surgery, will never be necessary in the United States.

We sincerely hope that Congress, the State and local governmental bodies, and private groups will study the recommendations of the Minnesota State Medical Association, that they will do what is needed now to improve medical care for nursing home patients, and that they will reject all proposals for limited programs at a soaring, unnecessary, and unlimited cost.

Senator LONG. Our next witness is Sister Mary Laurice, administrator of St. Francis Home, Breckenridge, Minn.

STATEMENT OF SISTER MARY LAURICE, ADMINISTRATOR, ST. FRANCIS HOME, BRECKENRIDGE, MINN.

Sister MARY LAURICE. I have been asked to speak on the importance of an activities program in nursing homes. During my 7 years of administration in nursing homes I have become convinced of its necessity. Any limitations in activities for the aged or chronically ill should be imposed by their own limitations rather than by a lack of opportunity on our part. To help maintain the independence that the aged prize, there needs to be an activities program in every nursing home. We need to provide for residents the recreational and diversional activities that are important in keeping their minds and bodies active for as long as they possibly can.

We feel that it is very important that we do for the elderly what is most helpful to them and to follow their ideas and suggestions insofar as is possible. We have seen the tremendous results of an organization within the home where residents plan, give ideas and suggestions, participate in and carry through projects that are of their own choosing. The spirit that prevails because of such close association of mind and heart has helped to make their home a happier place in which to live.

We call our places homes, nursing homes, or homes for the aged. The word "home" includes not only a place to eat and sleep, but a place of love, enjoyment, and friendship where each member of the family has an interest in other members and a concern for all that goes on. In order to have a family functioning within a home, individuals need to have something to say about their home. We know that people in their own homes have interests and activities that are a part of their daily living. When persons transfer to a nursing home, the only thing they really change is their address. They bring with them all the needs of any human being of any age. The type of activities they will do may change, but the fact that they need to be active in mind and body remains a need. Through the years, these

people have gathered much knowledge and wisdom and with maturity they have become independent individuals. In our work, we want to help them retain as much of this independence as they possibly can. We realize that no one wants to be dependent on another and if old people can be helped maintain their independence they will be much happier and more satisfied as residents. Since we know that activity is a very definite aid in preventing mental and physical deterioration, an active restorative program which includes diversional therapy, recreational therapy, and physical therapy is very important in a nursing home.

In anyone's life there needs to be a goal. This is true for each one of us; not only a final goal, but also a proximate goal. Why do we do a project or perform a work? Time has proven in our work with the aged that if they work toward an immediate goal there is greater enthusiasm and zeal. We have noted this as the residents united to help toward building funds, missions, community projects, and giving to the poor and needy. Many older people have given much to others during their lives. Many desire to keep on giving. We feel that this desire should find expression in our nursing homes. Projects such as fixing toys for poor children, making and fixing clothing for the needy, are ways that these people can give expression to their desire to help others. Our residents have these get-togethers and call them salvaging bees. Anyone, including wheelchair residents, contribute by lending a hand in fixing over, sewing, mending, ironing, sorting, preparing, and making ready items to be sent to those in need.

We give special attention to those residents who show mental deterioration. Our activities program for them is selective. We attempt to find out what their interests were and to help re-create interest in what they formerly like to do.

An understanding of the total person is essential for personnel in a nursing home. If there is a team spirit for the residents' welfare, a great deal can be accomplished. There must also be a coordination and cooperation between the groups concerned in the residents' total care.

In order that the residents may make their remaining years as happy and fruitful as possible, we feel that an activities program in a nursing home is a must. Most important is the interest and the motivation force which enables a resident to want to participate in the program. To carry out an activities program, we need a good activities director within the home, the good will of the community, and volunteers who can give individual help to residents. It is evident that the reactivation of our residents has resulted in less medical and nursing care required. A few of the residents have returned to their homes and many have progressed from bed to wheelchair, wheelchair to walker, walker to cane, to independence. As a result of the resident's working toward a goal, both proximate and remote, we are convinced that their lives can be lived in great dignity, respect, and independence.

Senator LONG. Thank you, Sister Mary, I appreciate your summarizing your statement for us. We are grateful to you for coming here and making your statement.

(The prepared statement of Sister Mary Laurice follows:)

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PREPARED STATEMENT OF SISTER MARY LAURICE, O.S.F. ADMINISTRATOR, ST. FRANCIS HOME, BRECKENRIDGE, MINN.

The importance of an activities program cannot be minimized. During my 7 years of administration in nursing homes, I have become convinced of its necessity. Any limitations in activities for the aged or chronically ill should be imposed by their own inability rather than by a lack of opportunity on our part. To help maintain the independence that the aged prize, there needs to be an activities program in every nursing home. We need to provide for residents the recreational and diversional activities that are important in keeping their minds and bodies active for as long as they possibly can.

We feel that it is very important that we do for the elderly what is most helpful to them and to follow their ideas and suggestions insofar as is possible. We have seen the tremendous results of an organization within the home where residents plan, give ideas and suggestions, participate in and carry through projects that are of their own choosing. The spirit that prevails because of such close association of mind and heart has helped to make their home a happied place in which to live.

We call our places homes—nursing homes or homes for the aged. Let us consider first what the word "home" includes. It means not only a place to eat and sleep, but a place of love, enjoyment, and friendship where each member of the family has an interest in other members and a concern for all that goes on. In order to have a family functioning within a home, individuals need to have something to say about their home. We know that people in their own homes have interests and activities that are a part of their daily living. When persons transfer to a nursing home, the only thing they really change is their address. They bring with them all the needs of any human being of any age. The type of activities they will do may change, but the fact that they need to be active in mind and body remains a need. We know that an adult differs greatly from a child. Through the years they have gathered much knowledge and wisdom and with maturity, they have become independent individuals. In our work we want to help them to retain as much of this independence as they possibly can. We realize that no one wants to be dependent on another and if old people can be helped to maintain their independence they will be much happier and more satisfied as residents. Since we know that activity is a very definite aid in preventing mental and physical deterioration, an active restorative program which includes diversional therapy, recreational therapy, and physical therapy is very important.

To explain the resident organization further, the people originated the Busy Bee Club, with the air of an adviser. A president, vice president, secretary, and treasurer were elected and various committees were then appointed by the officers. Their constitutions and bylaws are in writing. They have as their purposes: (1) To give opportunity for discussion of matters of interest to the residents; (2) to promote friendship and foster charity among the residents; (3) to provide a channel of communication between the staff and the residents which would promote greater understanding and cooperation; (4) to work together doing acts of charity for the common good. They have two general meetings a month. At one of these meetings a guest speaker is invited. All are welcome to belong and many wheelchair residents are members. They have a suggestion box and at each meeting this suggestion box is opened. It is very interesting to hear the suggestions that have come out of their meetings. Perhaps the most famous one was, "May we have a family cow?" and some of the others of interest were, "May we have an outdoor bowling alley? A pancake supper? May each one have his own plot of land for a garden?"

Some of the committees are, a welcoming committee, who welcome new residents and tour them through the home and tour visitors who come to see the home. Labels with their names and the committee to which they belong are worn by the members. The transportation committee transports wheelchair residents to activities at various times, such as those going to chapel, R.T., O.T., or the dining room. They have a birthday committee that brings greetings, a cake and a card to the resident on his birthday. As they present the cake, the group sings "Happy Birthday." Birth dates are listed on the weekly calendar and bulletin boards contain the sign "Happy birthday to ———" in order that the birthday may be known by all. The praying committee has two chairmen, one for the Protestants and one for the Catholics. They visit and pray for the sick and the dying.

They send "get well" cards to ill residents and send sympathy cards to the families of residents who die. The entertainment committee has been very active, and it was from this committee that the staging of the home talent show became a reality. There were 22 variety numbers in the program and about 50 of our oldsters participated in presenting it for the people of the community. They had four showings and did a marvelous job, but most rewarding of all, it accomplished for our people just what we had hoped. It promoted activity of their minds and bodies and motivated them to move forth with much vim, vigor, and vitality. People in wheelchairs were moving out of their wheelchairs and into walkers up and around doing much more than they had been doing. Some who were in wheelchairs wore formals for the first time in their lives. Costuming brought with it a real Gay Nineties parade, since the attire worn was old fashioned. As each costume was fashioned, it was modeled for the other residents. Individuals used their ingenuity to style their own costumes. Day by day the enthusiasm of the residents grew as they practiced for their part in the program.

The staff was pleased to see the fulfillment of their aims of rehabilitation. Residents became better acquainted with each other; appeared to capitalize less on minor ailments; exhibited a keener mental alertness and portrayed an exuberance of spirit. Some of the residents commented, "No one ever asked me to be in a program, but now in my old age they're asking me to be on the stage," or "This was the first time in my life I ever performed on a stage." At the performance, one of the news photographers came to take pictures for the paper. This made the residents feel very important. The local radio station interviewed them and comments that were heard by the people afterwards were brought back to the residents. We have a paper called "The Latest Buzz," which is written by the staff, and contains matters of human interest that occur in the home, especially the humorous happenings of the residents. In one of the publications we published some of the comments that were heard about their program. A few of them were:

"Where did you get all the costumes? It was like a Gay Nineties parade."

"The program was worth $5.

"The old people act so natural."

"That should be on TV. This was worth more than any TV program that I have ever seen."

"I never expected anything like this. It was simply overwhelming."

"Some scenes were heart rending, others were hilarious. I laughed and I cried."

"When I heard the old people were going to put on a show I thought 'Oh, just another kids' show,' but when I saw it I was amazed to see the talent in those old people. The show was just wonderful."

The entertainment committee functions very actively. Whenever people come to ask about performing for the residents, we check with the Busy Bees to see if the program would be to their liking and then schedule accordingly. We try to encourage entertainment in which our residents can take an active part, rather than that which provides passive enjoyment. When we do have entertainment by groups, we try to limit these to once or twice a week. The entertainment chairman will introduce the speakers or the performers. He takes much pride in this and calls it his "profession." At first he said his knees shook, the next time they quivered a bit, but now it's just a habit with him, since it's his "profession." He also thanks the performers after the program.

One of the busy places operated by the Busy Bees is the coffee shop. Here we find one of the residents making coffee each morning. This coffee is free to all the residents, their relatives and friends, at any time of the day. The ladies schedule themselves to make cakes or cookies, or whatever their favorite recipe may be. These homemade goodies are available, together with the other small items from their store. Some of the braver ladies have baked bread and with much success, and baking is done daily for the employees' lunch. When anything is needed in their kitchen, the ladies take turns in going uptown to do the shopping. They enjoy this activity very much and we hear comments like this: "We always wanted to do such things, but couldn't because when we were younger we never had the time. We feel so much more at home since we can bake and use our favorite recipes." We found that some of them have discovered a recipe that they hadn't used in some 30 to 40 years. They have their old cookbooks and they're using some of the favorites of years ago.

The residents have a choir which originated out of the Busy Bee Club also. They have many members and they have practice once a week. Hymns which they sing have been printed in large letters so they can see the words more clearly. They do a beautiful job of singing and continue to improve with each practice.

An outdoor bowling alley was constructed by men volunteers from the community. The equipment including writing stand, back stand, benches, and standard bowling balls and pins which were donated by a local bowling alley. Many residents had not bowled for a number of years and quite a number had never bowled. The establishing of teams for a bowling league was of real interest to them. They tried to arrange the team so that a wheelchair resident or one less fortunate would be on each team. The league teams were then sponsored by various departments in the home. Each team chose a name. The names were: Tri Hards, Spare Strikers, Clodhoppers, Tigers, Alley Cats, Aces, and Leaping Lizards. Many whose minds were poor remembered the time for bowling and were there from start to finish. After the final games scores were added and trophy awards were given to the winners by a local bowling alley manager. The results of the bowling activity was another proof of the importance of activities in the life of a resident. There was something to look forward to each new day. There was the anticipation, participation, and relating afterward, which was a real stimulus to mind and body. Visitors and relatives encouraged and followed through on their scores. There was much to write about when they wrote home to their loved ones.

One of the high light projects of the Busy Bees was their garden. The Busy Bee garden was a picturesque place. A large sign found in the center of the plot of ground was entitled "Busy Bee Garden." The section that each resident had selected was marked off with his or her name. Several wheelchair residents took part in the planning and were there to observe the planting and harvesting.

In the store that the Busy Bee operate, each member who wishes has a chance to be the clerk. An interesting point here is that our people may have a charge account and the clerk sometimes wonders if their credit is good. We always try to make it good, however, to accommodate the little grandma or grandpa who is just hungry for a bar of candy or a bottle of pop and has run out of funds. The Busy Bees keep a record of this and every once in a while the administrator receives statements of unpaid bills.

Professional square dancers have given their time to assist our residents in square dancing. They dance with an elderly man or lady and prove to be a "reactivating force." Many who haven't square danced for years are now enjoying the steps they formerly enjoyed. The professional caller and orchestra adjust their beat to a tempo that enables the oldsters to participate with ease and grace. The highlight of this activity is that it enables many residents to participate, since the wheelchair residents are "dancers" too, but in their wheelchairs. They are thrilled as they 'swing and sway' to the beat of the music.

Many events claim the interest and attention of the residents. When one event is over the question arises, "What are we going to do next?" Throughout the year there have been many programs such as appreciation programs for employees, chaplains and officials, and volunteers; parties and picnics for the community's senior citizens; preparations for the county fair; song fests; open houses; discussion sessions, and similar activities that challenge the mind.

In anyone's life there needs to be a goal. This is true for each one of us—not only a final goal, but also a proximate goal. Why do we do a project or perform a work? Time has proven in our work with the aged that if they work toward an immediate goal, there is greater enthusiasm and zeal. We have noted this as the residents united to help toward building funds, missions, community projects, and giving to the poor and the needy. Many older people have given much to others during their lives. Many desire to keep on giving. We feel that this desire should have expression in our nursing homes. Projects such as fixing toys for poor children; making and fixing clothing for the needy, are ways that these people can give expression to their desire to help others. Our residents have these get-togethers and call them salvaging bees. Anyone, including wheelchair residents, contribute by lending a hand in fixing over, sewing, mending, ironing, sorting, preparing and making ready items to be sent to those in need.

We give special attention to those residents who show mental deterioration. Our activities program for them is selective. We attempt to find out what their interests were and to help re-create interest in what they formerly like to do.

An understanding of the total person is essential for personnel in a nursing home. If there is a team spirit for the residents' welfare, a great deal can be accomplished. There must also be a coordination and cooperation between the groups concerned in the residents' total care.

In order that the residents may make their remaining years as happy and fruitful as possible, we feel that an activities program in a nursing home is a must. Most important is the interest and the motivation force which enables a resident to want to participate in the program. To carry out an activities program, we need the good will of the community, and many volunteers who give individual help to residents. It is evident that the reactivation of our residents has resulted in less medical and nursing care required. A few of the residents have returned to their homes and many have progressed from bed to wheelchair, wheelchair to walker, walker to cane, to independence. As a result of the residents' working toward a goal, both proximate and remote, we are convinced that their lives can be lived in great dignity.

We have a telegram from our next witness. He will not be here today, and he has asked that his statement be sent by mail and we will be happy to receive it. He is Mr. William J. Dettweiler, executive director, Community Health Center, Inc.

(Statement not received prior to publication date.)

Senator Long. I would like to hear Dr. Kenneth R. Larson.

I would also like to hear Mr. Foster. We have a letter from him this morning and I assume that he is here, and we would like to hear from him at this time for a rather brief statement.

Mr. Foster, if you have a copy of your statement, we would like to have it.

Mr. Foster. I am having copies mimeographed.

STATEMENT OF JOHN C. FOSTER, EXECUTIVE SECRETARY, SOUTH DAKOTA STATE MEDICAL ASSOCIATION

Mr. Foster. My name is John C. Foster. This statement I have prepared. I am representing the South Dakota State Medical Association. I am also a member, and have been for 14 years, of the board of directors of a nursing home management organization, a nonprofit organization that has some 350 beds, in South Dakota.

I am personally well acquainted with the problem we are discussing here this morning.

The South Dakota State Medical Association is a voluntary association of licensed physicians in the State and includes approximately 99 percent of all physicians. Its aims, since it was founded in 1882, have been to provide good medical care for all the people regardless of age, color, or income. The association has long been concerned with problems of the public health and welfare and has spent much of its energy and limited income in study of the real needs of the public.

Because of the physicians' unique position in the lives of most people, they have opportunity to research the problems at first hand.

Problems of the provision of nursing home care are being met in our State of South Dakota by concerted action of the medical profession, the nursing profession, religious groups, and private initiative.

Not too many years ago, the average nursing home in South Dakota was a converted frame house that constituted a fire and safety hazard.

Little supervision was given these homes and the caliber of nursing care left much to be desired.

Today our State is dotted with modern, well supervised, fire-resistant structures and dozens of new buildings are on the drawing boards. The organization I mentioned earlier has another 350 beds on the drawing board at the present time.

It is our feeling that religious groups, private entrepreneurs, nonsectarian groups, and others, with proper incentives can and will provide the facilities that our elderly citizens need.

We believe that Government has a function to provide incentives in areas where private capital is unavailable, but we feel that the best services and the best facilities are initiated locally by local people interested in their own health and welfare.

We deplore the interest of social planners in purely local problems and feel that those people who argue that "big government" is the only answer to problems arising from increasing population and longer life should face up to some challenges that have been unsatisfactorily answered in the past.

We challenge the social planners to act now on the problems of runaway inflation fostered by "big government" that has reduced the purchasing power of our retired people.

We challenge them to remake the social security program into a program of insurance that pays benefits at the proper age regardless of current income.

We challenge them to prove with accurate facts that the average oldster in the United States is sick and destitute as they now infer.

We challenge them to prove to our people that the American way of life is dependency on governmental dole rather than individual initiative.

We challenge them to come up with a reason why people who have saved money for their old age should be told by "big government" that their savings should not have to be touched for their nursing home care (aside from the fact that that is what they saved it for).

These 5 challenges could be increased to 50 if we wished to cover the entire area of health and welfare of the aged, but it suffices to indicate that proof of need has not been adequately documented. Individual illustrations of hardship are easy to find, but are we to condemn the complete system of individual initiative that made our country great because of a few individuals who don't have the initiative or the "breaks" to make the grade?

Until final proof is available to answer these challenges, the South Dakota State Medical Association respectfully submits that the problems must be solved where they exist, not by Government fiat or countrywide program styled by nations whose growth have been retarded because Government has reduced living standards to a common denominator of mediocrity.

I will toss one other challenge personally. I want to know where this tax money comes from if it isn't all from the people. You mentioned that Minnesota might have turned down Kerr-Mills because the people didn't want to produce the tax money. Where else does it come from, anyhow?

Senator LONG. I will be frank and tell you that as I understand the social security system it is paid half by the employer and half by the employee and it is not a tax problem.

Do you have the Kerr-Mills bill in South Dakota?

Mr. FOSTER. No, we do not. We couldn't find enough people who needed it. In fact, we were just startled at the old age——

Senator LONG. I am curious. You don't have any sick people or old age people——

Mr. FOSTER. I said we couldn't find any.

Senator LONG. I am curious. I read in the papers sometime back that the medical associations are collecting a fund——

Mr. FOSTER. I haven't seen any of that money.

Senator LONG. I must have read that in one of the papers. I did read that in a news article.

Mr. FOSTER. The State Medical Association of South Dakota has a dues income of $30,000 from its members and I assure you that not one penny goes anywhere but to the use of our own office.

Senator LONG. Mr. Foster, you mentioned that you wanted inflation cut down and, of course, that is something that we all want, and that has been the situation that all State and national officials have faced in the past years. You suggested that was one of the problems and then you suggested that our social security program and our people should be paid their pensions irrespective of the salary or income which they had and I am at a loss to understand how that would affect inflation.

Mr. FOSTER. The two things were stated separately. One, on people who are retired on limited incomes, whether it be social security or any other income, they have put away their money for the future, and it wasn't too long ago when if you could put away enough so that you would have $200 a month when you were 65 you were adequately taken care of, and now $200 a month doesn't go anywhere. It has been inflation that has eaten up the purchasing power of this $200.

The second point I made is that social security—I didn't say it this way—is not insurance. It has been held by the Supreme Court it is a tax. And if it is insurance, then it should be insurance. In other words, when I buy insurance from an insurance company to retire on and be paid $125 a month when I retire, I get it whether I am making $50,000 a year or nothing. But with social security I don't. We have marginal people who are making low incomes, who if they could draw their social security which they might have paid for for nearly 30 years, wouldn't have any problem that they may now have if they are paying for their nursing care or other types of care. This is a basic income problem rather than a problem of expense for nursing home care.

Senator LONG. It is your feeling that the pension should be paid irrespective of the income?

Mr. FOSTER. Yes, I do.

Senator LONG. That is one of the problems that this committee, of course, is considering.

Mr. FOSTER. I think it is a basic problem.

Senator LONG. Now, I assume you didn't say that your association is opposed to a system where if they pay in for that pension they are entitled to it, if they pay more into it and have their medical care.

Mr. FOSTER. You are talking about two different things. You are talking about money payments. Now, if you want to pay in more money and have the recipient get more money, yes.

Senator LONG. You agree to that?

Mr. FOSTER. Yes.

Senator LONG. Irrespective of his income, though, you would agree that he could still pay in a little more and in addition to his pension get medical care.

Mr. FOSTER. Would you give him groceries and determine what groceries you want to give him, too?

Senator LONG. The doctor told me awhile ago that insurance companies would write whatever the people wanted them to write.

Mr. FOSTER. I haven't seen the public demand. I have seen some people trying to create a public demand for such, but I haven't seen that public demand as such from our people in our State. Now, maybe our State is unique. We are one of the depressed States. We get 72.18 cents out of each dollar for Kerr-Mills——

Senator LONG. For pheasant hunters, I don't see how you can be a depressed area.

Mr. Foster, thank you so much.

We will recess until 2 o'clock.

(Whereupon, a recess was taken until 2 p.m.)

AFTERNOON SESSION

Senator LONG. The committee will come to order.

Our first witness this afternoon is Dr. Kenneth R. Larson, American Geriatric Enterprises in St. Paul.

Doctor, we are running on a very tight schedule this afternoon. I think perhaps we have a prepared statement from you.

Dr. LARSON. Yes.

Senator LONG. Just touch briefly on the highlights of it, please. Your entire statement will be included in the record for the consideration of the staff.

STATEMENT OF DR. KENNETH R. LARSON, PRESIDENT, AMERICAN GERIATRIC ENTERPRISES

Dr. LARSON. I am president of American Geriatric Enterprises, a company that was created in St. Paul to create work for older employees. We found that there are a lot of people who can't get work because of their age. I found that in my office some of my patients were suffering from what I diagnosed as unemployment, which is actually a feeling of insecurity because of the inability to get work. They were capable of working but couldn't get work because of their age. I suggested to these people that they try to do part-time work or get hobbies. They didn't like that; they wanted to get practical work. Because of this I got busy and interested other people in this idea and we established a company. It is not a Community Chest project; it is a corporation. We sold ourselves stock. We have about 25 stockholders, who raised something like $13,000 by selling stock. We have a company that has been running now for 5 years, it is going on the sixth year. It is solvent, we have on the average 15 employees, average age 66, and we do work that consists primarily of repair of beverage cases for the 7-Up, Coca-Cola and other beverage industries. We build, repair pallets and create work in that manner. We also

have a bottle exchange, we get strange bottles (bottles belonging to other bottlers), and sort them out, return them to the original owners. In so doing, we create work and create an income.

Last year our gross income was over $70,000; our payroll was $33,000 and this was for an average of 15 men. When we first started we limited our employment to those age 50 to 65. However, as time has passed those older men have stayed with us, so our average age now is 66.

I think it would be interesting to note that our average employee was out of work 9 months before coming to work with us; 40 percent of the employees were on relief for a period of 1 month to 2 years before getting a job, 50 percent of the employees last worked in firms that went out of business; in other words, these are displaced workers.

The most important thing about AGE is that we have shown that these men are good workers, reliable, safe workers. We have only had $150 of medical expenses for accidents and we have men working on power saws, power drills, power presses, and various other power equipment, but in 5 years we have had only one serious accident—a man ran a drill through his hand. These men do not cause problems by absenteeism, because they feel they are on their last job and they are going to keep that job. We could expand if the other officers of the corporation and I had time to spend with it. This company is a good illustration of what the senior citizen, if you want to call him such, can do if given an opportunity.

Senator LONG. Thank you so much. Certainly your work is very outstanding in that field. There is nothing that I believe is of more interest to our senior citizens than the opportunity of working after they reach 65 or older if they would just be able to do so. Many, many of them are anxious to be productive in any way they can, and certainly your organization gives many of them that opportunity.

Dr. LARSON. I would like to say for the record that I think this could be done on a national scale very easily and it should be done. Those men are happy. We have only had one man that we had to lay off for lack of health and some of those men that we hired were not in physical condition to go to work but when they got to work their health improved and they continued to work.

Senator LONG. Thank you so much.

(The prepared statement of Dr. Larson follows:)

PREPARED STATEMENT OF KENNETH R. LARSON, M.D., PRESIDENT, AMERICAN GERIATRIC ENTERPRISES

AGE, Inc., which stands for American Geriatric Enterprises, was established and financed privately to create employment for the ever-increasing number of workers in the age bracket 50 to 65, who need and can work, but who cannot obtain employment because of their age. This is a preretirement program. We started in a small way, but we have made a practical beginning at helping to solve an urgent need.

The idea for AGE came to me because of my concern for a few of my older patients whose chief ailment I diagnosed as "unemployment." This inevitably leads to psychosomatic disorders. I learned that I was unable to treat these patients, whose complaints were not due to any organic disturbances but were caused by feelings of insecurity due to their inability to obtain employment. Even though they were physically fit and eager to work, they were unable to secure employment because of industrial age barriers. Many were jobless through no fault of their own, but because their concerns had failed, consolidated with other concerns, or had been forced to discontinue certain operations because of

the obsolescence of their product. One patient in his late fifties had been employed by a gas manufacturing company all of his working life. When natural gas was piped into this area, the company went out of business and he could not find employment elsewhere because of his age. Another had worked for many years for a meatpacking concern which closed their local plant. Another had worked for a wholesale firm which had terminated its grocery business.

Some of the reasons industry cannot hire the older worker are increased costs of retirement and insurance programs, difficulties with seniority rights, and greater expense associated with on-the-job training due to decreased subsequent work periods.

I will not go into all the details, but about 6½ years ago I started to interest others in the problem of finding suitable jobs for the employable senior citizens of this community.

In order to lay the foundation for AGE, we formed a committee of about 30 industrial leaders and professional people with varied business experiences, and, with the help of the State division of security and unemployment, made a study in May 1956 that revealed there were more than 1,500 unemployed people in St. Paul and environs between the ages of 50 and 65 (exclusive of Minneapolis and environs). We wanted to include the senior achievement range of activities, but decided that we were shooting for too large an area. We decided to concentrate on the age bracket 50 to 65, because this is the group that cannot get help from pensions or social security—too old to get jobs, and too young to get aid. At the present time, because many of our workers have been with us for over 5 years, the average of their ages is over the age for our age group.

This committee then raised $1,500 to make a survey of the leading industries in St. Paul in order to determine what type of work could be obtained that people in this age bracket could do economically and efficiently. Over a period of 3 months, we uncovered numerous potential projects, and seven of these were very carefully studied.

At the first meeting of the board of directors in August of 1956, we elected officers and appointed committees. We then rented an empty garage, hired several workers, named as general manager a 72-year-old retired garment manufacturer, and went to work.

The first contracts were for repairing, painting, and stenciling cases for soft drink bottles, and for repairing and building wooden pallets used as platforms in industrial firms. We obtained our first contracts from companies whose executives were on our board of directors, but we emphasize that we are able to keep contracts only because of our ability to meet competitive bids and by giving them their money's worth. We are able to specialize in quality work because our workers are capable, conscientious, and efficient. They believe in doing a day's work for a day's pay. AGE is currently serving several other large local industries on a contract basis covering operations that cannot be performed efficiently in their own plants because of greater overhead and higher priced labor. We now have aproximately 30 contracts with 20 different companies, and a number of additional projects are being studied. A constant search is being made for new projects.

Ours is not a Community Chest project. We were incorporated as a profit-making concern, and were authorized to sell $25,000 in stock. To date we have sold only about 1,334 shares at $10 a share.

We want projects that require as much hand labor as possible and yet will bring income into the firm. Our equipment is expensive and we need working capital while laying the groundwork for a sound business establishment.

At this time we average about 15 employees. The average age is now 66, and the range is from 50 to 73. The average employee was out of work 9 months before coming to work with us. Forty percent of the employees were on relief for a period of 1 month to 2 years before getting a job. Fifty percent of the employees last worked in firms that went out of business—in other words, these are displaced workers.

From a practical point of view and one that every taxpayer will enjoy, during the fiscal year ending June 30, 1961, the payroll at AGE amounted to $33,000. During that same period of time, those who would otherwise have been on the relief rolls would have received at least $15.000 in relief payments. It should be noted also that five of the workers at AGE are on social security and therefore earning less than $1,200.

AGE was organized in an attempt to meet the problem of finding suitable employment for the older worker, a problem which is now being recognized on a

national scale. The corporate officers and directors are currently contributing their time and effort toward the realization of this goal. The incorporators have received no cash on their investment, nor do they expect to do so, but they have received satisfaction from helping others to help themselves. AGE has moved twice and survived a near disastrous fire. Last year we had a gross income of $71,000, and at the present rate, we should top that by a least another $25,000 in the current year. To quote from a recent article, "AGE means one less despondent man on a park bench, one less man in the parade to the welfare office. Instead, it is a man walking down Robert Street, head held high, feeling that at the age of 50 or 60 or 70 he is still useful and earning his way. The word 'AGE' has a happy, not a hollow, echo."

Senator LONG. Let me say to our senior citizens that we have a short panel discussion and then we will be able to take up their part of the program. We will endeavor to hear our senior citizens at the Town Hall discussion in just a few minutes after we have the panel discussion here. So if you will be patient with us we will have you on the program shortly.

In the panel discussion we have Prof. Arnold M. Rose, Department of Sociology, University of Minnesota; Prof. Wendell M. Swenson, Department of Clinical Psychology, University of Minnesota; and Prof. Marvin J. Taves, Department of Rural Sociology, University of Minnesota, and president, Midwest Council for Social Research in Aging.

I would like you gentlemen to take 3 to 5 minutes, not over that, if you could, and then bicker around among yourselves to discuss it for a few minutes.

Dr. Rose, if you would start, please.

STATEMENT OF ARNOLD M. ROSE, PROFESSOR OF SOCIOLOGY, UNIVERSITY OF MINNESOTA, AND CHAIRMAN OF THE MINNESOTA DELEGATION OF THE 1961 WHITE HOUSE CONFERENCE ON AGING

Dr. ROSE. Senator, and other members of the committee, you have heard expert testimony to the effect that Minnesota had made considerable progress in providing nursing homes for its incapacitated elderly citizens. While quality and quantity of nursing homes could stand improvement, the major problem today is how to make these and other medical facilities available to all the elderly people who need them. In other words, the major problem today for older people is how they are going to get the money to pay for medical services, including nursing homes.

My philosophy about services of all sorts is that sometimes they can best be paid for by the individuals benefited, sometimes they can be provided best by vountary organizations, and sometimes Government must step in to aid in providing them. After giving considerable thought to the matter, and after reading the many studies describing the conditions of older people in this country, including studies we have conducted in Minnesota, I have come to the conclusion that the further financing of medical care costs to meet the special needs of older people will require Government intervention. Specifically, I have come to favor financing medical care costs through the social security system, such as would be provided by the King-Anderson bill now before the Congress. I have several reasons for this opinion:

(1) Studies show that about 12 to 15 percent of the elderly population has enough savings to pay for almost any medical expense, and

another minority is covered for medical contingencies by private insurance. At the other end of the income scale are the indigents whose needs are being met at the public expense (through old-age assistance, and—in some States—through the Kerr-Mills Act). In between these two groups are the majority of the older people, middle-income people who have saved throughout their lives for their old age and who have saved up enough to take care of all their ordinary, everyday expenses, but not enough to pay for the huge expenses associated with caring for the major illness. It might be said that these people should have had the foresight to purchase private medical insurance, but the fact is that they didn't, and it probably will always be true that a large proportion of the young people of the United States will not foresee themselves getting cancer or heart disease in their old age so they take out medical insurance to pay for it in the distant future. These middle class people do not need and do not want government "relief" and they do not want, nor should they be subject to, a means test. They can afford to pay for insurance, but since many of them won't think to take out voluntary insurance, universal insurance under the law is the only answer.

(2) While illness has always been associated with old age, in one sense there is a new problem here. Until around 1945, most people died of "acute" illnesses—such as pneumonia and influenza—and they were carried off quickly and cheaply. With the advances in medical science—particularly the discovery of sulfa and penicillin—the acute illnesses became readily curable, and most people survived them to eventually get one of the "chronic" illnesses, particularly cancer, heart disease, or arthritis. Now the last-named illnesses are much more expensive to treat and to care for, and few middle class people can afford to pay for several years in a hospital or nursing home, even if they have been saving diligently all of their working lives for their old age. Now it is true that only a minority of people need to pay for several years of treatment and care of cancer or heart disease—perhaps 10 or 15 percent—but the problem is that no individual knows whether or not he is going to wind up in this minority. Thus older people today feel very insecure about the matter of medical care costs, unless they happen to be in that fortunate minority that are protected financially against any contingency. The logical solution, when any unpredictable minority of the population is going to face huge expenses that they individually cannot meet, is insurance. All individuals deposit small amounts regularly over a long period of time, and thereby build up a fund to take care of the extraordinary expenses of some of their number.

(3) This is very difficult to do by private insurance. If private medical insurance plans are going to cover the expensive illnesses of old age, they have to charge high enough fees to make it financially inadvisable for young people, who are seeking only current medical coverage for their young and growing families, to subscribe. Marion Folsom, former Secretary of Health, Education, and Welfare under President Eisenhower and now president of Eastman Kodak Co., has come out in favor of financing medical care costs for the aging by means of social security primarily for this reason. He wants to see the

private insurance companies do a more effective job of offering low-cost medical insurance for those under 65.

It is for all three of these reasons that I favor financing medical care costs by means of the social security program. As with any Government program, safeguards must be provided so that incidental abuses do not occur: There should be individual contributions to the expenditures for each illness so that the program is not overused; there needs to be some protection for those providing the services so they do not become victims of bureaucracy. In my judgment, the King-Anderson bill is a very cautious, conservative—in the true sense of that term—measure that safeguards against these and other possible abuses. Finally, in terms of overall national wealth, providing for medical care costs for the aging through social security is the cheapest way in which this Nation can handle the problem: The social security system is already in operation and it is very efficient. The tax needs to be raised only slightly (one-fourth of 1 percent on both employer and employee), and an additional payment system be inaugurated. Even if private insurance could be extended to cover most people—which I said before they cannot—or if the Kerr-Mills plan were to be extended to cover all aged persons with expensive medical costs—which is also not feasible in view of the variations among the States—such efforts would be far more costly than the social security approach.

I respectfully recommend to your committee that it strongly support the King-Anderson bill as the most feasible and reasonable approach to meet the current most serious problem facing the older people of the United States. Thank you.

Senator Long. The next statement will be by Prof. Wendell M. Swenson.

STATEMENT OF PROF. WENDELL M. SWENSON, DEPARTMENT OF CLINICAL SOCIOLOGY, UNIVERSITY OF MINNESOTA

Dr. Swenson. Senator Long, because the hearing this afternoon is primarily related to problems of older people in nursing homes I have been asked to present a very brief statement in summary of some of the research that I have been working on, both at the University of Minnesota, and at the Mayo Clinic in the past 3 years.

This research has particularly to do with experiences of older individuals in the very latest years of their lives, particularly with attitudes toward death and their experiences and thoughts about it. Certainly theærontic population with all its complexity and variability does have one common experience to be anticipated, death. We know the temporal aspect of life is one of the most empirically tested facts known to man. Because of this and with the cooperation of the senior citizen clubs in the Twin Cities, many of whom are represented here this afternoon, I was able to interview through questionnaire techniques about 250 individuals, primarily in the Twin Cities and all of them in the State of Minnesota regarding their general interests and attitudes, hobbies, and particularly their attitudes toward death. A checklist was developed and used in an attempt to elicit specifically whether the individuals had positive, healthy attitudes toward death,

whether they evaded the issue of death completely or whether they had specific fears toward the death experience.

The 210 subjects in this research were grouped generally into three different categories, those looking forward to death, those evading the issue of death, and those fearing it. A tabulation of the results revealed the following general breakdown of the individuals with regard particularly to their death attitudes. First of all, almost half of the group, about 45 percent, had a very healthy, positive, forward-looking attitude toward death. Almost half or 44 percent were evasive about their attitudes, indicating they preferred not to think about it, and third, and quite significant, only a very small and relatively insignificant number of individuals admitted to any particular fear of the death experience. By far the most significant relationship in the statistical aspect of this study was that religious beliefs and activities were strongly related to their death attitude, that is, people engaged in frequent religious activities or demonstrating a very fundamentalist-type religion had a positive death attitude, whereas those with little religious activity or interest either evaded reference to death or feared it. Perhaps the most significant result regarding the aspect of old age discussed here today occurred with regard to the subjects' living conditions and death attitudes. Individuals living in homes for the aged commonly looked forward very positively to the death experience, whereas individuals living with their spouse or living with other relatives tended to evade the issue of death. There was some evidence to suggest that a fear of death was found mostly among those individuals living alone outside of a rest home.

It is apparent that healthy attitudes will be seen more often in a community home for the aged situation. Group living fosters healthy attitudes toward the final years of life, and I think we should do all that is possible to encourage the development of facilities from whatever needs available to allow people to spend the later years of their life in group living arrangements. The individuals who lived alone seemed at almost every point to demonstrate the lowest level of mental health and adjustment.

Actually, no relationship between these attitudes could be determined whether they were men or women, their age, occupational status or their source of income had little or no relationship to these interests.

In relation to the problem of nursing homes there seemed to be some results of this study that are particularly applicable. Individuals in these homes for the aged look forward positively to death much more than do certain noninstitutionalized perontic people, whereas those who lived alone tended to fear the prospect of death. It is apparent, therefore, that living in solitary existence in old age is associated with a more negative or fearful concept of the later years of life, and I think one can infer from these results that older individuals living under relatively normal circumstances, that is, with husband or wife or other relatives, do not concern themselves with this problem, but those living alone, particularly, obtain a negative attitude toward death.

Thank you.

Senator Long. Thank you very much. At this point we will insert the statement of Dr. Swenson.

(The prepared statement of Dr. Swenson follows:)

PREPARED STATEMENT OF WENDELL M. SWENSON, PH. D., SECTION OF PSYCHIATRY, MAYO CLINIC, ROCHESTER, MINN.

DEATH ATTITUDES AMONG THE AGED

The merontic population with all its complexity and variability does have one common experience to be anticipated—death. The temporal aspect of life is perhaps one of the most empirically tested scientific facts known to man. Half a century ago when death came earlier in the human race the death process was experienced mostly in a sudden or trumatic manner. Now in the middle of the 20th century death commonly comes to individuals who have long since been retired from active social participation and are physically or psychologically incapacitated. This recent development in history poses a number of rather stimulating questions—Do millions of gerontic individuals all have the same ideas concerning death? What are some of the characteristics of this "death contemplation" and does it exist in all individuals? Perhaps still more important as people grow less and less productive in our society, do they have less and less a desire to live?

In an attempt to answer these and many other related questions the writer recently set out to measure the attitudes about death of a large number of older people.

Method

The present investigation described here involves an attempt to obtain an objective measure of the death attitudes of a reasonably good cross-section of aged individuals. The procedure is described below.

1. A death attitude checklist was presented to more than 200 individuals in the State of Minnesota, all over the age of 60 years. The individuals were obtained from three separate sources: (*a*) homes for the aged, (*b*) so-called golden age clubs, and (*c*) a number of industries and companies employing individuals over 60 years.

2. On the basis of their responses to the checklist the subjects were divided into three rather well-defined groups—those looking forward to death positively, those avoiding any thought of death, and those fearing the death experience.

3. These derived groups were analyzed to determine the relationship, if any, between attitude toward death and certain measurable physical and social characteristics. One general assumption was made—the closer the proximity of death through age, illness, loss of relatives, and so forth, the more acceptant or positive would be the individual's death attitude, that is, the more he would welcome or look forward to death.

Results

Tabulation of the results revealed the following general breakdown of the subjects with regard to their death attitudes.

1. Almost half the group (45 percent) admitted to a positive or forward-looking attitude toward death.

2. Also almost half the group (44 percent) were distinctly evasive in their attitudes, indicating they preferred not to think about death.

3. Only a small and relatively insignificant number (10 percent) admitted to having any fear of the death experience.

Specific predictions were made with regard to the relationship between attitudes toward death and age, physical condition, home living conditions, and religiosity. Using accepted statistical techniques, the significance of these relationships was determined. A brief résumé of the results follow.

By far the most significant relationship from a statistical point of view was found in the individual's religious beliefs and activities and their death attitude. People engaged in frequent religious activity or demonstrating a fundamentalist type of religion evidenced a very positive or forward-looking death attitude, whereas those with little religious activity or interest either evaded reference to death or feared it.

The second most significant relationship and perhaps the one of most importance regarding the aspect of gerontology discussed here today, occurred with regard to the subject's living conditions and death attitudes. Individuals living in homes for the aged commonly look positively toward the death experience.

Individuals living with spouse or living alone tended to evade the issue of death. There was some evidence to suggest that a fear of death was found most commonly in those individuals who lived alone outside a rest home. It is apparent from this result that "positive death attitudes" if they are to be fostered, will be seen more often in a "community home for the aged" living situation than they will in any solitary living.

The relationship between death attitude and level of education and condition of health was of much less intensity and showed only suggestive significance. The more educated subjects tended to face the problem of death—either looking forward to it or fearing it and the less educated individual tended to avoid consideration of it. There was a tendency for those individuals admitting to good health to be actively evasive in their consideration of death.

No relationship could be demonstrated between death attitudes and sex, age, occupational status, or source of income.

Discussion and implications

In relationship to the problem of nursing homes, there seemed to be some results of this study that are applicable. Individuals living in homes for the aged look forward positively to death much more than do certain noninstitutionalized gerontic people, whereas those living alone tend to fear the prospect of death. It is apparent, therefore, that living a solitary existence in old age is associated with a more negative or fearful concept of death. Fear of death then seems to be related to solitude. One can infer from these results that older individuals living under relatively normal circumstances, that is, with husband, wife or other relative do not concern themselves with the death process and, therefore, neither look forward to it nor fear it. Avoidance of death contemplations seems to be typically associated with the more normal type of social environment. It would seem, therefore, that the one recommendation regarding living conditions that can be made from this data is that older people should be counseled away from a solitary kind of existence because this apparently fosters a stronger fear of death than any other mode of living. If the individual cannot live with his spouse or relative in his own home, it is apparent that the next best environment is that of a rest home or nursing home.

Admittedly, the above study as described is a partitive aspect of human personality and attitudes. However, it does seem to contribute even though in piecemeal fashion to our knowledge of the general attitudinal development of the older individual. We must continually remind ourselves that death is truly a universal experience contemplated by all men. With the tremendous increase of individuals in the gerontic age group, this consideration of death takes on now much more important meaning than it did even a couple of decades ago. The problem is a vast and multivariate one which should demand further careful consideration of many different disciplines other than the science of psychology.

Leonardo da Vinci is claimed to have stated: "While I thought that I was learning how to live, I have been learning how to die."

Senator LONG. I find that all of you are Ph. D.'s. I am sorry I neglected to mention that.

Dr. Taves, I will be grateful if you will summarize your statement, please.

STATEMENT OF DR. MARVIN J. TAVES, DEPARTMENT OF RURAL SOCIOLOGY, UNIVERSITY OF MINNESOTA, AND PRESIDENT, MIDWEST COUNCIL FOR SOCIAL RESEARCH IN AGING

Dr. TAVES. Thank you, Senator Long and members of the committee.

In my expanded statement I prefaced my remarks by pointing to the paucity of empirical information on satisfactions and dissatisfactions among residents in nursing homes and then summarized information of nursing homes, and finally closed by noting some of the types of information needed and the feasibility of obtaining such types of information.

At this time I shall present only a few of the points made in each of the sections. As is true for the country as a whole, so for Minnesota, systematic reliable information on satisfactions and dissatisfactions with current facilities and services, social contact, and the maintenance of personal dignity in our nursing homes just doesn't exist. There are at best a few scattered relatively unsophisticated investigations of this matter. This is not to say that there are not many nursing home administrators who not only think they know the residents in their homes but who probably do have a wealth of information and understanding regarding satisfactions and dissatisfactions among those whom they serve. Our investigations over the last 2 years, however, have repeatedly discovered that residents of nursing homes—as well as in other homes for the aged—have not conveyed their true feelings even to the most sincere and competent nursing home personnel. In other cases the respondents have reported apprehensions and dissatisfactions which have been withheld from even their doctors and pastors.

Three social surveys were made. Let me turn to one of the three. This information is based on interviews with persons 60 years and over in a central Minnesota county. A good majority of those now residing in the nursing homes preferred to remain where they are. Practically all of those who would prefer to live somewhere else indicated that this would be impossible without help from members of their family or others in their community in the way of housekeeping services, home nursing care, financial assistance, and so forth. Among the things that residents particularly appreciated in the nursing homes were privacy, freedom to come and go as they chose, cleanliness, and a variety of other such assets as the surrounding of the homes, nearness to hospitals, availability of chapel and religious services. Things most complained about were insufficiency of space and lack of privacy, lack of hot water and bathing facilities, closets being inconvenient, and inadequacies in recreation or lack of comfortable furniture. Among the services particularly singled out for favorable mention by the respondents were kindliness, cheerfulness of staff, good food, beds and physical care, opportunities to be useful and opportunities for recreation, in the order mentioned. Complaints centered mainly on lack of courtesy or attentiveness on the part of the staff.

Finally let me note just a few of the types of information which nursing home administrators claim they do not now have either in sufficient quantity or with sufficient validity. Three-fourths of the nursing home administrators interviewed indicated a need for surveys on respondents' satisfactions with the physical facilities, even higher proportions called for studies on residents' attitudes toward administrative staff policies and procedures. Information was wanted on the effect of respondent's background, his occupation, work experience, and so forth, on his tendency or ability to adjust in the nursing home situation. Many of the administrators were also interested in development of record forms which would help them gather information on their respondents that would be useful in more adequately supplying their physical, social, and mental needs.

In conclusion, in my opinion the successful development of the information necessary to adequately guide the further development of

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efficient and effective nursing home care demands coordination of the public and private resources in a broad, purposeful, scientifically reliable research program. The primary stimulation for this is going to have to come from the Federal Government if it is going to proceed in an orderly and speedy fashion. Thank you.

(The prepared statement of Dr. Taves and a survey prepared by Dr. Taves and Gary D. Hansen follow:)

PREPARED STATEMENT OF MARVIN J. TAVES, PROFESSOR OF SOCIOLOGY, UNIVERSITY OF MINNESOTA, AND PRESIDENT, MIDWEST COUNCIL FOR SOCIAL RESEARCH ON AGING

ATTITUDES TOWARD NURSING HOME RESIDENCE

Let me preface my remarks by pointing to the paucity of empirical information on satisfactions and dissatisfactions among residents in nursing homes, then summarize information obtained from residents of homes, and close by noting some of the types of information needed and the feasibility of obtaining such information.

As is true for the country as a whole, so for Minnesota, systematic reliable information on satisfactions and dissatisfactions with current facilities and services, social contact, and the maintenance of personal dignity in our nursing homes just doesn't exist. There are at best a few scattered relatively unsophisticated investigations of this matter. This is not to deny that there are many nursing home administrators and others who not only think they know the residents in their homes but who probably do have a wealth of information and understanding regarding satisfactions and dissatisfactions among those whom they serve. Our investigations over the last 2 years, however, have repeatedly discovered that residents in nursing homes, as well as other homes for the aged, have not conveyed their true feelings to even the most sincere and competent nursing home personnel. In other cases, the respondents have reported apprehensions and then dissatisfactions which have been withheld from even their doctors and pastors. I do not mean to depreciate the knowledge of others regarding the psychological and social climate of our nursing homes but merely to urge proper caution in accepting the reliability and validity of the conclusions based on relatively unsystematized personal observations. How little we really know for sure becomes apparent as we now summarize three social surveys conducted in Minnesota during the last 3 years.

The first survey provides data on a sample of 1,600 persons over 65 years of age in Minnesota, of whom 401 were residents of homes for the aged including nursing homes. The second is a census taken in Morrison County, Minn., of all persons 60 and over resident in boarding or nursing homes and hospitals; of these, two-thirds were residents in nursing homes. Interviews were used to obtain the information in these two surveys. It should be noted that presently the analysis for neither of these surveys provides information on the nursing homes though in both cases the nursing home residents represent a very significant proportion of the total. The third set of data represents an appraisal of information desired by nursing homes administrators based on discussions with them and questionnaries which a number of them completed.

The first survey makes it possible to compare residents of nursing homes and homes for the aged with other senior citizens. This comparison shows the nursing home population to be an entirely selected one. They are relatively older—half of them being 80 or over. Higher proportions of those in nursing homes have never been married or are now widowed. A fourth of those of the community but only one-tenth of those in the homes are now married.

Nursing home residents are found more often without financial assets and incomes of less than $1,000 were reported by only one-fourth of those in the community but by over half of those in the homes. Residents in the home more often reported not having enough to live on. They were far more often on old age assistance. Far fewer of them have life insurance (12 percent versus 41 percent) or hospital insurance (two-thirds versus less than one-fourth). Less than 1 in 10 reports having medical or surgical insurance. Yet they report substantially higher medical costs than the nonresident counterpart.

With reference to health it is to be expected that nursing home residents will both be in poorer health and appraise their health as in poor condition more often than would others. One in five of the residents and 1 in 20 of the nonresidents agreed that if they didn't feel better soon they would just as soon die.

To a third of the residents health has become a new burden with most of these claiming they felt miserable most of the time. Fortunately the majority still felt quite well much of the time.

Restrictive mobility characterizes over half of the residents and somewhat under 10 percent of the nonresidents. Of those in the homes 20 percent were confined to their bed or a chair.

Uncared for health needs are reported somewhat less frequently by residents than by nonresidents. Also, fewer of the residents (10 percent versus 15 percent) had had no contact with the doctor during the previous year. This may reflect either the greater incidence of illness or easier accessability to doctors when in a nursing home, nevertheless, 1 in 10 not having had medical attention for what they consider a major health need.

Social contacts were more often missed by residents than nonresidents in homes. Residents twice as frequently (27 percent) complained about not having anyone to talk to about personal things while almost one-fifth of the residents but only one-fifteenth of the nonresidents claim to have so few friends that they were lonely much of the time. On the other hand, 73 percent of the residents and 85 percent of the nonresidents agreed with the statement "my many friends make my life happy and cheerful." Far more the residents than nonresidents complained about not having any work to look forward to and agreed with the statement, "I have more free time than I know how to use" (residents—69 percent in the nonmetropolitan urban communities and 57 percent in the metropolitan urban communities as compared with 29 and 35 percent respectively for the nonresidents.)

The survey shows the incidence of low morale to be much higher among nursing home residents although this is undoubtedly associated with their poorer health. It may also in part be associated with their complaints concerning insufficient opportunity for radio and television listening, visiting with friends and family, working, using their skills either productivity or at hobbies and so forth.

Nevertheless, both those in and those not in nursing homes place a high value on the contribution these make. In fact, when asked what type of housing for the elderly were most needed in their communities, nursing homes were mentioned more frequently than any other category (58 to 65 percent). This is almost twice the proportion who claim their community needed additional boarding homes, apartments or cottages for senior citizens. Of those not now in either nursing homes or some other home for the aged, 13 percent reported that they would like to be living in a nursing home.

The foregoing are a few of the highlights from interviews with the senior citizens from Minnesota. Let's note just a few of the highlights from interviews with persons 60 and over in Morrison County which is located in the center of the State.

In Morrison County the question asked was, "Which of the following facilities and services are needed and would be used by you if available?" In response 18 percent called for church sponsored nursing homes and 16 percent for publically sponsored nursing homes. There may be overlap in these two percentages. When asked if they would support it with their time, work, taxes, gifts, or help to organize and help run such a facility, the proportions answering affirmatively for each the church-sponsored and the public-sponsored nursing homes were 9 percent.

A good majority (two-thirds) of those now residing in a nursing home preferred to remain where they are. Of the third who would prefer to be living elsewhere only 3 percent would like to be in another nursing or boarding home, while about half would prefer to go back to their own home and the remaining group would like to live with children or other relatives. Practically all of those who would prefer to live somewhere else indicate that this would be impossible without help from members of their family or others in their community in the way of housekeeping services, home nursing care, financial assistance and so forth.

A pertinent question is how many of those in the nursing homes could live at home if home care services were provided. A fourth indicate they could. Almost half claim they could not, while the remaining would not venture an opinion. It is most significant that when asked whether they would prefer to live at home if these services became available to them in their homes, still only one in five would prefer to go home, the other four would prefer to stay.

Of all those who think they might be able to live at home regardless of whether they would prefer to or not, the following proportions would need the services indicated, housekeeping 64 percent, nursing care (mostly visiting nursing but a

few full-time nursing) 49 percent, meals (not included in housekeeping), 13 percent; assistance in personal care and other, 41 percent. Thus, relatively few of the 163 nursing home residents studied, only a relatively small minority believe they could live at home and if so, would be quite dependent upon special services in their homes. Only 2 percent thought they could move themselves out without help.

On the whole, most residents in the nursing homes were quite satisfied with their physical facilities, space, and equipment. When specifically asked to evaluate their situation with regard to these, 75 percent evaluated the physical facilities as adequate, 3 percent as generally not adequate, while 13 percent held them to be generally adequate but with certain exceptions, 9 percent gave no information. Among the things that different ones particularly appreciated were privacy, freedom to come and go as they chose, cleanliness, and a variety of other such assets as the surroundings for the homes, nearness to hospital, availability of a chapel and so forth. Things most often complained about were insufficiency of space and growing, lack of privacy, insufficient storage space, lack of hot water or bathing facilities, closets being inconvenient, and inadequacies in recreation, comfortable furniture and not being able to fulfill all of their needs on a single floor.

Asked about the adequacy of care received, 70 percent claimed complete satisfaction, 12 percent were generally satisfied but did have complaints about specific matters. Only one of the 163 respondents claimed to be not at all satisfied and the other 14 gave no information. Thus, of every 10, complete satisfaction with care is claimed by 8 while the rest tend to have only isolated complaints. Among the services particularly singled out for favorable mention by the respondents were kindness and cheerfulness of staff, the good food, beds, and physical care, opportunity for religious observance, opportunities to be useful and opportunities for recreation in the order mentioned. Complaints centered mainly on lack of attentiveness or courtesy on the part of the staff. These were all limited to not more than 5 percent of the respondents. When asked about their feelings for personal attention received from medical staff, 69 percent reported being generally satisfied, 4 percent as dissatisfied, and 5 percent as satisfied except for some specific complaint.

Finally, note the types of information nursing home administrators claim they do not have or do not have sufficient quantity or with sufficient validity, but desire to have. Three-fourths report need for evaluating degree of respondents' satisfaction with the physical facilities. Even higher proportions called for studies on residents' attitudes toward the administrative staff, administrative policies, and intake procedures. Information was also wanted on the effect of a respondent's background (occupational experiences, education, socioeconomic status, and so forth), on his tendency to adjust. Many of the administrators were interested in development of record forms which would help them gather information on the respondents that would be useful in more adequately supplying his physical, social and mental needs.

In conclusion, it is evident that research has just barely begun to answer questions frequently raised by nursing home administrators, prospective clients, or their families concerning satisfactions and dissatisfactions experienced by nursing home residents. The very importance of the extent to which and in what ways happiness or unhappiness with one's nursing home situation may affect mental and physical health has hardly been explored. Nevertheless, research to date does allow several significant conclusions. These include the observations that there is a general antipathy toward entering nursing homes, with the ones having become accustomed to life in the nursing home, few choose to leave it. Research experience also shows that administrators and residents both desire more adequate information on social aspects of nursing home care and are willing to cooperate effectively with competent research personnel in such studies.

The experiences of the Midwest Council for Social Research on Aging demonstrates the availability of a core of scholars interested in such research as soon as financial support becomes available.

The obvious trends toward increasing nursing home populations, demands for better health care and custodial services, and an increasing appreciation for the services which a nursing home can render efficiently all call for a long-range view of future research demands in this area. Such a long-range view calls for training of personnel, the upgrading of current personnel, and encouragement of a wide variety of careful studies on social aspects of nursing home care.

An examination of the attached schedules used in the previous study gives a small overview of the variety of useful information which may be obtained. The successful development of the information necessary to adequately guide the further development of efficient and effective nursing home care demands coordination of the public and private resources in a purposeful scientifically reliable research program. In my opinion, the primary stimulation for this is going to have to come from the Federal Government if it is to proceed in orderly and speedy fashion.

As Senior Citizens See Themselves—A Survey of Aging in the Upper Midwest

Prepared by Marvin J. Taves and Gary D. Hansen, University of Minnesota, in collaboration with the Midwest Council for Social Research in Aging, June 1961

FOREWORD

This preliminary report of findings of five-State surveys of older persons in Minnesota, Missouri, Iowa, North Dakota, and South Dakota has been made possible through the voluntary efforts of many groups and organizations. Approximately 6,000 older persons were interviewed by volunteer interviewers from the American Association of University Women, home demonstration units, schools of nursing, Retired Teachers Association, county welfare departments, county health departments, and councils of social agencies. The sociology department from the respective State universities tabulated and analyzed the data. In most instances, the State departments of public welfare assisted in the statistical tabulation of the data. Individual State reports have been or are being prepared by the respective State universities.

As an outgrowth of these surveys, a Midwest Council for Social Research in Aging was organized through initial efforts at the 1961 White House Conference on Aging for continuing research in this field. Universities, colleges, and research organizations in the Midwest are represented on this council. The Midwest Council will issue a subsequent report giving a more detailed analysis of the findings of the five-State surveys.

On behalf of the regional office of the Department of Health, Education, and Welfare, I wish to extend our sincere appreciation to all State and voluntary organizations for their contributions to the field of aging through these endeavors. As a result of these cooperative efforts, new knowledge will be obtained through research in the social aspects of aging.

JAMES W. DOARN,
Regional Director, Department of Health, Education, and Welfare, Region VI.

I. INTRODUCTION

During 1960, over 6,000 persons 60 years of age and over answered many questions about their lives. They told about their social activities, health problems, income, retirement and work patterns, recreation, housing and living conditions, and contacts with family and friends. The information was obtained by structural interviews with samples of senior citizens in Iowa, Minnesota, Missouri, North Dakota, and South Dakota. In many cases identical questions were asked in each State.

Many of the findings here reported are presented in greater detail in publications in process or already released by the five States. These State reports also indicate more precisely the problems involved in the various studies, the nature of the individual samples and the reliability of the data. The reader who desires a more intensive, comprehensive, or critical understanding of these studies and their findings is urged to refer to the more detailed reports.[1]

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[1] Citation on reports of the five States:

Iowa: "Life After 60 in Iowa: A Report on the 1960 Survey," Institute of Gerontology, State University of Iowa, Iowa City, Iowa.

Minnesota: Arnold Rose (ed.), "Aging in Minnesota; a Research Report on 1,700 Minnesota Senior Citizens." Marvin J. Taves and Gary D. Hansen; Minnesota Press, Minneapolis, Minn.

Missouri: Joseph H. Stokes (ed.), "Aging in Missouri" (app. I, Peter Kong-mig New), August 1960. Columbia, Mo. Pp. 146–305.

North Dakota: Courtney B. Cleland and Ernest D. Lovin, "The Senior Years: Survey of Aging." October 1960.

South Dakota: (In preparation).

2. THE SAMPLES

Each of the five studies was conducted independently and consequently the samples were drawn somewhat differently in each case. In Iowa a scientifically selected sample of 1,359 men and women, 60 years of age and over, residing in five of the State's metropolitan areas of Cedar Rapids, Davenport, Des Moines, Sioux City, and Waterloo, and eight more rural counties were interviewed. The samples were designed to represent the populations in the counties included in the study.

Minnesota conducted two independent studies. One study involved 300 social security beneficiaries whose eligibility was based on farming; drawn at random from among all beneficiaries in three widely separated counties of the State. The other study of 1,400 senior citizens used an area sample in each of 11 urban communities selected to represent the range and distribution of such nonmetropolitan communities in the State, plus area samples in each of the State's three major metropolitan cities, namely Duluth, St. Paul, and Minneapolis.

The 1,700 Missouri respondents were selected from a list of persons over 65 obtained from various community organizations, such as ministerial associations, extension clubs, the American Association of University Women, and numerous responsible individuals in the communities. Included were respondents from the metropolitan area of Kansas City, medium-sized cities of St. Joseph, Springfield, and Joplin, nine smaller cities and eight rural counties.

In North Dakota a quota sample of 917 respondents from 12 counties spread throughout the State was obtained.

Certain known biases exist in the samples. On the whole they tend to overrepresent the women, persons with high education, and higher income, the more urban, the more healthy, and the more communicative members in their communities. Thus, results paint a somewhat brighter picture than that which exists in the five States.

In some cases the interviewing was done by experienced professional interviewers, whereas in others it was done by persons selected from within the communities sampled. In the latter case interviewers were instructed by professional research personnel. Excellent cooperation by respondents and sincerest effort on their part to provide complete and reliable information were reported by both professional and volunteer interviewers. Even when the interviews lasted well over an hour, respondents consistently cooperated fully and willingly throughout.

As only Minnesota obtained data from senior citizens not living at home (that is, those living in homes for the aged and nursing homes) this report is restricted to persons living outside institutions for the aged. Also, only in the case of Iowa, which used a lower age limit of 60, were persons under 65 included in the studies.

3. METHODS AND RESEARCH TECHNIQUES

All data reported were obtained by interview using rather highly structured interview schedules. These schedules consisted of 10 to 20 pages of questions to which the interviewee responded with either brief answers of his own or selected one of a number of alternative answers provided him in the schedule. A large majority of the questions were of the latter so called closed-end type. With reference to the closed-end questions, interviewers were instructed also to encourage and report answers other than those offered in the schedule where such others might be more apropos to the respondent. The completed schedules were returned to the research offices where they were prepared by either professional research personnel or by volunteer personnel under the direction of professional research people for tabulating machine analysis.

Quite obviously the samples do not, necessarily. accurately represent all noninstitutionalized older persons in the five States studied. At least three of the studies followed generally accepted rigorous scientific procedures but were based on purposively selected segments of the State's total population (i.e., counties or towns not necessarily selected at random). The findings do present reactions of a large number of senior citizens in the Midwest who are most likely not very different from the rest of their group.

4. THEORETICAL ORIENTATION

The theoretical orientation tends to be largely that developed for the study of social security beneficiaries in Minnesota. It was the instruments designed for that study which formed the core for the interview schedules utilized in the succeeding studies by the five States. The senior years are viewed as an integral part of the individual's lifespan. Thus, as an individual embarks upon life he must first of all develop physically as an infant, then mature physically, mentally, and socially into a productive member of society. As an adult he is expected to fulfill a variety of roles in the family, in the work world, and in a variety of organizations within his community. During the retirement years these roles tend to be modified; some may even be denied the senior citizen while other new roles become available to him.

Among the roles most obviously associated with the senior years are those which revolve around retirement. Retirement often includes more than withdrawing from a job. It may involve withdrawing or being expelled from a variety of social and civic roles as well. The adequacy with which an aging person can cope with the changing demands he faces as he proceeds through life is influenced by many things. These include the facilities and resources available to him, the extent and quality of his education and prior experiences with adjustments, and his general philosophy toward the demands which his society, his community, his associates, and his family place on him as he progresses toward and through the senior years.

This frame of reference lends pertinence to questions about how the senior citizen views himself, his health, financial status, needs, and desires; and emphasizes the importance of the opportunities which his community offers or denies him. The five-State surveys are, therefore, an attempt to assess the senior citizen's image of himself and his environment. We now turn to the findings of the studies. Note the similarity of the findings in the five States and the small range of variation on most issues that follow. It can be assumed that aging is an orderly human experience with many elements in common wherever it takes place. However, this does not preclude great variability on some dimensions of life as one recognizes individual differences arising from the common core.

5. HEALTH

Concern for health increases with advancing age. Older persons express worry and concern for their health more often than for any other single matter. Though this is more true for those in ill health, it also holds for others.

In addition to the immediate impact upon the ability of the individual to care for his physical needs, it has many other ramifications. It affects his earning capacity, his general morale, and his degree of dependence upon others, as well as the contribution which he can make to the activities and happiness of his friends and family. Several of the studies also observed a high correlation between personal adjustment and good health. In turn, good health appears to be, at least in part, a function of education, income, and urban rather than rural residence.

In each of the States a wide range of responses was received in answer to questions about how a person felt physically. Thus in Minnesota 110 of 1,400 respondents stated that "if they could not feel better soon they would just as soon die." A similar proportion of Iowa senior citizens declared themselves in "very poor" or "poor health." The proportion reporting poor health was slightly higher for North Dakota (13 percent). On the other hand, somewhat over half of the Iowa and almost as high proportions in Minnesota, North Dakota, and South Dakota considered themselves to be in excellent or good health. The rest thought of themselves as in fair health.

Even though there may not be a perfect correlation between a person's self-appraisal of health and his actual physical condition, the self-appraisal does influence his morale and the energy likely devoted to satisfying and purposeful activity.

The tendency to evaluate one's health as excellent declines with increasing age. This very likely reflects the decline in physical well-being associated with older

age. This declining self-appraisal of health may also be influenced by other factors such as loss of social contacts with the demise of associates and conscious or unconscious rejection by friends and family as physical vigor ebbs.

Uncared for health needs

Despite the high proportion which expressed favorable attitudes toward the state of their health, significant numbers reported major health difficulties. One in eight reported major, uncared-for health needs in South Dakota and Minnesota. Approximately half of the respondents indicated no known major health problem. Of those who did report a major medical problem, 10 to 15 percent had had no contact with medical personnel or facilities during the previous year. A fourth of all respondents indicated no contact with health service personnel (doctors, dentists, or nurses) during the preceding year. The reason given most often for not seeking medical attention when presumedly needed was financial cost.

Medical diagnosis might have indicated either higher or lower incidence of both cared-for and uncared-for health conditions. The data presented reflect the senior citizen's own reaction to his state of health.

Medical costs

Less than 1 in 10 reported no medical costs during the previous year. Apparently some had paid for medical services obtained at a prior time. Medical costs of over $500 were indicated by 15 percent in Minnesota and by 12 percent in North Dakota. Expenditures in excess of $250 were reported by 23 percent in Missouri. Approximately half of all respondents spent between $100 and $150 or more on health care during the preceding year.

Close to half of the respondents carried hospitalization insurance, far lower percentages had medical and surgical insurance. Although many of the aged persons believed themselves to be able to meet the foreseeable medical costs, a third did not think themselves to have the resources for expenditures beyond $1,000.

Those who were covered by some form of health insurance had largely purchased it fairly late in life. This probably reflects a general growth of health insurance programs during the last few decades. Of those who gave reason for not buying health insurance, one-fourth think themselves capable of handling their medical needs without insurance, while a much larger proportion feel that they cannot afford the costs of such insurance.

A substantial majority of respondents favored the extension of OASDI to include hospital and medical care. About one-fourth opposed it.

6. INCOME AND ECONOMIC CONDITIONS

Net income in 1959 below $1,000 was reported by about one-fourth of all respondents. Net income between $1,000 and $2,000 was reported by 30 percent in North Dakota and Minnesota and less than 20 percent in Iowa. One-fourth to one-third had received between $2,000 and $5,000 while the remaining 7 to 14 percent had above $8,000. Iowa pointed out that women have much lower average incomes than men and that as age increases income decreases.

Net worth figures were available and very comparable between Minnesota and North Dakota. About 1 in 10 reported they were in debt or had no property, insurance, or other liquid investments or assets. Three in ten said their net worth was between $1 and $10,000. Over half had a net worth above $10,000. Minnesota observed that rural residents averaged a higher net worth than urban or metropolitan residents.

The amount of money reported as needed per month to live on for the respondent and spouse appears very modest, $1–$99, for about one-fourth in Minnesota and North Dakota. An additional one-fourth needed between $100 and $149. One-third need between $150 and $250 a month. The remaining 20–25 percent estimated needs over $250.

Between 10 and 15 percent of the senior citizens reported that they did not have enough money to live on. At the opposite extreme, about one-fifth had more than enough to meet all needs comfortably. About one-third said they had just enough to get by on and one-fourth to a third felt they had just enough to meet all needs comfortably. Thus, 1 out of 7 to 10 reported serious economic needs, about half to two-thirds were getting by, and one-fifth had a surplus. The major threat to economic security was a medical emergency,

or other major unforeseen expense. These were threatening to from one-half to three-fourths of those interviewed.

The most frequent source of income was social security. This was reported by half to two-thirds of the senior citizens in the various States. Between 60 and 75 percent said that their social security payments had allowed them to remain self-supporting. Between one-fourth and one-half said it had freed their children from supporting them financially.

The need for better economic conditions for senior citizens was reflected by the fact that financial problems or wishes for a stronger financial position were mentioned second only to health problems and wishes to improve health, respectively.

7. HOUSING

By far the most frequent living arrangement was to own and reside in one's own home (65 to 80 percent). This was much more prevalent than renting an apartment or house, an arrangement which serves from 10 to 25 percent of the senior citizens. Living with children, siblings, or nonrelatives was least often reported, although in the total aging population it is known that residence in a home for the aging, nursing home, boarding home or other institution accounts for 5 percent or less and would therefore be less frequent than living with children, siblings, or nonrelatives.

Annual housing costs were $500 or less for 40 to 52 percent. Another 30 to 40 percent had annual costs between $501 and $1,000. The remaining 15 to 30 percent spent over $1,000 on housing in 1959.

The overwhelming majority of senior citizens were relatively satisfied with their present housing and living arrangements (70–93 percent). Of the few who complained, the major problems were: too many stairs or stairs without guard rails; inadequate space; poor arrangement of facilities or floor space; or an undesirable geographical location.

The following discussion on housing is based mainly on the Minnesota and North Dakota reports and somewhat on the Missouri report. Even though the proportion of complaints is relatively small, the housing picture is not so bright when perceived from two other angles; (1) what senior citizens would desire if they moved to new housing and (2) what special housing facilities are needed in the community for the aging, as judged by them.

If the aging were to move into new housing, a majority were emphatically in favor of it being: (1) on one floor (56–65 percent); (2) the ground floor (50–67 percent); and (3) near public transportation (32–55 percent). Gardening space or plots were desired by over one-third. About 3 in 10 wanted children present and half as many (15 percent) didn't want children around. About twice as many wanted less space (15 percent) rather than more space (8 percent). Ten percent wanted housekeeping help. Only a few wanted a recreation program near by or asked for wide doors. All of these wishes provide some reason to suspect that many senior citizens are just making the best of their present housing without much complaining, but, if given a chance to project into the future and to anticipate an ideal housing arrangement they have many specifications to make. Perhaps one's present home is a "sacred castle" which if criticized reflects negatively on one's self with some pain; hence it is favorably thought of and spoken of even when less than adequate.

What housing facilities are needed in the community? Nursing homes were given highest priority by about 6 in 10 of the senior citizens of North Dakota and Minnesota. Need for apartments designed especially for the aging ranked second, according to 5 in 10. Boarding homes and separate cottages shared the third position, with 4 in 10 calling for them. A large majority assigned the responsibility to build or provide these housing arrangements in the community to Federal, State and local governments combined; each level of government individually was mentioned by 30 to 40 percent. The church was mentioned by the next highest proportion, 40 percent. Many senior citizens were not content to place the responsibility on private, commercial, or business enterprises (18 percent).

These housing facilities should be close to family and friends according to one-half of the respondents. A higher proportion wanted the facilities near town than away from the population center (35 and 17 percent, respectively). Only 17 percent in Minnesota and 7 percent in North Dakota thought that new housing for the aging should be in a community strictly for the aging.

8. WORK AND RETIREMENT

Full retirement describes the situation of two in every three senior citizens interviewed in three States and one-half of those interviewed in South Dakota and Iowa. Retirement was not forced or involuntary for the majority, as is popularly supposed. Mandatory retirement because of company policy was only reported by about one-fifth. Many retired as a matter of personal choice or because of poor health. Minnesotans who did not retire kept on working for two reasons: "I like to work," "I need the money."

The majority preferred the retirement or employment status they were in, however, of the minority who wished to make a change most wanted to be working more. Those most dissatisfied were fully retired and wished to be fully employed (15 to 25 percent). This is a significant proportion who wish a complete change to full time work.

The hardest problem to adjust to in retirement was that of not having anything to do or how to occupy their newly discovered freedom and time. A second difficult problem was getting used to the loss of communication and interaction with associates on the job and otherwise. One-fourth of the Minnesotans said they didn't like retirement at all.

Pleasures most often mentioned in retirement were: freedom from heavy work, job pressure, demanding schedules, and time available which could be used as desired in resting, hobbies, reading, traveling, and loafing.

Financial planning for retirement had not been the rule. Only about one-half had made plans particularly for retirement.

9. TIME USE

Time, for the majority of the aging especially those retired from gainful employment, is an abundant resource. The increasing availability of free time to almost every segment of our population deserves our individual and collective attention. The ability to use free time in a useful, creative, and satisfying way may be as significant for individual happiness and development in the future as is preparation for work and execution of work today.

The question is, How do they use their time? Are they enjoying their leisure? What ways of using time bring them most satisfactions? To what extent do their leisure activities upgrade themselves and contribute to society?

After age 65 or retirement there is a dramatic increase in watching television and in listening to the radio—as a matter of fact or preference—by 6 to 8 out of 10. Staying around the house with the wife or husband was also much increased and preferred by a greater proportion than just "working" around the house. Another feature of aging is suggested by those who just sit and think. Whether this time and thought is other- or self-directed; toward the present, future, or past in time orientation, and more "thinking," than just sitting, will determine its value and usefulness for the individual. Hobbies receive more time among about one-third. About the same proportion are doing things now they never had time to do before. Volunteer community work was increased by 10 percent.

It may be important that one in four, according to North Dakota and Minnesota data, were not satisfied with the way they spent their time.

Respondents were asked at what activities they would like to spend more, less, and the same amount of time, given their present health. Social desires, needs, and feelings arise with a surprisingly consistent hierarchy. In Iowa, Minnesota, and North Dakota the rank order was for more time to be spent with (1) children, (2) brothers and sisters, and (3) friends or neighbors. This response is socially acceptable and nonthreatening to the self.

However, being socially acceptable is hardly an adequate explanation as may be seen from several lines of converging evidence. One of the main wishes of Minnesota seniors was for companionship. The experiences enjoyed most in daily life were visiting and communicating with family and friends. These were answers volunteered and not of the check list variety. Going to church or participating in religious activities ranked fourth. Women appear to be more interested than men in going to church, reading the Bible, and praying, according to the Iowa report.

Radio, television, and reading ranked high as preferred leisure in Iowa but not something at which to spend increased amounts of time in North Dakota and Minnesota. Indoor activities similar to these were the second highest source of daily enjoyment in the latter two States.

At the bottom of the list of daily enjoyments and things at which to spend more time are just sitting and thinking, taking part in the leadership of social or community organizations, working and staying around the house (two States), listening to radio and watching television (two States).

Minnesota concluded that not only did senior citizens fail to preplan to do things after they reached 65, the majority also was not characterized by planning for the future after having reached 65. One in seven of the seniors in two States had future plans simply to maintain the status quo. About an equal proportion planned to travel.

10. COMMUNITY SERVICES DESIRED

Respondents were asked who they thought should have major responsibility to provide for older people when they can no longer care for themselves. The Government, including State, Federal, and local, was given this responsibility by the highest proportion of senior citizens (40 to 50 percent). Children, the church, and employers were each given about equal responsibility by one-fourth to one-third.

A large majority (60 to 80 percent) of the senior citizens in the four States indicated their approval of the inclusion of hospitalization and medical protection under social security even though this might increase the amount of taxation.

Turning now to specific services which communities can render, it was found that low-priced health clinics and visiting programs were desired by the greatest proportion of senior citizens (50 to 65 percent). More Iowans favored a higher priced health clinic where one could choose one's doctor than a low-priced one where one could not choose. Almost two-thirds of Iowa's seniors favored a visiting nursing service and a medical relief fund.

Generally, about twice as many who would actually use various services desired them to be available in the community. Apparently they considered the broader benefit to other elderly people and future generations.

About one-third of the senior citizens were interested in a homemakers' service which would provide help with household chores at a reasonable price. Prepared meals delivered to their home at reasonable cost were desired by about 30 percent of all. Adult education classes were favored by between one-fourth and one-half of the respondents. Between one-third and one-fourth were also interested in hobby shops. About one-fifth of the senior citizens in Iowa and Minnesota were interested in work on community improvement programs at little or no pay. Sixty percent of Iowa's respondents indicated that they would like to have more part-time work for pay. Activities which received least support were pool, dances, indoor sports or games, and outdoor sports (5 to 20 percent).

Professionals and lay persons interested in community organizations for the aging may be guided by the following considerations. Senior citizens do not wish to be excluded from the social life of the rest of the community, nor do they as a whole want to be fully engaged in the community's activities to the extent that younger citizens are. Some senior citizens wish to have programs designed exclusively for them although the majority do not. Projecting from various information sources, it seems desirable to maintain a reduced amount of integration with the organizations and activities of the community, while at the same time increasing somewhat the activities designed exclusively for the elderly. Community leaders should be vitally concerned about maintaining health through private and public clinics, home visits by health specialists and through health education in small groups or through mass media.

The next concern which senior citizens hold in highest regard is companionship. Their desire to visit, to interact on a friendly, sociable, discussion basis with many individuals their age and at other ages is very pronounced. Visiting services and programs, particularly for those who are isolated, homebound, or lonely, would be vitally important to maintain morale and adjustment. A formal organization of club per se does not appear to be as important to the senior citizen as a place for various kinds of activity such as a day center, where many individuals could come, who have varied, multiple interests, and have opportunity to exercise those interests and obtain satisfactions from them. Only a few prefer to be sitting and thinking—to fulfill the rocking chair image. Senior citizens are concerned about having opportunities to maintain their creative interests through work, discussion, sharing hobbies, education, and various kinds of games and sports.

11. SOCIAL PARTICIPATION

To what extent are senior citizens involved in the organizations of the community? In what organizations are they most often and least often participating? What is the extent of their participation; are they leaders, committee members, or do they merely attend? How has their participation changed?

The church or religious organization ranks first among all organizations as the center for participation and memberships among senior citizens. The majority of senior citizens in all of the States were members in religious organizations, ranging from 70 to 95 percent. Memberships in all other organizations combined (i.e., civic, social, professional) just barely total to equal memberships in religious and church organizations. Social organizations were participated in next most often, but the proportion of senior citizens who are members averages only about 20 percent. Civic organizations ranked third in memberships (15 percent), while professional organizations ranked fourth.

The data suggests that membership in churches is proportionately highest among the rural aging and among the women. According to Missouri's findings, the level of education does not appear to affect participation in churches as much as it does participation in civic, social, and professional organizations.

One-half to three-fourths of North Dakota and Minnesota senior citizens report less participation in church or religious organizations now than before they reached 65. It is interesting to note that the religious organization is still the predominate one even though a majority participate less now than before age 65. The relative time, energy, and thought that the church and religious organization receives from this generation of senior citizens in our society appears to be rather great.

Between 35 and 45 percent of the senior citizens in Minnesota and North Dakota indicated that their activity level had not changed in organizations since reaching 65. For those who did experience a variation in their activity level the predominant change was to become less active; however, as high as one-fourth indicated a greater amount of activity in some organizations, although the more common proportions indicating an increase in activity was one-tenth or less.

Between 10 and 20 percent of the senior citizens interviewed did not belong to any organizations.

Officer or committee positions were held by 18 percent in the North Dakota sample and by 15 percent in Minnesota. Rather small proportions of senior citizens indicated a definite desire to belong to different organizations than those they now belonged to. However, they were interested in activities of various kinds but not necessarily with joining another organization. Social or recreational clubs were desired for themselves or others by about one-third. Card games were desired by about one-third in North Dakota and Minnesota.

12. FAMILY RELATIONS AND FRIENDSHIPS

About half of the senior citizens interviewed in all of the States were married and living with spouse. Between 25 and 40 percent were widowed. Widows are much more prevalent than widowers. One-fifth of the respondents were living with their children or children were living with them; between 13 and 20 percent had no living children; about 10 percent had never married.

Basing the estimates on Iowa and Minnesota data, 10 percent of the senior citizens with children have no "regular or frequent" contact at all with their children. This is partially due to the fact that about 6 in 10 of the senior citizens report that they have children living outside of the State. Only half of the senior citizens reported children living in the same town or within 25 miles, a distance which should permit fairly easy contact.

Even though so many of the children are not living within this easy traveling distance, only between 5 and 10 percent complained about their children neglecting them or not paying enough attention to them. However, family life may be a dimension in their lives in which they were unwilling to reveal their heartaches and problems. This may be reflected somewhat by the fact that senior citizens reported the most interesting and enjoyable things in their daily lives were their associations, visits and communications with their children and brothers and sisters. When they were asked how they would like to spend more of their time, over half indicated that they would like to spend it visiting and communicating with their families. It may be inferred that the quality of contact may be more important than the frequency of contact.

For at least a 15 percent minority the quality of contact does not appear to be satisfactory either. Five percent in Minnesota said that their family was always trying to boss them. Combined with the other extreme of being neglected by the family, previously reported by 10 percent, one in seven report dissatisfaction with family relations.

The Iowa data reveals that the children more often lived in their parents' household rather than grandpa and grandma living in the household of the children. As age and widowhood increased, the likelihood of the older parent living with a child increased. Children, especially daughters, were responsive to the needs of elderly parents (mostly mothers) who needed help daily. Of almost 150 who needed help daily, one-half said their daughters gave it while only one-third received help from their sons. Thus interfamilial reciprocal helping and sharing between generations is the pattern for over half of those who need help in getting around and meeting daily needs.

Minnesota and North Dakota both show that about one in seven did not have any living brothers or sisters. About 1 in 20 lived with a brother or sister. Only one-third had a brother or sister in the same town or within 25 miles.

Since family contacts are not possible for many senior citizens it seems desirable to activate programs whereby they can establish strong ties or friendly relationships with members of both sexes. This can be done through visiting activities, social, recreational, hobby, or educational clubs, day centers, and through individuals of all ages taking an interest in the elderly.

Evidence for possible success with such efforts is suggested by the fact that 5 to 6 in 10 senior citizens said they wanted to make new friends. Minnesota found about one-tenth who had no one to talk to about personal things. An equal proportion said they had so few friends, that they were lonely much of the time.

North Dakota and Minnesota reported that about half of the senior citizens had had no contact with work associates during the past year. Approximately 3 in 10 preferred more contact with former work associates.

13. PERSONAL AND SOCIAL ADJUSTMENT

Aging and retirement in a complex, urban, industrialized and ever-changing society is full of many challenges, opportunities, and problems. Individual capacities and demonstrated practices in coping with these forces vary greatly. Our system of social welfare services is designed to help individuals who have less capacity to adjust or are beset by greater hardships. Social welfare is also geared to planning and executing measures which enable individuals to independently or cooperatively take preventive steps or to positive things which may assure a good adjustment. In this enterprise it is particularly pertinent to know how different factors are associated with adjustment, either positively, negatively or neither. This will suggest actions designed to create desirable environments and favorable self images in the later years.

How many of the important factors can be controlled by the individual or society? What factors are impossible to control or which can be compensated for through the manipulation of other related factors? What does a profile of the individual characterized by high personal adjustment, satisfaction, morale or happiness look like as compared to the profile of a person who is unhappy or poorly adjusted?

On the basis of a 24-item attitudinal scale, the senior citizens in the North Dakota, Minnesota, and Missouri samples were divided into classifications of high and low personal adjustment. The following discussion is based on this comparison of high and low adjusted senior citizens.

Being married and living with one's spouse is positively associated with adjustment, while being widowed is negatively associated. Widowers were characterized by lower adjustment than were widows. Being a male or female by itself does not appear to have a significant relationship to the adjustment level. However faint suggestions in the data indicate that men are more often characterized by either high or low adjustment (at the extremes) while women are more often somewhere in the middle, according to the Minnesota report.

A variable that cannot be altered is increasing chronological age, and it is negatively associated with adjustment. The reasons for the decline in adjustment are not simply the addition of years, but are encompassed within the many health, social, and economic changes that accompany increasing years.

North Dakota data suggest that rural living is more favorable to adjustment than urban living, however, comparable data are not available in other States.

Minnesota found no difference in the level of adjustment between residents of different rural counties, so that geographic location per se does not appear to affect adjustment level among rural residents.

More highly associated with adjustment level than geographic residence is the housing arrangement of the senior citizens. Minnesota found those institutions were on the average less well adjusted than those in the open community and all States report that homeownership is positively associated with adjustment. Whether this is a direct or indirect association remains to be determined.

High education is associated positively with adjustment, although not as significantly as some other variables. Low income was negatively associated with adjustment in three States, as was the perception of one's income as being inadequate. Being dependent upon children or upon old-age assistance was not favorable for adjustment. At the same time, being a recipient of old-age survivor's insurance benefits does not appear to be negatively or positively associated with adjustment. Minnesota found that having health and life insurance, especially for one's family rather than just for the interviewee himself, was related positively to adjustment. Social participation, activities, and hobbies all appear to be positively associated with adjustment.

Factors which are very strongly associated with adjustment are self-conceptions about one's age, health, and employment preference. Senior citizens who conceived of themselves as "old" or "elderly" rather than "middle aged" or "young" were characterized more often by low adjustment. Those who said that they were in "poor health" or who conceived of their health as being "fair" or "poor" instead of "good" or "excellent" were also characterized by low adjustment. South Dakota data also supports these generalizations. Individuals who were fully employed or partly employed were better adjusted than those who were completely retired. Individuals who were still able to do their main lifework or who were in the employment or retirement situation which they preferred were characterized by better adjustment than others.

These findings suggest that it is important to maintain a positive self-image with regard to health, employment, and age. It also is desirable in preparing for the later years to build up one's economic resources and a positive evaluation of the adequacy of one's income. Keeping active, useful, and creative through activities, hobbies, and work also contributes importantly to adjustment. Other goals which appear to be desirable are education, homeownership, health and life insurance, and marriage. The factors which do not appear to be associated very strongly with adjustment and hence of not as great concern, are one's sex, one's geographic location in a given State, and rural, urban, or metropolitan residence. Most of the significant variables could be cooperatively manipulated by the individual, social welfare programs, and private organizations to create a more favorable environment, positive self-image, and better adjustment in the later years. Life situations per se do not appear to be as important to adjustment as the individual's self-conceptions or subjective definitions of situations and experiences.

Senator LONG. Now, we just do have a few minutes for a discussion between you gentlemen. I am sure that three Ph. D.'s couldn't agree entirely with each other's statements. For the sake of argument let's say you didn't, anyway, and would one of you care to lead off and comment or get some discussion going for a few minutes.

Dr. ROSE. I would like to ask Dr. Taves about one thing that he did in one of his studies that is pertinent to something that I raised. You did a study which covered a good share of Minnesota, covering, I believe, 10 small cities, 3 large cities in the State and some of the rural counties, and also a similar study was done in some of the other Midwestern States—Iowa, Missouri, North and South Dakota, as well as Minnesota—and one of the questions you asked, as I recall, had to do with the way in which older people looked forward to how they saw themselves being able to pay for medical care of any sort including for nursing homes. What were their attitudes toward various proposed ways of paying for the medical care costs?

Dr. TAVES. In this expanded statement, which is in the hands of the committee, there is some reference to attitudes toward responsibility

for nursing homes. With reference to nursing homes respondents assign first responsibility to the Government. They also indicate that they would like to see certain private organizations, particularly churches, take some responsibility in this field. I think you were also referring to our findings relative to attitudes toward the inclusion of medical care under social security. I would have to check my data on some of the other States, but for Minnesota the general feeling of a significant majority favors inclusion of certain types of health care under social security.

Dr. SWENSON. I would like to ask Dr. Taves a question.

In the early part of his statement he referred to a percentage which I don't recall now of the group of individuals who were dissatisfied with their nursing homes in which they lived. I am wondering if you can present specific evidence in summary form to give us an idea of whether these dissatisfactions were things that could be relieved by greater financial aid to the nursing home or whether they were dissatisfactions that were more complex than could be changed by the addition of funds to the nursing home budget.

Dr. TAVES. My impression is that most of these things could be satisfied with better financial support because many of them had to do with such things as lack of space, crowding, unsatisfactory facilities, lack of handrails where they wanted them, inconvenience. For example, one of the specific points often mentioned was that they had to go to another floor in order to use laundry facilities, they wished everything to be on one floor. These things could be remedied with the right type of financial assistance. There were also other factors which related to the competency of the personnel. That, then, would probably require a better training program. A significant proportion of administrators themselves feel that they could definitely benefit from an upgrading of their professional group.

Senator LONG. Do any of you other gentlemen have a question of the other members?

(No response.)

Senator LONG. If not, we are grateful to you for your time and for your contribution to this hearing, your statements. You have been very helpful to us and we are very grateful to you.

We are now prepared to start with the town meeting part where the elder citizens are given the opportunity to present their problems to the committee. The presence of the newspaper and radio people here indicates that the public is interested in this. We feel certain that there is no one who knows more about the problems of senior citizens than those citizens themselves. There is no one or group of individuals who has given more thought or attention to what the remedies could be or how they could be implemented than these citizens themselves who have spent their lives as good citizens of our country and are now in those closing years where certainly their experience and training and so on, we should give them every consideration. You can realize there are quite a number of these citizens who would desire to speak. Some of you have prepared statements and we would like to have you give those to the committee so they may go into the permanent record. I do want to ask that you limit your discussions just to 2 or 3 minutes, if at all possible—there may be some questions—so everyone will have the opportunity to be heard that is possible for us to hear this afternoon. We can't let two or three monopolize the

entire time. So if you will follow that practice and try to limit your statements.

As I understand, we determined that the senior citizens are past age 65. If any of you attempt to speak who are younger than that, I may want to see your birth certificates. We will assume that this afternoon that the senior citizens themselves have the floor. My staff tells me that a number of senior citizens have contacted them about being heard. There is a Mr. E. B. Ringham, who is president of the Senior Citizens Council of Minneapolis. We want to hear Mr. Ringham. We have his full statement. I would ask that he not read his statement to us but he very briefly summarize his statement.

STATEMENT OF E. B. RINGHAM, PRESIDENT, SENIOR CITIZENS COUNCIL OF MINNEAPOLIS

Mr. RINGHAM. Thank you, Senator Long. I want to thank you first for the opportunity of being here and speaking to you. I am speaking in behalf of the Senior Citizens Council of Minneapolis of which I am the president, which is an association of 36 senior citizens clubs having a total membership of over 3,000 senior citizens. I am representing the club to present our views on the subject of the so-called King-Anderson bill before Congress. We took a vote and adopted a resolution some time ago favoring that bill and sent a copy of the resolution to the committee and to the Congress. We believe that that is a practical way of handling this problem.

As you say, I have prepared a paper which is already on file with your committee but if I may read just a portion of it, Senator.

We are aware of the fact that some opponents of the bill claim that many retired citizens who are now receiving social security benefits have ample means and do not need this hospitilization benefit through social security. That is true, but, according to a survey conducted in Minnesota under the direction of the University of Minnesota, not more than 42 percent of the retired persons are so situated, at least 58 percent of the retired persons do need financial help to take care of hospital and medical expenses and retirement.

The survey also showed that 55 percent of all the people over 65 years of age had incomes of less than $2,000 per year, and 33 percent had a net worth of less than $2,500. I want to say also that we do oppose the need test.

Reference has been made this morning to the Kerr-Mills Act which has not been activated in Minnesota. But, as I understand it, in order for a beneficiary to take advantage of that he must practically sign a pauper's oath. We protest against that. We prefer that deductions from their earnings made during the earning years be accumulated as insurance and cover hospital and medical need in their retirement in the same way as retirement pensions are accumulated now under social security.

It has also been charged that the King-Anderson bill, by those who oppose that bill, there are many that are not covered by social security but social security has been expanded and no doubt will be expanded further to include those who are not now covered. As a matter of fact, 90 percent of the workers in the United States are now under social security. We do not think it is fair either to say that this King bill is a step toward socialized medicine. There is nothing in this bill which would prevent any beneficiary from selecting the doctor of his

choice or the hospital of his choice, and the fact that the beneficiary must stand the first $90 of this hospital expense under this bill will prevent any so-called chiseling. We realize that there always will be cases of dire need that will have to be taken care of by local or county welfare boards but we believe that the vast majority of senior citizens will be able to take care of their hospital and medical expenses after retirement with the help that will be provided through the social security, under the provisions of the King-Anderson bill. In the brief that I have filed with you I have quoted from a number of institutions and persons who have expressed their approval of this bill. Perhaps I better not take time to read that, Senator. It is in the copy, or may I read some of those quotes?

Senator LONG. I don't want to take too much time on it. I might point out to you, as you know and as you have indicated in your statement, that actually this committee is not a legislative committee. The problems you are discussing are certainly of interest to all of us but that problem has now been considered by the committee, the recommendations have gone in and the proposed legislation, as you have indicated is now before the Finance Committee of the Senate and the Ways and Means Committee of the House. As I say, we are interested in that, but perhaps there are other problems that we should turn to that would be more beneficial to this committee since we have already passed on that particular phase of the program.

Mr. RINGHAM. There are a number of quotes in this statement that I have submitted and I hope the committee will take note of them and I believe they may be influential in your consideration. Thank you.

Senator LONG. Thank you, Mr. Ringham.

(The prepared statement of Mr. Ringham follows:)

PREPARED STATEMENT OF E. B. RINGHAM, SENIOR CITIZENS COUNCIL OF THE MINNEAPOLIS AREA, MINNEAPOLIS, MINN.

First, I want to thank you for the opportunity of appearing before you.

I am E. B. Ringham, and I represent the Senior Citizens Council of Minneapolis, of which I am president. The Senior Citizens Council is an association of 36 senior citizens clubs in Minneapolis, having a total membership of more than 3,000 senior citizens.

We wish to present our views on hospitalization for our aged citizens. Our association unanimously adopted a resolution favoring the enactment of the so-called King bill (H.R. 4222) which was before the Congress at its last session, and we filed with Leo H. Irwin, chief counsel of the Committee on Ways and Means of the House of Representatives in Congress, a written statement of our views.

We are aware of the fact that some opponents of the bill claim that many retired persons who now are receiving social security benefits, have ample means and do not need hospitalization or medical benefits. That is true, but according to a survey in Minnesota, conducted last year by the American Association of University Women, under the direction of the University of Minnesota, not more than 42 percent of the retired persons are so situated. At least 58 precent of the retired do need financial help to take care of hospital and medical expenses after retirement. The survey also showed that 55 percent of all people over 65 years of age have incomes of less than $2,000 per year, and that 33 percent had a net worth of less than $2,500.

We oppose the idea of a "need" test. We submit that retired senior citizens do not wish to be treated as charity patients, but prefer that deductions from their earnings made during the earning years be accumulated as insurance to cover or partly cover hospital and medical needs in their retirement years, in the same way as retirement pensions are accumulated now under social security.

It is also charged by those who oppose the King bill, that there are many who are not covered by social security. That is true, but social security has been

expanded and no doubt can be and will be expanded further to cover those who are not covered. As a matter of fact, 90 percent of workers in the United States are now under social security, according to information we have received.

We do not think it is fair to say that this King bill would be a step toward socialized medicine. As we understand it, there is nothing in this bill which will prevent the beneficiary from selecting the doctor of this choice and the hospital of his choice, and the fact that the beneficiary must pay the first $90 of his hospital expenses, will prevent any so-called chiseling.

We realize that there will always be cases of dire need that will have to be taken care of by local or county welfare boards, but we believe that the vast majority of senior citizens will be able to take care of their own hospital and medical expenses after retirement, with the help that will be provided through social security under the provisions outlined in the King bill.

In further support of our contention that hospitalization and medical benefits for those over 65 years of age should be financed through the social security system, as insurance paid for by the beneficiaries during their working years, I beg to quote from a few statements by various organizations, institutions and individuals of note:

AFL and CIO.—"It is our conviction that the established social security system is the most appropriate method through which the Government can assist aged citizens with problems of financial medical care."

American Nurses Association.—"Certainly, insurance coverage against the cost of illness which may occur after retirement, which insurance can be paid for during the working years, would be less costly to the public than tax-supported public relief for health care, a dependency which is distasteful and degrading to the citizens of this country."

Governors' conference (52d annual meeting, 1960).—"*Resolved*, That Congress be urged to enact legislation providing for a health insurance plan for persons 65 years of age and older to be financed principally through the contributory plan and framework of the OASDI, system."

Business Week.—"The health needs of the aged can be met only by themselves when they are young or by other younger people who are still working. The only way to handle their health problem is to spread the risks and costs widely. That can be done through the social security system to which employers and employees contribute regularly."

Life magazine from editorial, April 25, 1960.—"The least burdensome method of insurance is for the whole society to spread the costs over the whole life cycle. The cheapest and most logical way of doing this is by extending the existing system of social security. This aid need not be socialized medicine, as some opponents claim, since patients select their own doctors and hospitals."

The New York Times from editorial, May 10, 1960.—"There are many positive advantages in using social security. For example, it would avoid what amounts to a 'means test' for eligibility—something abhorrent to Americans. Also, it would take effect nationally at once, while State cooperation might be far from unanimous and also slow in coming."

The Washington Post from editorial, February 20, 1960.—"While a man is employed, he can enjoy the protection of some sort of group or private insurance program to cover medical and hospital bills. When he retires he may no longer enjoy such protection; yet, this is the time when he will need it most, when the cost of such private insurance is prohibitively high. The McNamara subcommittee came to the conclusion that this problem should have top priority for legislative consideration, and recommended in its report an expansion of the OASDI. That the American Medical Association would offer its usual doctrinaire opposition was to be expected. This is not 'socialized medicine.' It is simply a system that would enable a patient to go to the doctor and hospital of his choice—and pay the bills resulting from the care he needs in old age. It would enable American men and women to retire in their old age with more security and self-respect."

National Council of Jewish Women (January 1960).—"A priority step in expanding our social security system must be the inclusion of medical care benefits for the aging."

Walter Lippmann (in Washington Post, June 16, 1960).—"What is wrong about its being compulsory that a man should insure himself against the needs of his old age? What is so wonderful about a voluntary system under which a man who doesn't save for his old age has to have his doctor bills and his hospital bills paid for by his children or public welfare funds?"

Basil C. MacLean, M.D., former president, National Blue Cross Association.— "A lifetime's experience has led me at last to conclude that the costs of care of the aged cannot be met, unaided, by the mechanism of insurance or prepayment as they exist today."

Senator LONG. There is one gentleman I wanted to introduce, a man responsible for the work of this committee. He is the man, the head of our staff, the other members work under him. All of these committee hearings are set up under his direction. There is no more dedicated man to our senior citizens than this man. He flew here today to be here today. He is leaving tonight to attend other meetings in the East, but he has done a grand job for this committee and I think you people would like to meet him. He is the staff director of the Senate Committee on the Aging, Bill Reidy. He may look over 65 but I don't think he is that old.

Mr. REIDY. I am not supposed to participate in this hearing, but I would like to say that this is one of the greatest shows of interest that we have had in our hearings throughout the country, so I think we should thank you people of Minneapolis.

Senator LONG. Mr. Roy Luttrell has asked for a minute or two. We would be happy to hear from him at this time.

Mr. Roy Luttrell, would you step up, please.

STATEMENT OF ROY LUTTRELL

Mr. LUTTRELL. Mr. Senator and friends, I think I might say the vast majority of Americans have come to realize the importance of insurance against catastrophic financial losses as a necessity of modern life, and the most important domestic issue before the American Nation at this time is how to finance adequate insurance, hospital insurance, for about half of the 17 million citizens over 65. There will be 18 million in 1963. More than half of them have incomes less than $1,000 a year. That's $83 a month and the average social security pension check is $74 per month. Less than half of these people have health insurance of any kind but they have much greater need for hospital care than younger people. Private insurance has tried to meet this need but has succeeded only with individuals in the higher income brackets who can pay the high cost of their high-risk coverage. Blue Cross is canceling out its older policyholders by raising the rates and reducing the coverage. Half of the over 65 aged are a high-risk group with incomes so low that private insurance cannot give them the adequate coverage at a price they can pay.

Old age assistance is not the answer. It is degrading to the thrifty individuals who have to prove how poor they are and sign a pauper's oath to qualify for its benefit. It encourages pauperism and requires an army of welfare workers to administrate it. It is financed from general taxes, from our State and National, and its costs are very great and steadily increasing. The Kerr-Mills law is financed from general taxes and extends public charity to a few more people in addition to those on old age assistance and on similar terms. Recipients of its benefits must prove that they are indigent and sign an oath similar to the old-age assistance program. It adds to the increasing drain on Federal and State taxes and penalizes its low-income citizens who must pay these taxes that are used in part to pay the

hospital bills of the indigent for care that some of these poor taxpayers cannot afford for themselves.

The social security plan would be financed entirely from payroll taxes paid by all workers and their employers in industries, which includes nine-tenths of all the workers in the United States. A small percentage of their wages from 25 to 36 cents per week would be collected and put in a fund to pay the major part of their nursing home needs when they are retired. Its benefits would be claimed as a matter of right and not as a matter of indigency or pauperism. This is not a proper plan for dispensing charity. It would not draw on general tax funds. This plan would not introduce socialized medicine and that fact can be proven by a careful reading of the text of the bill by any fair minded or unprejudiced person. Those who fear that this bill will lead to socialized medicine lack facts in the judgment of the American citizenry. They are afraid to touch the people.

The social security law has been in force for 25 years. During that time control of our Government has shifted from one major political party to the other and back again. It has been amended to extend its benefits to more and more workers. Its benefits and its payroll taxes have been increased. It has never failed to meet a payment or obligation that was due. It has never accepted or paid out 1 cent of general taxes. Its cost of admission is about 2 percent. American workers will entrust their payroll savings to this sound institution with full confidence that it will meet every obligation in full and on time.

Thank you.

(The prepared statement of Mr. Luttrell follows:)

PREPARED STATEMENT OF ROY E. LUTTRELL

The vast majority of Americans have come to realize the importance of insurance against catastrophic financial losses as a necessity in modern life.

And the most important domestic issue before this nation today is how to finance adequate hospital insurance for about half of the 17 million citizens over age 65. There will be 18 million in 1963. More than half of them have income of less than $1,000 a year. That is $83 a month. The average social security pension check is $74.

Less than half of these people have health insurance of any kind but they have much greater need for hospital care than younger people.

Private insurance has tried to meet this need but has succeeded only with individuals in the higher income brackets who can pay the high cost of their high risk coverage.

Blue Cross is canceling out its older policyholders by raising the rates and reducing the coverage. Half of the over 65 aged are a high risk group with incomes so low that private insurance cannot give them adequate coverage at a price they can pay.

Old age assistance is not the answer. It is degrading to thrifty, deserving individuals to have to prove how poor they are and sign a pauper's oath to qualify for its benefits. It encourages pauperism and requires an army of welfare case workers to administer it. It is financed from general taxes from our State and Nation and its costs are very great and steadily increasing.

The Kerr-Mills law is financed from general taxes and extends public charity to a few more people in addition to those on ald age assistance and on similar terms. Recipients of its benefits must prove that they are indigent and sign an oath similar to that of the old age assistance program. It adds to the ever increasing drain on Federal and State taxes and penalizes the thrifty, low income citizens who must help to pay the taxes that are used, in part, to pay hospital bills of the indigent for care that some of these poor taxpayers cannot afford for themselves.

The social security plan (H.R. 4222) would be financed entirely from payroll taxes paid by all workers and their employers in covered industries, which

includes nine-tenths of all workers in the United States. A small percentage of their wages, in amounts ranging from 25 to 36 cents per week, would be collected and put into a fund to pay the major part of their hospital and nursing home needs when they are retired, aged 65. Its benefits would be claimed as a matter of right and not as a matter of indigency or pauperism. This is not a program for dispensing charity. It would not draw on general tax funds.

This plan would not introduce socialized medicine and that fact can be fully proven by a careful reading of the text of the bill (H.R. 4222) by any fairminded and unprejudiced person. Those who fear that this bill will lead to socialized medicine lack faith in the judgment of the informed American citizenry; they are afraid to trust the people.

The social security law has been in force 25 years. During that time control of our Government has shifted from one major political party to the other and back again. It has been amended to extend its benefits to more and more workers. Its benefits and its payroll taxes have been increased. It has never failed to meet a payment or an obligation that was due. It has never accepted or paid out one cent from general taxes. Its cost of administration is less than 2 percent. There has never been a scandal connected with its operation. American workers will entrust their payroll tax savings to this sound institution with full confidence that it will meet every obligation in full and on time.

BLUE CROSS INCREASES RATES ON HOSPITAL INSURANCE AGAIN

"DEAR BLUE CROSS SUBSCRIBER: Effective your next billing date, monthly rates for the Blue Cross contract you now hold (non group 80/20 contract) will be adjusted as follows: Monthly rate, single $9.10; family $16.20.

"MINNESOTA BLUE CROSS."

My last premium payment on my 80/20 family contract was at the rate of $13.95 per month. This will be an advance of $2.25 per month. We assume that the same rates will apply to all non group 80/20 contracts with Blue Cross. This is just another of several periodic increases in the cost of Blue Cross hospital insurance through the past 10 years or more. Blue Cross sent along a little booklet to explain the reasons for the increase which it says, "is based on the actual cost of hospital care." One page of the booklet shows a tabulation of the variations in medical care costs in 19 cities of the United States and the percentage of increase of such costs from a base period (1947–1949) to 1959.

Approximate increase in 10 years

	Percent		Percent
Atlanta	42	New York	40
Baltimore	58	Philadelphia	55
Boston	60	Pittsburgh	62
Chicago	56	Portland, Oreg	42
Cincinnati	54	St. Louis	68
Cleveland	68	San Francisco	55
Houston	35	Scranton, Pa	30
Kansas City	70	Seattle	50
Los Angeles	48	Washington	48
Minneapolis	96		

The above are not exact figures. They are approximate, according to the statistics of the Blue Cross booklet. The tabulation also shows that the percent of increase in medical care costs in 1 year, 1958–59 was more than 10 percent. The booklet gave no indication that the present rate of increase would not continue. This poses a grave problem for the citizens of advancing age who are living on fixed incomes that do not increase with the price index. Write to Minnesota Blue Cross, 2610 University Avenue, St. Paul, 14, Minn. Ask for their booklet "Hospital Costs and Blue Cross Rates."

A number of bills have been introduced in our National Congress to provide health care for the elderly at a cost they will be able to pay. Unfortunately this problem has become an issue of partisan politics and the two parties, at the present time, seem to be deadlocked on the issue.

Shall we provide a system of payroll taxation where the workers contribute small sums during their working years to provide hospital care for their re-

tirement years? Shall we insist that aging citizens continue to pay constantly increasing costs for their hospital care in the conventional way until they have reached a state of near pauperism at which point they will be aided by funds provided from general taxation? That question seems to state the issue.

WOULD THE SOCIAL SECURITY HEALTH PLAN INTRODUCE SOCIALIZED MEDICINE?

Well, what do we mean by "socialized medicine"? Under a system of socialized medicine the Government owns and operates all hospitals, nursing homes, and other health facilities and employs physicians and surgeons on a salary basis. That is the kind of medical system they have in some European countries and there is a similar system in some provinces of Canada. Our veterans hospitals are probably the nearest approach to that system that we have in this country.

This bill (H.R. 4222) certainly does not propose that the Federal Government or social security agency will own or operate hospitals, nursing homes or employ physicians or surgeons on salary. It will not pay physicians' or surgeons' fees. It specifically says that beneficiaries shall have free choice in selecting their doctors and any nursing home with which there is an agreement to furnish hospital or nursing home services. Federal officials or employees will not exercise any supervision or control over the practice of medicine or the manner in which medical services are provided or over the selection, tenure or compensation of any officer or employee of any hospital, nursing home or health facility.

This plan will not materially affect or change the present doctor-patient relationship or the present system of hospitals, nursing homes, and home health facilities. It may bring about better systems of health services in some of our poorer and more backward States so that elderly citizens may feel free to move or visit from State to State with assurance that adequate facilities will be available to care for their health needs.

The whole system of hospital, nursing home, and home care services provided for by this bill leaves the doctor in charge; as physician, supervisor, and director of every phase of the services without any interference and with no supervision by the Government.

But this plan will not pay the doctor bill. It will not pay the doctor a salary, a fee or anything whatsoever for his services. This is a plan to enable workers to build up, during their years of active life, by small amounts taken from their earnings (less than 25 cents a week), a fund that will insure them at age 65 that the major part of their needs for hospital, nursing home, and home care will be met without disastrous drains on their monetary resources for the rest of their lives. Then the aging citizen can provide, in some other way, to pay his physician or surgeon. This certainly is not socialized medicine.

A. CITIZEN SR.

[H.R. 4222—S. 909]

THE SOCIAL SECURITY HEALTH PLAN—WILL IT BE COMPULSORY? WHY?

As the bill is now written, it will be compulsory for all workers under the social security system. And we want it that way.

The original social security law is a compulsory savings plan. It takes from workers and their employers, in covered industries, small sums during their years of employment and puts them in a fund to provide a pension for the workers when they are old. There is not now much objection to this compulsory savings plan. In fact there is a demand that it be extended to more and more workers. And this is being done. Social security now covers 90 percent of all workers in this country. But because of inflation and rapidly increasing costs of hospital and nursing home care, many retired people are unable to pay for the care that they need.

We have seen many young people, healthy, strong, and self-confident in their youth, who may say, "I don't want social security. I don't want hospital insurance. All I want is the freedom of the United States, and the opportunities that freedom insures, and I can take care of myself; let others do the same."

We could admire the physical vigor and self-reliance that prompts such declarations, if experience had not taught us that it is foolhardy. Windstorms, floods, fire, earthquakes, sickness, bad habits, misjudgments, depressions, loss of employment, inflation, and war, all operate to frustrate the aspirations of youth and many fail to provide adequately for the necessities of their retirement years.

We are too humane to let them die in neglect and misery. We can relegate them to the category of beggars and paupers or to be taken care of under the old-age assistance law—and many are there now. And the cost of that system is very great and is growing rapidly. And who pays that cost but you and me as taxpayers, even though many of us are struggling to keep ourselves out of the pauper class?

That is why we say that boastful youth should prove to us that we (or our children), will not have to carry his burden and pay his hospital bill when he is old. We want the youth to pay one-fourth of 1 percent of his earnings, about 25 cents a week, to be kept in a fund to insure him hospital and nursing home care in his retirement years and let him still retain his freedom and his self-respect.

WOULD THE HOSPITAL INSURANCE BILL, H.R. 4222, PROVIDE BENEFITS FOR RICH PEOPLE WHO DO NOT NEED THEM?

Opponents of the bill often make the statement that "the bill would provide benefits for rich people (even millionaires) who are well able to pay their own hospital bills and that it would leave unprotected many poor people who need help."

This is a subtle appeal to class prejudice. Most people, of course, are not rich. And it is human nature to envy or feel prejudice against those who have more of the world's goods than we ourselves have. This prejudice is felt especially against the "idle rich" who seem to have a liberal share of the good things of life and produce nothing.

There is a subtle inference that under this bill the Government would spend tax money to pay hospital bills for rich people who can take care of themselves while denying help to poor people who need assistance.

Let us lay aside our prejudice against the rich and be fairminded. Let us consider the facts in this case.

In the first place this bill (H.R. 4222) is not intended to provide charity for anyone, rich or poor. It is proposed as a new way for people to provide hospital insurance for themselves in their later years when they usually need it most. They will pay during their working years and receive the benefits in their retirement.

Some well-to-do or relatively rich people work. It is possible for them to earn wages or self-employment income and if they work in industries where the workers pay social security payroll taxes, they will pay such taxes just as other workers do. That would make them eligible for social security benefits which they have earned and paid for. At age 65 they would have a paid-up policy for hospital and nursing home care for the rest of their lives. What's wrong about that? If they work and pay their payroll taxes, they are entitled to the benefits they have worked for and paid for, just like other workers. We think that is fair and just.

In effect the Government would collect small sums (25 or 30 cents per week) from all workers in "covered industries" and put them in the social security trust fund. When a worker who has attained to age 65 and is retired, needs hospital or nursing home care, the Government (social security) would take money from the social security fund and pay his hospital or nursing home bill.

The social security law has been extended several times to cover more and more people. About 90 percent of all workers in this country are now covered by social security. The law will, without doubt, be extended again to cover still more workers and this will reduce the number that must be cared for by private or public charity.

Benefits under this bill would be paid out of funds collected from the workers during their working years. They would not be paid from general taxes or from income taxes but from payroll taxes collected from workers who will ultimately receive the benefits.

The "idle rich"? They will get nothing from this bill. This is for people who work.

Senator LONG. It has been pointed out to me that there are representatives of some groups composed of people who are not 65 but who are dedicated to the problems of the senior citizens. I don't want to limit it entirely to people over 65 but I don't want our younger

people taking over the entire program. We want to hear primarily from the older people but we will hear from some of the younger people who desire to be heard. I do want to come as near as we can to limiting it to 2 minutes so that we can expedite these various people. Some of our staff people will be out in the audience to pick up people who want to speak.

STATEMENT OF A. SCOTT HANCOCK, PRESIDENT, OLD GUARD CLUB OF MINNEAPOLIS

Mr. HANCOCK. My name is A. Scott Hancock, president of Old Guard Club of Minneapolis, an organization of 550 retired men, representing about 150 different vocations. However, I speak as one individual because of club laws which prohibit political discussion as far as the club is concerned, but it is my opinion that at least two-thirds of membership are in accord with my thinking.

Mr. Chairman, I rise to present my views in support of the hospital and medical aid bill, better known as the King-Anderson bill H.R. 4222, under the social security structure, for the care of retired citizens.

I am convinced that this bill is the answer for protection against the high cost of medical aid for untold thousands of retired people who have had to neglect their much needed medical care because of their low income, though they may own their own home, with high cost of upkeep and taxation, are forced to endure uncertain and miserable conditions in their senior years, because they have been unable to pay for medical aid; especially the widow who has been left to carry on alone, because of her small income, and huge medical expense, is often forced to dispose of the only possession left to her, her home, and is often, yes, very often, placed at the mercy of charity, which must be supported by funds from the public, and is alone and forgotten when she should be enjoying the golden age, and could if this bill is enacted.

Gentlemen, figures are and have been available for some time as to the method in which this is to be supported if enacted into law, and that is by the already proven social security system, without any cost to the Government or taxpayer and will do away with many of the new existing charitable organizations and their continuous plea for funds from the public, which is many times very painful, because if treatment can be had at an early stage, much suffering and heartache can be, and will be, avoided and senior years can be spent at home in happiness and peace.

It is, of course, opposed by the AMA and is about to be kicked about like a football by some big interests and politicians, but there are many, many organizations who favor this bill and are anxious to see it enacted into law along with myself.

Senator LONG. Thank you, Mr. Hancock.

STATEMENT OF RAYMOND GANYAU, MEMBER, SENIOR CITIZENS COUNCIL OF MINNEAPOLIS

Mr. GANYAU. I am Raymond Ganyau, I am a member of the Senior Citizens Council of Minneapolis, and one or two senior citizen clubs.

We have heard through the day a lot of things said about housing, nursing homes and congregate care homes, and boardinghouses, and

things of that kind, but there has never been anything said about a certain segment of our senior citizen group, and there are a great many of them, and I am talking about the people that are left alone. We will say widows, for example, the family is gone, the husband is gone, they are left with a great large ramshackle house, three or four bedrooms on two floors. They are not physically able to take care of those places, they are not financially able to. They are good candidates for boardinghouses and nursing homes.

We have the couples where one is perfectly healthy and able to do things, but the other is slightly handicapped through health. They also do not have financial means to support the home that they have now. They are not able to take care of maintenance of that home due to physical disabilities. They are forgotten. They are candidates for nursing homes and boardinghouses, and they will get there soon if there isn't a helping hand extended to them so that they can carry on as independent individuals in their own homes.

Now, I believe, I think I have talked to a great many senior citizens that would like some way pointed out to them whereby they could dispose of this big white elephant of a house or the other one that they can't take care of and take their small money and invest it in some sort of independent housing. Now, I do not mean that they are looking for isolated small-cost homes, low-cost homes, they are more interested in the communal type of housing where they can have the social contacts with people of their own age, and we get into things of that sort.

We have the real low income people who are very well taken care of in our low-cost public housing. They can get in, and they have wonderful facilities here in Minneapolis. Our high priced housing is for the wealthy people that can get into these foundered types of housing projects where they have to put down, oh, anywhere from $15,000 to $30,000, and their monthly maintenance runs as high as $300 or more a month.

Well, the segment that I really think needs some encouragement, some help somehow, are the people that are in this middle segment. They are too rich to get into low-cost public housing, they are too poor to get into expensive high-cost housing, and they are sitting in houses alone. They are lonesome, and lonesomeness, we have been told by some of our very fine educated people, is one of the main things that put people in nursing homes and congregate care homes.

Now, if something could be done to give these people encouragement, some way to encourage either nonprofit organizations, such as churches that are building nursing homes, to include this type—we have one example of that in the Wilder Foundation in St. Paul. I have information from another one in St. Paul, the Lutherans are contemplating building that type of facility on North Pasco Street. But I believe we should find some way to let these people know that they are not forgotten senior citizens. Thank you.

Senator LONG. Thank you for bringing that interesting phase of our problem to us.

You say they are either too rich or too poor, as we say in Missouri, between the devil and the deep blue sea.

STATEMENT OF MRS. JOSEPH NATHANSON, PRESIDENT, MINNEAPOLIS SECTION, NATIONAL COUNCIL OF JEWISH WOMEN

Mrs. NATHANSON. I am Mrs. Joseph S. Nathanson, president of the Minneapolis section of the National Council of Jewish Women, representing the Minneapolis and St. Paul sections of the National Council of Jewish Women. The two sections have a combined membership of approximately 2,000 women. A major part of our program, both nationally and locally, is concerned with the problems of our senior citizens. We were the founders and sponsors of the Minneapolis' Council House for Senior Citizens, which is a nonsectarian recreational center for older adults; we are presently the cosponsors of an extensive Golden Age program at the Jewish Community Center of Greater Minneapolis, where we give both financial support and volunteer service. We also sponsor a Leisure League for Retired Adults in conjunction with the Jewish Community Center in St. Paul. We have studied the problems of our older adults in our study groups and have taken action in support of legislation which we have felt would increase the security and dignity of our aging population.

In February 1960, at a members' meeting sponsored by our Social Legislation study group and attended by 50 women, we discussed medical care insurance programs with representatives from the American Medical Association, Blue Cross and one of the commercial insurance companies. This group of women ranged in age from 25 to 70 and were from the middle income and higher middle income group. At the conclusion of this meeting, it was the overwhelming sentiment of this group that a medical insurance program under the social security program would be the best means of providing adequate medical care for our older adults. It was strongly felt that however well-intentioned these programs are, they are not structured to meet the increased health needs of our increasing older population.

It was expressed at this meeting that most older people could not afford the premiums for adequate health coverage in their retirement years. It was also felt that in the event of a catastrophic illness involving an older parent, most families would have difficulty recovering from the disastrous financial effects resulting from a long-term illness. In addition, most families in this particular middle income and higher middle income group would find turning to a public agency for medical assistance a humiliating experience.

In March 1961, the Jewish Community Center of Greater Minneapolis and the Jewish National Welfare Board cosponsored a five-city older adult program, which included Minneapolis and St. Paul. The workshop unanimously agreed that medical care under the social security program should be enacted, and the entire assembly of the five-city conference passed a resolution on March 14, 1961, supporting President Kennedy's plan for integrating medical care into the social security system.

The National Council of Jewish Women testified in August of this year before the House Ways and Means Committee on behalf of medical care under the social security program. Their testimony was based on the results of a survey of medical costs among the members of council's Golden Age recreation centers and participants in other council-sponsored programs for the aging in 200 communities across the country.

It was concluded from this survey that a program of social insurance which places a small financial burden on everyone would relieve many older people of the worrisome burden of meeting staggering medical bills which they can ill afford to pay.

The Minneapolis and St. Paul sections of the National Council of Jewish Women reinforces the position taken by our national organization in regard to medical care under the social security system because of our own experiences in working and talking with older people, and also because of our discussions with members of our own group. We therefore believe that a medical care program which enables people to insure themselves through their own efforts against the prohibitive costs of illness in their later years would contribute substantially to the dignity and security of their later years. Thank you.

Senator LONG. I am sure that you and members of your organization realize a great feeling of satisfaction for this fine work that you do in helping the senior citizens in their golden years. It is a satisfying service that you and your organization render.

STATEMENT OF REUBEN ERICKSON

Mr. ERICKSON. I am senior citizen Reuben Erickson.

For 34 years I have been in a general medical practice in this city. During that time I have taken care of many senior citizens over long period of illnesses. I am qualified for social security, and I found that my wife and I, if we went on social security, now would get $135 a month, and, of course, I could make $100 more on the side. But I also have investments so that if I went on social security, I could have an income of $600 a month, and we probably would get along fairly well on that money, but I don't intend to go on social security because I want to work as long as my health holds out and as long as I can take care of other senior citizens like myself.

Now, don't you honestly think that it would be ridiculous for somebody with an income like ours to become beneficiaries of this legislation that we are talking about today?

However, on the other hand, I have a brother, he is a retired farmer, retired before farmers got social security. He has a very small income, he lives with my sister.

Now, he cannot get any benefits from the King-Anderson bill. It is up to his brothers and sisters to take care of him, and I may say that we have always taken care of our own up to this time. My mother and father and sisters and brothers, we have never needed any outside help.

The other recourse, of course, he would have to go to the old-age assistance, which, I may say, in this State is functioning very, very well. I found that out by taking care of many patients. Now, isn't it kind of ridiculous that my brother, who is in need, or may be in need, can get no benefits from this legislation, whereas my wife and I, who do not need it, would get a whole lot of benefits?

It seems to me that it is sort of a type of segregation here between two different groups of people, those that have and those who have not. And I don't think it is fair. Now, just before I came over here, I had in my office a Mrs. Wall, 81 years old. I have taken care of her for many years. I have had her in hospitals and rest homes. She has always been satisfied with our old-age assistance. I have always been

satisfied with the pay I have received from the welfare department. And when she gets sick, she wants me and she wants her own hospital. And under the King-Anderson bill, you don't have a choice of hospital unless the hospital has already pledged to be on the program. And I think that we should think of these things. And I like Mrs. Wall, and she likes me, and we would like to continue the way we are. She doesn't want this legislation here. Thank you.

STATEMENT OF J. N. GROVES, LEGISLATURE GOLDEN COMMITTEE, SENIOR CITIZENS COUNCIL

Mr. GROVES. My name is J. N. Groves. I live at the Minnesota Soldier's Home. I am from the Legislature Golden Committee of the Senior Citizens Council.

There are thousands of people in Minneapolis who are living on old-age assistance only, which, at most, provides $71 a month. This low-income group constitutes the largest group, and they have great difficulties in being able to take care of their expenses on this meager income.

Most people try to provide some means of support for their future, but when long periods of hospitalization are followed by death, it ofen exhausts the savings that a couple were able to accumulate and leaves the remaining one of the couple exhausted physically and financially.

Many of these elderly people are in poor health, lame, mentally disturbed to the extent that they cannot properly care for their own needs.

They may have grown children who are not able to assist them financially or are just not inclined to render any financial or personal aid. We must remember that these pension and aid plans were inaugurated, in the beginning, to enable elderly people to be able to live alone as long as possible and maintain a degree of respect for themselves.

And their children and relatives, for the most part, are willing to let the situation stand that way rather than burden themselves with the responsibility of caring for their aging relatives.

This is a common practice, and not the exception. Also, in many instances, elderly people have great pride and dislike very much to call on their children or relatives for aid. Some would rather die a pauper's death before they would ask for aid. Asking for aid from their children, in many cases, would be taking benefits and perhaps necessities from their grandchildren, and this, to them, would appear intolerable.

Many elderly people are in need of hospital care, but refrain from going to a hospital because they cannot afford it. A short stay in a hospital such as for an operation, badly needed, might prolong their life and provide more comfortable living for several years.

My belief is that people in the lower income group should have a somewhat larger income to provide at least the necessities of life. Also, people in the lower income group should be able to have hospital care provided at no cost to themselves.

I am much in favor of the low-cost housing projects provided by our Government. However, there are many needy people who would

have difficulty in paying the rent for an apartment in one of those low-cost housing projects unless their present incomes were raised.

Retirement is forced on many people by ill health and, under those circumstances, they have very little chance to add to their incomes after retirement.

Senator LONG. Mr. Frank Adams has asked for 2 or 3 minutes. Mr. Adams is here now. We will be glad to hear him.

Is Mr. Adams in the audience now?

(There was no response.)

Senator LONG. We will hear another witness.

STATEMENT OF MYRTLE HARRIS, UNITED AUTO WORKERS UNION

Miss HARRIS. I am Myrtle Harris from the United Auto Workers Union International, also representing Minneapolis Central Laborers Union Council Old-Timers Club.

We have many members who are retired and are interested in good legislation for our members and all other people in Minnesota who have reached that age. We can't understand why the medical profession is against medical care for the aged. It seems that the doctors would benefit also. We hope that the Senate committee will recommend this bill to be enacted into law.

Thank you.

Senator LONG. Mr. Frank Adams will now appear.

STATEMENT OF FRANK ADAMS, MINNEAPOLIS CENTRAL LABOR UNION

Mr. ADAMS. Senator Long and Committee on Aging, I am here as a spokesman for the Minneapolis Central Labor Union. I have submitted a prepared statement for your committee.

I simply want to state that it was a great philosopher who stated some time ago that society institutions never stand still, they either move ahead or go behind. It is my feeling that the old method of payment of hospitalization just is not adequate to meet the situation for the aged today. About 18 months ago the Minneapolis Central Labor Union sponsored a petition on which we have thousands and thousands of names in support of the Forand medical bill. We presently support the King-Anderson bill. We support it because we know that this bill eliminates the means test for medical care. We want our senior citizens to live in dignity. This bill will permit them to have this dignity.

We also know that there are strong forces that oppose this bill. Those same forces opposed the social security enactment in 1945 when I was an undergraduate at this same university. They also opposed such things as Blue Cross and Blue Shield, workmen's compensation and other things too numerous to mention.

It is going to take some real effort on the part of many, many citizens to get this legislation enacted.

I want to tell you, Senator, that as a spokesman for the Minneapolis Central Labor Union we wholeheartedly support the King-Anderson bill.

Thank you very much.

(The prepared statement of Frank Adams follows:)

PREPARED STATEMENT OF FRANK ADAMS

A great philosopher had made an observation that is quite appropriate to this meeting. His observation was as follows: "Society and institutions never stand perfectly still. Either you move ahead or you slip backwards. Improvements, on the other hand, just don't happen without effort. They usually result from a strong will to improve." I am convinced that there is always a better way to handle health insurance for senior citizens.

As a spokesman for the Minneapolis Central Labor Union Council, I strongly believe that we in labor have a responsibility to speak up and be heard and that is the reason for my appearance here today. Your committee has given us the opportunity to state our position in regard to the problem of the aging. I will speak only of one facet of the total problem and so I will confine my remarks to that of medical care for our senior citizens.

First, let me say that the Minneapolis CLUC sponsored a petition about 18 months ago which carried thousands of names in support of the Forand bill. In our opinion the Forand bill held out hope for medical care for our senior citizens without the stigma of the means test. Candid observers recognized that the Forand medical bill involved the difference between constant peril and peace of mind between humilation and dignity, between pauperism and true social security.

The Minneapolis Central Labor Union now supports the Anderson-King bill. No doubt this bill will be up for consideration in the next session of Congress. We support this bill for the following reasons: (1) paying for health care through social security is the only commonsense method of minimizing the tragedy that illness imposes on older people; (2) benefits can be the same no matter where the patient lives and he can choose his own doctor and hospital; (3) the new Federal payments can supplement whatever he or his children provide through individual effort and resources; and (4) financing can be assured through a small increase in social security contributions by people still working. Persons already retired would pay nothing but would share in the new program just as they have in the past improvements of the old-age survivor's and disability insurances.

Those who state that there is no need for such legislation can refer to various studies. For example, the Brookings Institution recently published a study of Herman Somers and his wife, Anne Somers, a husband and wife team of economists. Their findings stated that medical costs of the aged appear to average about one-third of their income, while existing insurance plans, they conclude, pay no more than one-sixth of the cost for those who actually have some insurance coverage, and meet only about one-fourteenth of the total medical costs for the aged as a whole.

In the April 11 issue of Look magazine, Roland H. Berg, medical editor, wrote the following: "The financial and medical problems of men and women over 65 are obvious. More than half of these 16 million Americans live on incomes of less than $20 per week. More than two-thirds get along on less than $40 per week. This compares with the $100 a week income of the average wage earner under 65. While struggling along on reduced incomes, the aged face bigger doctor and hospital bills than their juniors.

Still another aspect of this matter of payment for health insurance like any term insurance is that one of the chief causes for the continuing sharp rise in their premiums is the fact of the high cost of hospital care for the aged. So in an indirect way, wage earners are already absorbing a significant part of the hospital care of the aged. It is our studied judgment that social security offers a less costly method of financing health care for the aged for it would tend to level off the rise in medical insurance premiums, and in addition could open the way to wider benefits for persons covered by such insurance.

The process of changing and modernizing existing institutions is not an easy one. We recognize that strong forces oppose change. These forces opposed the social security concept back in 1935; they opposed Blue Cross and Blue Shield, workman's compensation, and many other such programs too numerous to mention.

Labor has always been in the forefront for sound, progressive social legislation and for that reason we now urge the pasasge of the Anderson-King bill.

STATEMENT OF MARY STOLZE

Mrs. STOLZE. My name is Mary Stolze. I am an ex-teacher, public health nurse, plus woman farmer. I have worked since I obtained employment between the years of 1913 and 1957, with the exception of one year just before my husband died and I have been working before and since.

I thank you very much that you have arranged this wonderful opportunity for the senior citizens to be heard and to give a true picture of their needs and problems. Though the senior citizens have many needs and problems, I also want to say that I am from the legislation club that studies the needs of senior citizens. I do give priority to the social security health plan, H.R. 4222, the King-Anderson bill, because there is an urgent need for it, and also I feel it is the only health plan for senior citizens so far that treats senior citizens like good citizens, as persons who have worked most or all of their lives and have made vast contributions to society and should be treated, a plan that preserves their dignity and gives them the security that they deserve. It is not based on need, which to them means sickness and charity, but instead it is a savings and insurance plan, at least to me, to be used when their earning days are over, the same as retirement plans are. It is a safer way to save for this purpose which is almost impossible to save for any other way.

Less than half of the aged have insurance of any kind. They either can't get it or they can't afford it.

The Kerr-Mills bill law is a tax law paid for through taxation by you and me and by a large number of our senior citizens who own homes and who have a tough time paying the increasing taxes to avoid losing their homes, yet senior citizens know the value of money and can budget until major illness strikes, and then they are penniless. Next follows a lien on their homes which gives them a feeling that the home is no longer theirs because there is practically no way of redeeming it at this age when their earning power ceases. No wonder statistics show that older people have two or three times as much hospitalization as young people do, especially those in the lower retirement income bracket. A shock like this can do it. We know that mental and emotional stress causes much illness. Legislation like the Kerr-Mills bill causes unhealthy attitudes among the senior citizens. They sign their homes and their possessions over to their friends and relatives who often leave them stranded. They are tempted to hide and spend their money to avoid having it snatched from them almost instantly when illness strikes.

Much of this could be avoided with the aid of a health plan like the social security plan, H.R. 4222, which would enable senior citizens to pay for their own health needs, rather than to be penalized and to be forced to accept charity through a taxation plan like the Kerr-Mills bill and similar plans. Thank you.

STATEMENT OF ALMA SMALL, PRESIDENT, SENIOR CITIZENS CLUB

Miss SMALL. Senator Long, committee, and ladies and gentlemen, this is the testimony of Alma Small. I am the president of two senior citizens clubs. I am happy to be here, and give my wholehearted sup-

port to the proposed bill H.R. 4222, which would provide medical care for the elderly people under social security. Little has been done to help those on social security. I was one of the first ones to sign up on social security back in 1936 and started paying in 1937. They made it a law. It was a compulsory law then that the employer hold back a small percentage of our wage to pay into this new social security plan. It was a compulsory plan, and that is the way we want it.

Why can't we have a compulsory plan to take care of our senior citizen who now needs medical care? Medical and hospital insurance keeps raising the rates until we can't afford to keep them up.

In 1936 I was paying 75 cents a month for Blue Cross; now I am paying $100 a year. In 1957 the Blue Cross and Blue Shield together was $17.10. In January of 1959 the cost raised to $20.40; in December 1959, $23.10; in February 1960 the Blue Cross alone was $16.05. In December 1960 the Blue Cross raised to $19.50. Now 1 year later, it raised another $4 which is $23.10.

Living expenses have gone out of sight and we don't have that weekly income any more.

Senator LONG. Are those figures per month or what?

Mrs. STOLZE. Per quarter.

I also think the minimum payment of social security should be raised to at least that of the old-age assistance program in this State, which is paying $71 per month with free medical expenses.

I started working for myself in 1943, and at that time we paid no social security on ourselves, and I never heard tell of freezing the wages, so the average of my wages went over a number of years. Now I get $47 social security and that doesn't go very far these days. So I say raise the minimum of social security as well as the proposed bill H.R. 4222. I appreciate you coming here to hear us. Thank you.

STATEMENT OF LUCY COBB, MINNEAPOLIS FEDERATION OF SETTLEMENTS

Miss COBB. Senator Long and members of the subcommittee, my name is Lucy Cobb and I speak for the Minneapolis Federation of Settlements.

We consist of seven settlement houses in Minneapolis. We have clubs for social and educational groups of older people throughout the city. We know how badly services are needed to compensate for the devalued dollar. Hospital services here were the highest in the country. Savings were quickly used up, and rates of insurance made policies prohibitive with fixed incomes.

There is need for medical insurance on the basis of social security. The Federation of Settlements favors the passage of the King-Anderson bill as the fairest way to solve this problem for our entire population after retirement.

Thank you very much.

STATEMENT OF HELGA FLYNN

Miss FLYNN. My name is Helga Flynn. I would like to speak to you for medical insurance as provided in H.R. 4222.

There are many senior citizens who have worked hard all their lives for small wages and haven't been able to accumulate a large bank account. They have tried to keep up their medical insurance, but the prices have been raised so high in the last 5 years that many have had to drop their insurance.

In 1956 when I quit work on account of my age, the cost was $16.50 for 3 months for doctor and hospital; now it has raised to $33 and some cents for 3 months. And when I paid $16.50 it was a $25 deductible insurance. Now I have to pay 20 percent of all hospital bills. No wonder the old folks are getting worried about what they are going to do to pay their bill. Thank you.

STATEMENT OF MARY HEGG, LEGISLATIVE CLUB

Miss HEGG. I am Mary Hegg. I am representing the Legislative Club.

The root of my troubles started during the depression. It put me in the hospital for 7 months. After many years of chronic heart trouble my husband passed away in 1947. Five years ago my little brother died after suffering from a chronic arthritic condition. Then last year I had the responsibiilty of caring for until death one of my lodge members. You wouldn't believe how expenses can mount through the years of illness. Returning home I found an eviction notice; the building in which I lived was to be razed and only 2 weeks in which to get ready to move. It was the middle of winter. To find a place I answered ads, telephoned, advertized, and walked miles looking and found nothing suitable for what I could afford to pay. You should be surprised at what I was shown. Some people do not know how the other half lives. Due to high rents many were using their apartments in day and night shifts. Tenants were to do their own decorating, rents were exorbitant, a $35 apartment is now $85. The simplest apartment is over $100. It was indeed disheartening not to find a reasonably decent place. I was utterly discouraged, as moving day was near. Finally a friend advised me to send my eviction notice to the development authorities. Their response was immediate and they gave me a choice of an upper or lower apartment. I chose first floor, brand new, warm as toast, with three picture windows looking over a spacious lawn. You can't know what a relief this was to have a place at last.

But my worries were not over and the building in which I lived was already being demolished. I simply had to get out. What stared me in the face were accumulations of years. There were grandmother's cherished things, mother's precious possessions, as well as my own. My new apartment being small, I had to dispose of loads of stuff, give much away and sell for little or nothing. My $1,600 mahogany dining room set went for $35; an almost new oriental rug, $300; authentic oils for a song, as did my Limoges Belgium china and other imports. Even now I miss some of my nice things, especially my baby grand piano. But I really don't mind as there are many in the same boat with me and not nearly so lucky.

I wish to say that I am grateful to the housing and development authority for my reasonably nice apartment. I hope they will build thousands. Ours is a rich, vast country with unlimited resources and

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with good management every good citizen throughout the land desires a comfortable home.

Right here I want to thank the housing authority for giving me a lift when it was most needed.

In closing I wish to thank our honored guests for what they have done and what they will be trying to do for our senior citizens. Thank you.

Senator LONG. From here on we are going to have to stick rather closely to our 2-minute rule. Our time is fast running out. We want to give everyone an opportunity to be heard and I am going to ask my assistant here on my right to keep time. We will appreciate it if you will cease as the 2 minutes are up.

STATEMENT OF MRS. OSCAR MALVICK, CHAIRMAN, AIKEN COUNTY COMMITTEE ON AGING

Mrs. MALVICK. Senator Long, I was born down in the Ozarks, Springfield, Mo., but now I am from the Jack Pine country, north of here about 130 miles. I am Mrs. Oscar Malvick. I am chairman of the Aiken County Committee on Aging.

I think enough has been said about the health insurance. We have a day center we haven't paid for. We have a hostess 6 days a week One day we have hobbies, another day music, another day pictures, another day birthday clubs. Now, what we are trying to do is prevent them from going into nursing homes, and we know of four, if it hadn't been for this day center, would have been committed.

We have organized four golden age clubs over the country and last Saturday they sold their hobbies, those that had made hobbies, they sold them. We also had a food sale, and through the cooperation of our county commissioners our very efficient social welfare leader, and our businessmen and the different organizations, we have about $4,500 in this day center and we have money on hand. We have still got to keep raising money in order to keep this going. But it is gratifying to know that these older people, this is what they need. Finance is what makes a lot of people sick. I know during the depression of 1929 and 1930 we were almost wiped out. And my husband and myself—he is 70 today—he is still working, neither one of us has taken social security. We will when the time comes when we have to. But I don't think there is enough consideration given to our talented old people.

Thank you.

STATEMENT OF MRS. E. M. DESSLOCH

Mrs. DESSLOCH. Senator Long, members of the committee, I am Mrs. E. M. Dessloch from Wisconsin. I manage two nursing homes in that State.

There does not seem to be any problem as far as finances are concerned. We have both private and welfare patients. The private patients take care of themselves and any needy patients are taken care of by the local welfare department. The nursing care is excellent and there is a good recreational program. The surroundings are pleasant and the patients appear happy and contented. As I have already stated, there does not seem to be a great problem. Thank you.

STATEMENT OF MRS. E. M. RUSTEN

Mrs. RUSTEN. I am Mrs. E. M. Rusten, Wayzata, Minn. I am a registered nurse and have done work in the field of social welfare for 20 years, this is public housing, medical problems of the aged and supervising the aged.

I recognize that there are unmet medical needs for our senior citizens. I believe this is a State responsibility to care for these unmet needs and only financial assistance should come from the Federal Government, regulatory powers should remain with the States. Provisions for such action are made possible through the Kerr-Mills law. I see no further need for legislation in this field.

I defend my position in opposition to Federal Government as citing, for example, the experience here in public housing. Here is an example of what happens when regulations come from the Federal Government: 15 years ago I spent much time getting permissive legislation for public housing in the State of Minnesota. What is the situation today in Minneapolis? Hundreds of our aged on old age assistance, receiving $71 a month, for whom public housing was originally designed, are living in substandard housing while people with over 3½ times this income are permitted to live in public housing. This is inequitable.

I consider it a privilege to have this opportunity to air my views.

STATEMENT OF T. A. GUSTAFSON

Mr. GUSTAFSON. T. A. Gustafson, living in Minneapolis, former teacher and insurance man. I am happy to be here.

I have been on the legislative committee for the last month or two and in that capacity I have learned a great deal about all of these organizations that have been discussed this afternoon.

I am reminded of the story, in which you all remember, regarding the four blind men who came upon an elephant. After feeling of the elephant they afterward discussed what the elephant is like. You know the story, one felt the leg and said he was like a tree; the other felt his side and said he was like a house, and so forth. You know the story. We are also happy to live in a country where free speech still prevails. We are also encouraged to express our convictions on controversial questions, as I have been led to understand this meeting is for the purpose of letting our leaders hear from the grassroots, so to speak.

I assume you are all familiar with the provisions of the Kerr-Mills bill passed by the Congress of the United States. Under this bill the U.S. Government would aid the States in a financial way. Minnesota could or would have benefited to the amount of $200,000 this past year if Minnesota had accepted it, that is, by the legislature. Now, that is gone for this past year but it could be taken up again. The amount is determined by the services each State elects to provide. This would put the administration of this bill under State control instead of the U.S. Government at Washington. At present more than half of the States are implementing this bill in some form or other. Thank you.

Senator LONG. You mentioned the story about the elephant. Of course you know my politics, but we know that the Republicans get old the same as we Democrats. We are not supposed to speak politics.

STATEMENT OF MABEL LIPE

Miss LIPE. My name is Mabel Lipe. I live at 11 East 17th Street. And if I do anything I have to do it myself. I have no storm windows. I have to put paper over the windows so I don't freeze myself. And President Kennedy promised to raise our old age assistance, but he hasn't done so.

We need our bus tokens and fares lower, too.

I was a widow. When I lost my husband, at that time they didn't take social security out of our checks like now they do.

Thank you.

STATEMENT OF MRS. VIRGINIA URINGA

Mrs. URINGA. I am Mrs. Virginia Uringa.

I head a committee, a steering committee, that has studied the feasibility of combination nursing and retirement program. We find there is a dire need for care for our senior citizens but we find a blank wall for financing. Why are the requirements for the Hill-Burton or FHA so high? We feel that they do need a comfortable, well-kept home.

We try to keep senior citizens closer to home where they can be happier and have closed contact with friends and relatives. We had some people who had to be put in rest homes too far away for this contact. These are the ones that started us worrying about our older senior citizens. Thank you.

STATEMENT OF LEO BARTHELL, COMMISSIONER, WRIGHT COUNTY

Mr. BARTHELL. Senator Long and committee members, I am County Commissioner Leo Barthell from Wright County. I have been serving on the welfare board for some 20 years, and in Wright County we have three nursing homes and the plans were just completed and the contract was let for a 60-bed nursing home under the FHA loan.

I do admire, respect, the old people very much, also the labor movement and what have you. In Wright County, as the statistics read, we had over 15 percent of the people over 65 years of age, and I think we have been giving all of the best of care that they are entitled to. We try to keep them satisfied, and if there is any case where one has been denied, we use the whip on somebody else who can support them. Furthermore, as I said, I do admire and respect the older people and all the people who were here respecting the aged and so forth, but I am representing a group which is not called the citizens group but it is a tax group that has to pay the bills. Furthermore, like I say, I do admire and respect the old people but I do also admire and respect and feel that we owe an obligation to the people behind us. I have sons, grandchildren, and who is going to pay the bill? I am 60 years of age and undoubtedy will be eligible for social security at 62 or 65,

but, nevertheless, if all of these programs are going to be discontinued tomorrow, somebody else has to pitch in and take it over.

Thank you.

STATEMENT OF JOHN KOORN, OLDTIMERS GROUP, CENTRAL LABORERS UNION, LOCAL NO. 7

Mr. Koorn. My name is John Koorn. I represent the oldtimers group of the Central Laborers Union, Local No. 7. I have been a member for almost 40 years. We don't come here to beg for anything, but we have spent billions and billions of dollars to relieve the suffering in foreign countries, and we would like to see this law enacted to give more security to the unfortunates of labor under social security, who without any fault of their own, have become in such a condition physically that they cannot work any more and perhaps can't take care of their own selves. It would be a great blessing and it would be a humane act of Congress to pass this bill for those who have labored so long and were not able to save enough to take care of themselves in a very honorable manner. We come here in honor, we don't come here to beg. I think it would be a blessing for this country as well as in Scotland, as it is in England and anywhere else. My sister was in the hospital twice in 14 months with a very high bill and it must be paid. I think we need it. Thank you.

STATEMENT OF WILLIAM HAUGEN

Mr. Haugen. Senator, ladies and gentlemen, as a citizen of this land of the free and the home of the brave and especially the brave, since our freedoms, inherent rights and so-called equality all have been and are today dependent for assistance on brave men who blazed the trails and led the way through the wilderness, hence, for this reason, I would like to say a few words in their behalf, as very often they became the forgotten men, the so-called senior citizens of today. However, in speaking in their behalf, I would like to believe I speak for all the people as we are bound together in the bundle of life where an injury to one is an injury to all. A new golden rule of a true enlightened self-interest must become the guiding star of the people and the representatives in the legislative halls of the Government. If capitalism is to survive it must become a people's capitalism, with a government of the people, by the people and for the people. As soldiers on the high seas in the First World War we were told that we fought to make this world safe for democracy, a democracy forever on the move, obedient to eternal law of change. Time and events in the last 40 years have convinced most people that this is true.

Senator Long (interrupting). Your time is up.

Mr. Haugen. Thank you.

STATEMENT OF MRS. HAROLD ANDERSON

Mrs. Anderson. Senator, I am Mrs. Harold Anderson. I am just a mother of five children and it is on behalf of those five children that I would like your attention this afternoon. We have been trying to teach our children that freedom is worth preserving. We have tried to teach our children that our forefathers left security, they left all

security, social security, all material security for what? For freedom.

I would suggest, Senator Long, that under the Kerr-Mills law all of us who feel just as keenly, perhaps, I would suggest that all of us feel as keenly for the welfare of our senior citizens for whom we have great respect and let us give the Kerr-Mills law a chance to prove what it can do for our senior citizens and for our children and for ourselves if we reach the age of 65. Thank you.

Senator LONG. I would like to inqure, do you anticipate that you will pass legislation in Minnesota to come under the Kerr-Mills bill?

Mrs. ANDERSON. I would hope that Minnesota would, to every extent possible, make use of the Kerr-Mill law.

STATEMENT OF MISS MARIE HOAGLAND, PRESIDENT, UNITED HEALTH WORKERS OF AMERICA

Miss HOAGLAND. Mr. Chairman, I am Marie Hoagland, president of the United Health Workers of America, and president of the oldtimers group which is made up entirely of people that have been former union members.

We of the oldtimers club are in accord with the Minneapolis Senior Citizens Club insofar as the care for the aged and medical care through social security. Minnesota, I believe, has the highest rate per day of hospitalization. While working I belonged to a group insurance, but when my place of business moved out of the State I was dropped and had to go into the single group which does create quite a hardship and at one of our meetings some of our members who had been visiting in foreign countries stated that Sweden, Norway, Denmark, and England have a better way of taking care of their senior citizens than we have. I didn't check this but I am just giving this information. I believe the United States should be in the lead rather than to be lagging.

I didn't come prepared, but I would like to say this. I have been in the hospitalization since its inception and I find now that I have to pay more than I did before, and being that my working, my earning capabilities now are such that they are nil, therefore I am almost unable to pay my hospitalization. I would like to ask some of the people who are not in accord with this, we people are too young to be sitting around twiddling our thumbs and too old for work according to age statistics, and I would like to know what they are going to do with us. Thank you.

Senator LONG. The next gentleman who will testify will be the last gentleman who we will be able to hear. It is almost 4 o'clock now. I am sorry that we haven't been able to hear everyone who wanted to be heard.

STATEMENT OF DR. C. A. OLSON, BALDWIN, WIS.

Dr. OLSON. Senator Long, my name is Dr. C. A. Olson. I come from the neighboring State of Wisconsin, and I am not representing any particular group. That is Baldwin, Wis., 35 miles from St. Paul.

I am here representing the general practitioner. I feel I am one of the vanishing tribe of family doctors and general practitioners. And you have heard repeated statements that the doctors are not

for the care for the aged. That is not true. I assure you that we doctors at the family level are certainly most interested in the care of the aged. However, I read in "The Case for Socialized Medicine" by a man named Tucker, who, I believe, was intimately associated with the Socialist Party, and he says this is definitely socialized medicine. And I read where the doctors have left England because they were fined for prescribing medicine for their patients. I read where the family physician in England is not allowed to follow his patients in the hospital.

You heard the story about Humpty Dumpty, where he fell down and couldn't be put back together. Perhaps that's what the majority of the people want. If so, we doctors will do our best to take care of you, but I personally am opposed to any form of socialized medicine because it is not going to be for the best interest of my patients.

Senator LONG. Ladies and gentlemen, booing or that kind of conduct is beyond the dignity and the appreciation that I have for senior citizens. I hope that you won't do that.

I want to say to you or anyone here that I am just as bitterly opposed to socialized medicine as any doctor might be. For myself, as a member of this committee, socialized medicine as they have it in England, I am opposed to. So it is a matter of interpretation. But I do hope, while we are enthused about our particular viewpoint, I hope any witness that appears before a Senate committee will realize it is entirely improper to express yourselves that way.

It is nice to be here in Minnesota. You have been very kind and courteous to us; you have been very helpful to the committee. And I am sure that there are many of you here who would have liked to have had the opportunity to speak, but I didn't get to you. Many of you wanted to, but because of the necessity to adjourn at 4 o'clock, it was impossible to do so.

Our committee wants to hear from any of you who have any thought on this matter, so, if you do have any statement that you would like to make, you will find on the table here sheets of paper that have been prepared for you. There will be envelopes there. They don't require a stamp. And if you will mail them back to me, they will go into the record and will be considered by the committee and by the staff as your views.

At this point I will insert in the record, various communications we have received and statements of people who were unable to appear before the subcommittee due to the time schedule.

PREPARED STATEMENT OF MORRIS HURSH, COMMISSIONER OF PUBLIC WELFARE, STATE OF MINNESOTA

FINANCING MEDICAL CARE FOR INDIGENT PATIENTS IN NURSING HOMES

Medical care costs in the old-age assistance program in Minnesota have shown an alarming increase in the past several years. Nursing home costs constitute the largest single item in these expeditures. Attached is a comparison of cases and costs for the past 3 years.

It will be noted that total medical costs have increased from $21,800,000 in 1959 to $25,500,000 in 1961. (They are now approximately 50 percent of the entire cost of the OAA program in this State.) Just as significant is the fact that from 1959 to 1961 medical expenditures increased 15 percent despite the fact that during the same period our OAA caseload declined by 5.3 percent.

In 1959 we had 11.6 percent of our OAA recipients in nursing homes. This increased to 13.7 percent in 1961 (6,227 patients). The expenditure for nursing

home care increased from $8,270,000 in 1959 to $10,192,000 in 1961. Such costs now constitute exactly 40 percent of the total medical care cost. This compares with 33.5 percent for hospital care, 10.3 percent for drugs, and 8.6 percent for physicians services.

During the past 4 years several thousand new nursing home beds have been constructed in Minnesota and several thousand more will be built during the next 2 years. With the increased availability of beds, we can look forward to an increasing number of OAA recipients being placed in nursing homes. Since this item of medical care is already the largest we have, it seems imperative to me that we consider a new method of financing such care. Under the present plan these costs are paid entirely from tax funds, with the major portion coming from our State and counties.

OAA medical costs compared to total program costs

Year	Average monthly		Percent	Total OAA costs	Total costs	
	Total caseload	Medical care cases			Medical cost	Percent
1959	48.074	24,090	50.1	$48.814,846	$21,800,000	44.7
1960	46,744	24.426	52.2	49,703,921	23,300,000	46.9
1961	45,455	25,061	55.1	51,268,617	25,500,000	49.7

The OAA nursing home patients and costs

Year	Number of patients	Percent of total cases	Costs	Percent of medical dollar
1959	5,577	11.6	$8,270,000	37.9
1960	5,796	12.4	8,920,000	38.3
1961	6,227	13.7	10,192,000	40.0

NOTE.—About 60 percent of all persons in nursing homes are OAA recipients. (This is based on bed capacity as of Apr. 15, 1961, of 11,196 and better than 95 percent occupancy.)

Other medical costs for fiscal 1961

	Amount	Percent
Hospitalization	$8,546,000	33.5
Drugs	2,632,000	10.3
Physician services	2,194,000	8.6
Other medical	1,936,000	7.6

STATE OF MINNESOTA,
DEPARTMENT OF PUBLIC WELFARE,
St. Paul, November 21, 1961.

U.S. SENATE,
Special Committee on Aging,
Senate Office Building,
Washington, D.C.

GENTLEMEN: I am pleased to offer these statements in testimony before the U.S. Senate Special Committee on Aging.

My views are based on several years of experience with aged persons admitted to hospitals for the mentally ill. This experience has been both directly clinical as well as administrative in nature.

The problem of mental aberration and breakdown among the aged is both a serious and subtle one. In my opinion the supposition that aged persons are sent to mental hospitals on the basis of social or family rejection is an oversimplification. Studies in New Hampshire showed that in 92 to 94 percent of cases, clinical symptoms observed in hospital checked with descriptions of pre-

hospital events, and could be construed as valid reasons for hospitalization in the absence of other solutions.

The absence of other solutions is apparent rather than real. It is not a simple matter of people not wanting to find other solutions. Rather it is a matter of despair, anxiety, and ignorance as to what other solutions might exist. For example, much breakdown among the aged can be prevented by sound medical care, with particular attention to the delicate problems of fluid balance and biochemical equilibrium. Proper attention to sensible schedules of exercise and rest; sleep and wakefulness; nutrition; and psychological needs for affection, self-esteem, and intellectual stimulation can be shown to prevent and even reverse mental breakdown. Skilled use of tranquilizing and energizing drugs can help maintain balance. Some disturbances are caused by small strokes, whose effect may be naturally self-limited. These facts are too little known.

A basic aspect of the problem is the concept in medical teaching that mental symptoms in the aged are the result of irremediable brain damage and thus irreversible. Whereas forgetfulness and confusion are viewed as normal accompaniment of senile brain deterioration, behavorial disturbances appear to be superimposed; the result of circulatory, nutritional, or psychological deficits as noted above. It is the behavorial disturbances, which to a significant degree appear to be preventable and/or reversible, rather than confusion per se, which bring about admission to mental hospitals. In their most acute and severe phases, such breakdowns may require periods of close and specialized care that a psychiatric hospital can provide.

Some more serious behavior difficulties are occasionally noted. These again are related more to an accentuation of previously existing personality traits than to changes resulting from aging itself.

Thus, as the behavior disturbances arise the family and the family physician, or the nursing home staff and the medical consultant, come to the conclusion that the situation is hopeless and that mental hospitalization is the only solution. It is important to bear in mind that these decisions are made, in a majoriy of instances, in good faith. Despite the best of intentions, significant differentials in cost of care would be bound to exert an influence. The tragic feature is that with the difficult aged person out of the situation, those remaining rapidly reach a new adjustment in which after a short period (probably less than 6 weeks) there is no further room for the aged member.

In summary, there should be two broad approaches to programs in this area, (1) acute intensive psychiatric treatment where necessary, and (2) prevention of mental breakdown and subsequent hospitalization if possible. In regard to the former, there should be provision for temporary admission or commitment for aged persons, if they require psychiatric care, until through intensive efforts reversible symptoms can be reversed. In regard to prevention there appears little question but what prompt, intensive medical care by physicians properly trained in geriatrics could prevent much mental hospitalization in this age group (we emphasize the educational aspect of this problem and define "geriatrics" as including an understanding of mental and emotional problems of the aged).

With the development of nursing homes in Minnesota, and suitable programs in them, we have seen a decrease in mental hospital senile commitments. A continuing increase in nursing home beds; the establishment throughout of staff training, volunteer, and socialization programs; and an increase in affiliated community and hospital psychiatric facilities could be expected to have a significant effect on the incidence of mental hospitalization among the aged.

Yours respectfully,

David J. Vail, M.D.,
Medical Director.

Fire Safety in Homes for the Aged

[This report prepared and submitted for Cyrus E. Magnusson. State fire marshal and commissioner of insurance, by Eugene L. Weber, assistant commissioner of insurance-fire investigation supervisor.]

Fire protection problems of the nursing and boarding care home are filled with tribulations and satisfactions to the State agency responsible for this service. In the State of Minnesota this responsibility is that of the office of the State fire marshal. The importance of the mission overshadowed the tribulations

and provided the determination to our State among the best in the assurance that fire safety became as much a part of this industry as medical care.

The 1951 legislature passed a "law for licensing hospitals and related institutions" for the State department of health which, we believe, paved the way for the original success we had with our program. This law read, in part:

"The State board of health shall, in the manner prescribed by law, adopt and enforce reasonable rules, regulations, and standards under sections 144.50 to 144.58 which it finds to be necessary and in the public interests and may rescind or modify them from time to time as may be in the public interest, insofar as such action is not in conflict with any provisions thereof.

"In the public interest the board, by the rules, regulations, and standards, may regulate and establish minimum standards as to the construction, equipment, maintenance, and operation of the institutions insofar as they relate to sanitation and safety of the buildings and to the health, treatment, comfort, safety, and well-being of the persons accommodated for care. Construction as used in this subdivision means the erection of new buildings or the alterations of or additions to existing buildings commenced after the passage of this act."

The standards permitted under the law became effective February 10, 1952, and read, in part:

"Fire protection. Fire marshal approval required. Fire protection shall be provided in accordance with the requirements of the State fire marshal. Approval by the State fire marshal of the fire protection of the institution shall be a prerequisite for licensure."

The fire marshal realized that it would be necessary to have detailed standards to insure uniformity in the surveys and decisions of the field and office personnel at all times. Our first standards for nursing and boarding care homes was adopted and effective July 1, 1952. Although it was not as rigid or restrictive as we know and accept laws and standards to be today, it did meet with some opposition from the industry. However, we overcame this by attending industry meetings, explaining the new regulations and selling the need for safety; while pointing out the substandard conditions existing. It soon became apparent that the industry realized that we were not trying to regulate them out of business and the compliance received is a compliment to this progressive group. Patience and understanding were needed by both the operators and the regulatory body to obtain "compliance by convictions."

Although codes, standards, and regulations designed to provide increased fire safety for the occupants of nursing and boarding care homes do cost money, it must be remembered that this expenditure also increases the valuation of the property.

In the early days of operation with the new regulations, most of the homes were of the type converted from old dwellings, hotels, and occasionally an old hospital building. The Federal Hill-Burton Act which provided financial assistance to communities for the construction of hospitals actually was responsible for a part of the growth in the nursing home program. Those communities that took advantage of the Federal assistance suddenly found themselves with an old hospital building that had very little value other than to convert it into a nursing or boarding care home.

When the fire marshal began the inspection program of these properties, we found that the most common criticisms were:

1. Inadequate number of exits and improper location of many of the existing exits.
2. No identification of exits.
3. No fire alarm or fire detection systems.
4. Stairways open and unprotected.
5. Boilerrooms unprotected.
6. Maintenance and laundry equipment located in open basement areas.
7. Excessive storage of combustible materials, such as lumber, furniture, clothing, etc., throughout building.
8. Exit corridors of passageways were inadequate in size and location.

It was in these areas that we concentrated our initial efforts. These were the very obvious hazardous conditions that had to be corrected in order to insure minimum safety from fire. Combustible storage rooms, maintenance shops, laundry rooms, and boilerrooms were isolated by separate enclosures of fire-resistant construction. Fire alarm systems and electric exit signs were required in all-wood or wood-frame interior homes housing eight or more residents or patients; automatic sprinkler systems were required in wood or wood-

frame interior buildings that housed or cared for 24 or more patients or cared for bed patients on the second floor. Regardless of the total number, additional exits were ordered either inside or outside the building; identification was required for all exits and exit passageways were enlarged and relocated to permit safe travel.

By 1956 we observed a trend toward more new construction. This included additions to existing facilities and completely new facilities housing from 25 to 100 persons. It was also apparent that the fire safety standards needed revising. We, therefore, decided to gain legislative approval of our program by requesting authority to establish a fire safety code for several types of buildings and occupancies. This approval was granted by the passage of the following enabling act in 1957.

Minnesota Statutes of 1957, Sections 73.41 Through 73.44

SECTION 73.41. The State fire marshal, after holding a public hearing in accordance with Minnesota statutes, section 15.042, shall establish a fire safety code. The regulations in the code shall provide for reasonable safety from fire, smoke, and panic therefrom. In all hospitals, nursing homes, rest homes, board and care homes, as defined by the board of health, schools, hotels, as defined by Minnesota statutes, section 60.91, subdivision 2.

SECTION 73.42. REQUIREMENTS OF CODE. The code shall specify reasonable minimum requirements for fire safety in new and existing buildings and facilities. Regulations may be in accordance with the size, type of construction and nature of use or occupancy of such buildings or facilities. No regulation made in accordance with sections 73.41 to 73.43, shall be inconsistent with the provisions of the statutes nor impair the rights of municipalities to enact ordinances and make orders with respect to buildings as provided by law, so far as such ordinances or orders specify requirements equal to, additional to, or more stringent than the regulations issued under the authority of sections 73.41 to 73.43.

SECTION 73.43. FILING OF CODE AND AMENDMENTS. The code and all amendments thereto shall be filed with the secretary of State and published in accordance with Minnesota statutes, sections 15.046 to 15.049, and in addition thereto a copy shall be provided each local fire marshal, fire chief, building inspector, or other governmental official who requests a copy of the code.

SECTION 73.44 VIOLATIONS. Any person who violates any provision of the fire safety code shall be fined not more than $200 or imprisoned not more than 3 months or both. No person shall be convicted of violating the fire safety code unless he shall have been given notice of the violation in writing and reasonable time to comply.

(Copies of the code are available upon request to: State fire marshal, 230 State Office Building, St. Paul, Minn.)

This newest fire safety code for Minnesota may not be as restrictive as some found in other States but it is a workable code. It is workable because it still permits the conversion of existing buildings without sacrificing fire safety. We now require fire alarm systems for all the licensed homes and automatic sprinkler protection for those wood or wood-frame interior buildings that house bed patients on the second floor or have a total capacity of more than 15 patients. Perhaps the major restriction placed on the conversion type building is that no building of wood or wood-frame interior construction over 2 stories in height will be accepted.

Our requirements for new buildings are very similar to other codes in that we permit only fire resistive incombustible materials for construction.

The adoption of this new code was made without opposition from the industry when the public hearing was held. We hasten to explain that this was not because of a lack of interest on their part. The State nursing home association was most helpful and cooperative during those trying months while the code was being formulated. Their committee and the committee of the fire marshal met at least six times to explore and discuss all the changes proposed. Without their cooperation we could have spent many additional months before final acceptance of our code.

This report would not be complete without making mention of the support and cooperation we have received from the Minnesota Department of Health. The dedication displayed by personnel from that department made it possible for us to double our efforts, so that today we have developed a successful working team in the two State departments. Although the department is the licensing

agency for nursing and boarding care homes, no license is issued until a clearance has been received from the State fire marshal for fire safety.

Medical science has done well to increase our life span which to us means a steady increase in the development and expansion of the nursing and boarding care home business. More and more of our aged will be spending their last years, either by assignment or voluntarily, in one of these homes. We believe that everyone, regardless of age and regardless of the type of building they live in, are entitled to the assurance that the State has done its job in requiring fire safety for them.

Our State fire marshal records are public to all for study or review, in the hope that from them may come ideas that will improve our own efficiency.

PREPARED STATEMENT OF MRS. IRENE H. WILLIAMS, CONSULTANT ON AGING, COMMUNITY HEALTH AND WELFARE COUNCIL OF HENNEPIN COUNTY, INC.

I am sure I express the sentiments of all those working in the broad field we have come to call aging when I add my word of greeting and appreciation to this Senate committee which has done so much to alert and inform the Nation about its unfinished business regarding older citizens.

The community in which you are meeting has, through its health and social service organizations, given increased and particular attention to older people for at least 15 years. To mention only a few of our earliest efforts, local senior citizens clubs began in 1947, as did our family and children's service foster home placement program. The after 60 hobby show was started in 1950; our day center, council house for senior citizens, in 1952. Hennepin County Welfare Board was the first public assistance agency in the Nation to employ in 1950 a group work consultant to spearhead development of social organizations of older people.

For 4½ years a full-time consultant on aging has been employed by the community health and welfare council, and it has been my privilege to hold this position (the most exciting, challenging, and rewarding in 25 years of social work). Working through planning and study committees and relying on our older citizens as full partners and guides in the problem-solving process, we have sought to coordinate, strengthen, and stimulate services, to gather facts, offer assistance in setting up new programs, provide for better communication, and carry on a broad-scale educational campaign.

Our philosophy has been that older people must remain (or regain the status of being) fully integrated in the life of the family, neighborhood, and community. Our primary efforts have been to make their needs and desires understood, and to achieve the kind of services and community atmosphere which facilitate achievement of the good life. Our gratification has come from the high level of interest and support throughout the community, the inspiring leadership of our senior citizens themselves, and the constructive changes and improvements in programs and facilities across the board. Our frustrations have emerged from the contrast between what has been accomplished and our dreams for what we would wish to achieve.

Since time does not permit a full sharing of our experience, learning, and recommendations, I would like simply to emphasize some of the basic supportive services which the planning committee on aging of the community health and welfare council believes are imperative. We know we will have increasing numbers of older people. We assume, from all available evidence, that retirement incomes will rise, health levels will improve and that older people will prefer to live as independently as possible in homes and neighborhoods of their own choosing. There seems no question that both individual happiness and community well-being will be enhanced by this kind of dignified and self-determined living. However, large numbers of persons, especially as they reach very advanced age, cannot hope to achieve this goal without a network of services being available in every local community. The Social Services Section of the White House Conference on Aging stated as a basic principle:

"* * * High priority should be given to services which will enable persons to continue to live in their own homes, or will make it possible for them to return to their family or to independent living when feasible."

We believe this principle cannot be overemphasized.

Services necessary to achieve these ends would include: personal and family counseling; protective and/or guardianship services; home medical nursing care;

housekeeping aids; volunteer visitors, shoppers, and escorts; foster homes, educational programs of all kinds; recreational facilities (centers, clubs new devices); volunteer service opportunities; information and referral services.

Our experience indicates that often only a very small amount of counseling or other assistance is sufficient to work out safe and gratifying living arrangements, which are accompanied by individual peace of mind, and community economy. We regret that many of the above services are still sketchy and fragmented, if developed at all, and we have a long way to go before we can be satisfied that we have even tested their full usefulness. Demonstration projects and creative experimentation are urgently needed in the fields of home care, friendly visiting, and provision of household helpers in this community.

I would like to mention, also, the importance of especial services aimed at health maintenance. It has been demonstrated in Minneapolis that older people have an intense interest in educational programs designed to prevent breakdown and maintain physical fitness. Over 500 men and women, aged 50 to almost 90, enrolled in two 4-week nutrition and cooking classes conducted in 1958. Their sustained attendance and enthusiasm, as well as their responses to evaluation questionnaires, showed their strong motivation toward health improvement and their interest in additional courses in special diets, home management, budgeting, exercise, foot care, et cetera.

Annual "Health Days for Senior Citizens," sponsored by the Hennepin County Medical Auxiliary, and related programs in senior citizens clubs have met some of the need for continuing health education and have all attracted eager audiences. Much, much more remains to be done in this area, and radio and television should be employed in bringing information to a larger audience. We know that sound teaching requires a personal touch and we hope to continue developing our own local educational programs. However, the preparation of really good audiovisual materials which could be loaned to local communities would be most helpful to those of us struggling to stretch our limited resources of time and funds.

I have barely suggested a few of the services required to keep people independent, active, and well in their own homes. This general goal presupposes that there will be decent and suitably priced housing in which they can remain. This is a matter of grave concern. In Minneapolis we have been thrilled with the development in public housing for the elderly. Our high rise apartment, in operation for 2 years, is claimed by many residents to have transformed their lives. Neighborliness, informal visiting, self-help, group activities have been built into the pattern of living, partly through the unobtrusive guidance of an on-the-scene social worker. We are heartened not only by plans for an additional 1,056 units of public housing, but by proposals of a few philanthropic groups to develop similar kinds of apartments. We are also worried about achieving enough such safe, economical, and convenient homes for all the older people who will need them.

We urge continued attention to these twin objectives: services to help people remain in their own homes, and homes in which they, and the community, can feel pride.

PREPARED STATEMENT OF BEA KERSTEN, AFL–CIO COMMUNITY SERVICES REPRESENTATIVE, HENNEPIN COUNTY, MINN.

Chronic disease and disability resulting from an aging population are currently the Nation's No. 1 medical problem.

Minnesota is among the leading States in longevity of its residents. It is estimated by 1975 better than 15 percent of the population in our State will be over age 65.

While the shortage in nursing homes in Minnesota of a few years ago has been greatly alleviated there is still much cause for concern in our State and throughout the Nation.

The care given in too many nursing homes and homes for the aging is limited primarily to nursing and custodial care with no restorative or rehabilitation services. As a result the great majority of the people in these homes deteriorate physically and mentally to the point of total disability.

Much of this could be prevented and the people in these homes could maintain or regain varying degrees of personal independence in meeting the normal demand of daily living if they were provided restorative and rehabilitative services.

Many of us believe this could be done more effectively through Federal legislation. I urge Congress in their next session to pass the bill for independent living.

We can ill afford the waste of skill, ability, and human suffering as a result of the passive acceptance and neglect of chronic illness which seems to be the traditional attitude of the public and yes, of physicians.

I also urge Congress to take action providing at least minimum standards for nursing homes and homes for the aging in the areas of personnel training, housing, and services, including restorative and rehabilitative services, with adequate staff at the State health department levels with authority to insure proper inspection and enforcement of standards.

The very wealthy and the medically indigent can get good medical care including nursing home care in the State of Minnesota. However, by far the greatest majority of our population including the aging are in the group in between.

I would like to point out that while the older people in our State and in our Nation face problems peculiar to their age group, in the broadest sense, these problems are but a reflection of the economic and social problems of all ages.

By far, most disability in middle age and older persons is caused by disease. Prevention through the medium of complete medical examinations at frequent intervals can reduce disability and chronic illness.

In Hennepin County the greatest percentage of the welfare budget goes for medical care. People apply for old-age assistance only after all resources have been exhausted and in a majority of cases their applications are for medical care.

I cannot agree with those who say "people fail to plan to meet their own medical needs" or "relatives are no longer willing to help those members of their family in need." As evidence may I present several cases that are typical of the many that go across my desk every month:

1. Mrs. A, a widow in her late thirties, is the sole support of her 12-year-old daughter and herself. Her 72-year-old mother worked until age 70. Since then she has been in the hospital and nursing homes almost constantly. All financial resources including hospitalization were exhausted. Mrs. A came to ask if I might advise her where she could borrow more money (she had already borrowed $500) at a reasonable rate of interest. When I advised her that she discuss her mother's problem with Hennepin County Welfare Board and apply for old age assistance she said, "Oh, but my mother is very proud, she couldn't accept charity."

2. Or take Mr. B, a married man in his late forties—seven children—five still at home, a mother 86 whom he has supported for years. While Mr. B is a good worker and draws average pay, the expenses of raising a family of 7 children, a wife who for the past 4 years has had to have expensive treatment for cancer, and an invalid mother in a nursing home, Mr. B had to mortgage his home to meet financial obligations. He is now on the verge of a nervous breakdown and is losing his home. They too are not willing to have the aged mother's medical care through old age assistance; the family is too proud.

3. Or take Mr. C who was out of work as a result of compulsory retirement and lost his wife after a long siege of illness, during the same month. His own health failed a few months later. After having exhausted his savings during his wife's illness he was unable to meet his own medical needs with his social security as his only financial resource. He was unwilling to apply for old age assistance. He was too proud, he said, he had always been able to pay his own way. Due to lack of medical care, Mr. C ended up in the hospital for a long time and then was sent to a nursing home. The income from his modest little house (which his son sold for $8,000) has long become exhausted, as has his hospitalization.

4. Or take Mr. and Mrs. D. Mr. D in his late sixties suffered a stroke. They have five children, all still in school (Mr. D married late in life). The family refused assistance through the county. Mr. D has very strong negative feelings about accepting charity. He cannot afford to pay for restorative services or nursing home care. As a result he is at home. His wife is trying to care for him. She is now on the verge of collapse as a result of the strain of caring for the invalid husband and her five children. As it appears now, the family will soon be forced to accept assistance and the welfare office and the taxpayers will be caring for the entire family rather than meeting the medical needs of the disabled husband only.

Case after case similar to those which I have mentioned above, all point to the need for medical care and rehabilitation for independent living as a matter of right not as a result of passing a "means test." This leads me to my third urgent appeal that Congress place first on their agenda and take action to pass Federal legislation providing medical care through social security. This would be a concrete step toward early detection and prevention which is so necessary if we are to begin to meet the problems of the chronically ill.

Every week during the past 8 years in my position as AFL-CIO community services representative of Hennepin County, one or more persons have come to my office seeking advice and help in the difficulties they face as a result of the health problems of a member of their family. I repeat, only as a last resort will they apply for medical care through old age assistance. In conclusion I reiterate the chronic diseases and disability resulting from an aging population are currently the Nation's No. 1 problem.

Congress can help to solve the problem to a large degree, if our U.S. Senators and Representatives want to by passing—

(1) The bill for independent living;

(2) Standards for nursing homes and homes for the aged in the areas of personnel training, housing and services, including restorative and rehabilitative services;

(3) Medical care for the aged through social security—or they can refuse to pass such legislation and governmental local, State and Federal can continue to subsidize more and more nursing homes for the aged, providing merely nursing and custodial care.

The welfare budget in Minnesota, the largest percentage of which goes for medical care has increased $1 million a year for the last 10 years and with the rapid percentage increase in our older population, the welfare budget increase can be expected to grow even more rapidly in the decade ahead unless we have a medical plan that will encourage early detection and prevention and rehabilitation.

Prepared Statement of Miss Laura N. Hegstad, Minnesota Department of Health, Division of Hospital Services, Minneapolis, Minn.

Rehabilitation Nursing in Facilities for the Chronically Ill and Aged

The Rehabilitation Section of the White House Conference on Aging opened its report with the statement: "Rehabilitation is the only hope for those afflicted with and disabled by chronic or degenerative conditions until such time as specific means are found to prevent and cure them. The rehabilitation program must be dynamic and total, designed to meet the physical, emotional, social, and vocational needs of the chronically ill and disabled. Only a fraction of those needing these services can secure them, due to lack of facilities, personnel, financial resources, and knowledge as to the opportunities available through such dynamic rehabilitation."

The above statement implies the active involvement of all disciplines. Nursing, by reason of its close contact with patients, becomes intimately involved in the day-to-day practices which add up to total patient care.

The principles of rehabilitation can be applied to all nursing, whether in hospitals, nursing homes, patients' own homes, or in industries. Included are practices which aid the patient in maintaining physical and mental health at a maximum degree, by providing high quality basic general nursing care at all times. Basic nursing includes attention to such factors as correct body mechanics, proper positioning in bed, hygiene, nutrition, exercise, elimination, rest, recreation, and occupation.

Preventive and restorative aspects of care are equally important, but both are often left to chance. However, early ambulation of patients in hospitals has had its impact on patients in nursing homes, and today we find many homes encouraging and assisting patients in getting up for a part or most of the day. When this corresponds with mealtime it has the added advantage of creating interest in meeting fellow patients, in activities inside and outside of the home; it aids digestion, elimination, respiration, and general well-being. Every improvement, however slight, will change the patient's outlook from hopelessness and dejection to one of renewed interest in living and hope for the future.

The concept of rehabilitation is being integrated into nursing school curriculums, and the graduate nurse knows much about rehabilitative nursing techniques.

Today our educational efforts must be pushed among the nursing personnel, at whatever level they function, to impress upon them the importance of starting these techniques early. Too often, active rehabilitation practices must be postponed while the results of neglect are rectified.

Specific educational programs being conducted in Minnesota to improve rehabilitative practices in patient care:

1. Rehabilitation nursing courses at Kenny Rehabilitation Institute (Minneapolis) eight times per year, 3 weeks each. Since the inauguration of these courses in June 1959 through November 3, 1961, 208 registered nurses have been in attendance. Of the 208, 108 have come from Minnesota. About one-half have come from public health agencies, the other half from hospitals and rehabilitation centers (92) and nursing homes (14). Applications are accepted from nursing instructors, nursing supervisors, head nurses, and public health nurses from any area. Preference is given to those applicants whose positions of leadership will provide the greatest opportunity for improving patient care through their educational programs.

The 3-week course consists of didactic lectures, demonstrations, supervised practice, clinical experience, student practice teaching, discussion, testing, and followup. Nurses learn the unique techniques developed at the Kenny Institute for working with hemiplegics, paraplegics, quadriplegics, amputees, paralytic poliomyelitis, cerebral palsy, and other severely disabling conditions. Special emphasis is given to preventing decubitus ulcers, contractures, and other complications that ultimately limit rehabilitation potential.

Material covered in the course includes: positioning of the patient, passive range of motion, transferring, activities of daily living, crutch walking, bowel and bladder training, instructing the patient and the family, care of equipment, and the use of community resources. Audiovisual aids and materials used in the course are made available on loan to nurses who have completed the course and who wish to use them in their own educational programs.

2. Professional postgraduate seminars. Thirteen organizations and agencies, professional, public, and voluntary are pooling resources and leadership to conduct professional seminars for physicians, dentists, and nurses. The program for nurses features various phases of rehabilitation, with special emphasis on the patient who has had a cardiovascular accident. The importance of early care and the continuation of care following hospitalization are stressed.

During the past year these seminars have been presented in four centers with one 2-hour session per week for 6 consecutive weeks. The average attendance for nurses has been 120 per session.

3. The Minnesota League for Nursing, the Minnesota Hospital Association, and the Minnesota Department of Health have cooperated in conducting 1-day institutes on rehabilitation nursing techniques. These sessions have been open to registered nurses and nursing personnel in hospitals, nursing homes, and in public health agencies. Plans are being made for similar institutes during the winter and spring months of 1962 on the problems of the incontinent patient.

4. Institutes on nutrition, medical records, sanitation, and patient care are being conducted by the staff of the Minnesota Department of Health.

5. Planned and incidental teaching by the staff members of the Minnesota Department of Health in their visits to nursing homes and homes for the aged.

6. Inservice educational sessions in patient care for staffs of nursing homes by the Minneapolis Department of Health.

7. Workshops on activities for older residents in nursing homes and homes for the aged, by the Department of Public Welfare.

To strengthen and extend rehabilitative nursing practices for the care of the chronically ill and aged, the following programs need expansion:

1. Evaluation of the professional seminars for nurses.
2. Extension of the rehabilitation nursing course conducted at the Kenny Rehabilitation Institute.
3. The provision of stipends for registered nurses for the course at Kenny Institute.
4. Extension of educational sessions for staffs in facilities providing care to the chronically ill and aged.
5. Active coordination of all programs which provide medical, nursing, and related services to the patient and his family.
6. The organization of homemaker services.
7. The organization and strengthening of present services of volunteers.

8. A planned and supervised program of diversional therapy and activities of daily living which would do much to create a feeling of usefulness, independence and happiness.

PREPARED STATEMENT OF SIBLEY COUNTY WELFARE BOARD, GAYLORD, MINN.

As members of the welfare board for the Sibley County Welfare Department we know that aged persons are heavy users of nursing homes and that much of this care is publicly financed. We know that there is an insufficient number of good nursing home beds. We also know that our aged citizens need to leave their home communities many times in order to get nursing home care. We also know that our public assistance recipients remain in hospitals longer than necessary because there is not a suitable nursing home facility to care for them. We are also aware that private nursing home patients often are paying primarily for residential and custodial care at high rates. In this way they soon become eligible for old-age assistance and become a complete public charge. This is through no choice of theirs but because of their not knowing any other way to manage. It is our experience that physicians recommend nursing home care many times when the patient could be cared for at home or in a boarding home. The aged persons known to our county welfare department are placed in the proper facility and at a cost according to our country welfare schedule. The need of nursing care is determined by our social work staff based on detailed medical information from the attending physician.

We feel that the Congress needs to develop ways and means of developing services so that the general public is better informed with respects to the problems of the aging and aged. It appears to us that there needs to be coordination of health, education, welfare, and agriculture departments on the Federal level, on the State level, and on the county level. The multiplicity of services given by government and voluntary organizations on Federal, State, and county levels are staggering.

We believe, on a county level, that the public health nurse, the county agricultural agent, and home demonstration agent and the schools could do much more in the way of offering services to assisting the needy aging and aged.

We believe the Congress needs to look seriously at our present public assistance programs. We believe that the categories of assistance should be eliminated and that there should be one public assistance program financed by Federal, State, and county participation. By the elimination of the categories of assistance, our public welfare social workers could assist all families and prevent disaster early. By developing means of prevention and control of dependency and family breakdown many aged persons would not be in long-stay institutions now.

By eliminating the categories of assistance, much redtape would be eliminated in proving eligibility and all the other requirements that, after all, are for people. It seems to us that this would free much skilled personnel at the Federal, State, as well as county levels to really work on and develop prevention services and make resources available to families as they are needed.

It is recommended that the Congress consider elimination of all residence requirements for all of the States. This would not only save time for all public welfare agencies but would help families with problems earlier and get them back on payrolls faster.

Our Sibley County Welfare Board has done much in the way of providing services to the aging and aged in Sibley County. We have had a program since 1953. These activities and services which do not involve financial assistance are available to all citizens in the county. We believe that these services need to be available to people who can pay their own way as well as to those on public assistance. This seems to us the only way to prevent and control human impairment.

We commend you for holding public hearings and want you to know that we, at this grassroots level, are interested in what you do as it concerns public welfare. Public welfare programs are the concern of all of us and we need to make the public aware of this. We are not proud of the articles we see in the newspapers about welfare scandals. We believe that the basis of all of this newspaper publicity is that the public is beginning to demand action to really help people.

We want you to know that we will help your committee in any way that we can if you will but ask us.

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SIBLEY COUNTY WELFARE BOARD MEMBERS

LeRoy Pinske, Arlington, Minn.
Willard Frauendienst, New Auburn, Minn.
Walter Eklund, Winthrop, Minn.
M. J. Kehoe, Green Isle, Minn.
Edgar Niebuhr, Gibbon, Minn.
Mrs. Delpha Sallstrom, Winthrop, Minn.
Mrs. Evelyn Sweeney, Arlington, Minn.

PREPARED STATEMENT OF HARVEY H. GLOMMEN, DIRECTOR, AITKIN COUNTY WELFARE DEPARTMENT, AITKIN, MINN.

The Aitkin County Welfare Board is concerned with the needs of the aging population. The 1960 census reported that 15.35 percent of our citizens were over 65 years of age. A recent report of the Minnesota Department of Welfare indicates that out of each 100 persons over 65 in Aitkin County, 27 were on old-age assistance. This compares with a State median of 14.3 In the calendar year 1960, $500,513 was spent on OAA as compared to $383,340 in 1955. From 1955 to 1960 the county share of the OAA payments increased 33 percent while the State share increased 6 percent and the Federal share about 25 percent.

The figures indicate that our OAA payments are going up. The number of persons receiving OAA is going down. Medical costs are going up, social isolation is increasing, and housing facilities are getting poorer. In November 1959 the county welfare board appointed a county committee on aging. Since that time the committee has come to the conclusions that there are acute needs for income maintenance, nursing care facilities, housing, and social-recreational facilities for our older people.

Because of the cost, the county committee has been able to take some steps in meeting the social recreational needs of the people. They have established four Golden Age Clubs, they operate a day center 5 days a week, they have held countywide and area hobby shows, picnics and numerous other events to decrease social isolation, and to increase social recreational opportunities. At the present time over 50 percent of the persons over 65 are involved in the committee activities.

The welfare board feels that these activities are valuable in that they have had an effect on committments to mental hospitals. We have one lady who had not left her house for over 5 years but upon the beginning of the Golden Age Club, she went and has since been very involved. Her physician said that if she had not become active she would have required hospitalization.

All of these things cost money. It is true in Aitkin County, as is probably true in other similar areas, that where there are few economic opportunities our population is growing older and the younger people are leaving, our resources become more limited and our needs greater. This means that the older people themselves are paying the costs of these increased services while they have less ability to do so.

In view of these circumstances, we recommend that the Federal Government provide leadership and funds in the area of aging. We recognize the housing bill of 1961 will help much, but there still remains the need of nursing home, income maintenance, and social recreational needs. We recommend Federal participation in the creation of these facilities.

Most important, we recommend that the social security program be expanded to include all persons over 65 with a minimum grant equal to minimum standards of health and decency. We also encourage the inclusion of a comprehensive medical care plan under social security. We feel that the mental anguish of the senior citizens over high medical costs is inhuman and unnecessary in our modern society.

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517 EAST 28TH STREET,
Minneapolis, Minn., November 27, 1961.

The McNamara Senate Committee on the Aging:

I am a member of the Golden Age Fellowship Club of the Bethesda Free Church. I believe the senior citizens need the social security bill. Our income isn't enough to take care of rent, food, and medical expenses. Those of us who get social security and still working some. Many don't get more than $160 per month. We pay rent, food, clothing, etc. and money doesn't go around.

If we could get our medical expenses paid that would be a big help. We could also use a raise in social security. We also need housing for the elderly. Some clean warm places with reasonable rent in locations where it is light at night. Wish I could be at the meeting but am working that day.

Trust they will decide in our favor December 4, 1961.

Yours truly,

LILLIAN MULLER.

PREPARED STATEMENT OF MRS. MARY H. STOLZE, MINNEAPOLIS, MINN.

Mr. Chairman and friends, I visit many senior citizens groups and gain much firsthand information as to their needs and problems.

I give top priority to the social security health plan (H.R. 4222). I feel it will meet an urgent need and it is the best health proposal for senior citizens that has been proposed so far. It is the only one that would treat deserving elderly persons like good citizens.

I do not think of its payroll taxes as taxes in the usual meaning of that term. Payroll taxes are not like other taxes. Payroll taxes are more like deductions from our salaries for retirement plans. They are savings for a time in our lives when our earning days are over. It is a more sure way to save because our present economy makes it difficult to save for this purpose in other ways.

This plan provides benefits that we have earned and can be proud of. Its benefits do not come to us as charity. Charity is something that persons who have worked all their lives should not be forced to accept.

Our doctors, through their American Medical Association, tell us that we do not need this health bill, that many doctors treat needy patients without charge. Yes, some do, and we appreciate their generous charity. But it is charity and we do not want charity.

We want and need a health plan like the social security health plan (H.R. 4222) which will help us to pay for our own health care.

More than half of the people over 65 have less than $1,000 cash income. The average social security check for retired workers is $74. We know that many receive in the neighborhood of $40 or $50. People over 65 have twice the medical bill of younger people. They stay twice as long in the hospital so that the cost of hospital care is greater for the elderly. Hospital costs have doubled in the last 12 years and are increasing. Other living costs are also increasing. Less than half of the aged have insurance of any kind. They either can't afford it or they can't get it. The cost of insurance is increasing, especially for the elderly.

The Kerr-Mills bill supported by the AMA and some others is limited at best. It is a tax bill which you and I are paying for through taxation. Our taxes are also increasing year by year. Most older people own homes but have little money. It is difficult for them to pay the taxes to keep from losing their homes.

The Kerr-Mills type of legislation encourages pauperism and dishonesty. Some will sign their homes and other possessions over to friends or relatives. Others will hide or spend their money in order to be able to qualify for benefits under such a law with its pauper's oath. There is restlessness and insecurity among older citizens. They are in constant fear as to what tragedy may befall them if they suddenly become ill and are left penniless as a result of it.

Their emergency funds that were so hard for them to accumulate, can vanish almost instantly when serious illness strikes. Imagine their state of worry and shock when they suddenly find themselves paupers. They have seen friends and others around them fall victims to these circumstances. They dread to think of the time when they may be next.

Some argue that the social security health plan will not cover all who need it. It will cover nine-tenths of all the workers in this country. And of the remaining one-tenth, many are covered by other plans like the Veterans' Administration; the postal and other Federal employees who have a plan which includes hospitalization; teachers and many State and municipal employees, even the game wardens of Minnesota, have their own retirement plans.

Some express the fear that the social security plan will introduce socialized medicine. It will not because it will not interfere with the patient's choice of a doctor. What about our public health departments? Our food inspection system? Our quarantine system to prevent the spread of disease? They are maintained and paid for by the Government. Are they socialized medicine?

The great and ever-increasing number of senior citizens on relief rolls, old-age assistance, and Kerr-Mills relief, and the staggering costs of that system should

give cause for serious thought about the advisability of extending that system and saddling the already overburdened general taxpayer with its ever-increasing costs. The social security plan would relieve the general taxpayer of much of this burden and put the burden where it justly belongs, on the workers who will become the beneficiaries.

Housing is also a problem. Many senior citizens do not have suitable housing. Rents are higher than they can afford to pay and they are sometimes evicted in midwinter. They need to be protected against these hardships. They need comfortable, sanitary, and safe housing with provision for housekeeping so they can care for themselves. Such quarters should be located near shopping centers and churches so these elderly persons can be a part of the community life around them and not feel isolated or ostricized and lonesome.

More should be done to prevent elderly citizens from being railroaded into mental institutions simply because they are old, down and out, and there is no other place for them. Adequate rest homes with adequate staffs of social workers or other personnel to investigate and prevent this sort of thing would be a good goal to look forward to.

Prepared Statement of Lloyd Brandt

My name is Lloyd Brandt, manager of the Legislative Department of the Minneapolis Chamber of Commerce. I would like to read into the record here today, the findings of a joint survey made by the Minneapolis and St. Paul Chambers of Commerce in April 1960.

We were interested in knowing just how widespread industry retirement programs are in this area. A total of 980 firms were contacted and 32.6 percent of them responded.

Sixty-four percent of the firms had retirement pension programs; 35 percent did not. The returned questionnaires represented 27 percent of all people employed in nonagricultural employment in Minnesota.

Of the firms that replied, approximately 65 percent offered hospitalization, medical, surgical insurance to former employees and their dependents.

Of the responding firms, 86 percent offered group life insurance; 76 percent of the firms made it possible for an employee to continue this coverage after employment.

One-third of the firms offered preretirement counseling to assist employees.

Out of 199,500 employees represented by responding firms, only 4,105 were over 65 years of age. This demonstrates that not all employees are retired at 65, but maybe it does indicate that too often skilled, valuable manpower is lost to industry due to an arbitrary retirement age.

We have no previous, similar survey to use as a benchmark of industry activity in this field. We do believe, however, that there is much evidence to support the statement that industry is rapidly moving into this area of retirement benefits. We believe this survey indicates that for most employees, the task of planning for retirement income is being shared by the employer.

Employee Benefit Questionnaire—Minneapolis Area Chamber of Commerce-St. Paul Chamber of Commerce Combined Results—Summary

1. Nine hundred and eighty firms were contacted: 320 replies were received—32.6 percent response.
2. Two hundred and three firms have retirement pension programs or 63.4 percent of respondent firms.
3. One hundred and fourteen firms do not have retirement pension programs—35.6 percent of respondent firms.
4. Approximately 199,496 Minnesota employees are involved in these returns or 26.6 percent of the State's 750,846 total nonagricultural workers (excluding Government employees).
5. Four thousand one hundred and five employees are age 65 or over.
6. Ten thousand four hundred and eight Minnesota employees now receive benefits from these pension plans.
7. The following percentages of former employee's final wage was replaced with company pension benefits combined with the primary benefits under the Federal Social Security Act: 0 to 33⅓ percent, 42 firms; 33⅓ to 50 percent, 88 firms; over 50 percent, 47 firms.

INSURANCE COVERAGE

1. Hospitalization insurance—210 firms have this or 65.6 percent of respondent firms.
2. Medical-surgical insurance—230 firms have this or 63.4 percent of respondent firms.
3. Two hundred and six firms said hospitalization was available for dependents of former employees—64.4 percent of respondent firms.
4. One hundred and ninety-six firms said medical-surgical was also available to dependents—61.2 percent of respondent firms.

GROUP LIFE INSURANCE

1. Two hundred and seventy-seven firms have group life insurance plans—86.6 percent of respondent firms.
2. Two hundred and forty-three firms make it possible for employees to continue part or all of this coverage after employment—75.9 percent of firms replying.
3. One hundred and nine firms provide pre-retirement counseling to assist employees.
4. Fifty-one firms provide other benefits or services to retired employees not enumerated in this survey.

3518 34th Avenue South, Minneapolis, Minn.

Dear Sirs: I wish to say that I am a firm supporter of a social security health plan. As you reach the age of retirement you are often deprived of your group insurance plan and it becomes almost impossible to keep on with the same coverage at the exhorbitant rates which are charged in individual plans. Seems as if the person with a small pension or social security is the one who is penalized. It may mean that you will have to take a chance on no coverage and in the event that you become ill you will have no choice but to become a burden to your community.

I am employed at the Veterans' Administration—have been a career employee. But I was let out in a reduction in force. I have been working again for 2 years but am on a temporary basis, because of approaching automation. For this reason I am not allowed to be a member of the group insurance plan anymore, as the Government now pays part of the insurance. I am paying over $35 a quarter for my hospitalization insurance. The Blue Shield has increased its rate and Blue Cross has made a big increase in its rate for me. It would be impossible for me to pay the rates they are now charging when I become unemployed and it is even a hardship for me now. I am a widow (age 58) and have to worry about my own future.

There are many of us in like circumstances. Please give us a chance to hold up our heads and not be a burden to the community and have to accept charity, which I have never done—even though I had a crippled husband for 18 years who was too ill to ever be a veteran. So, I have no rights as a veteran's wife.

Thank you sincerely,

Mrs. Evelyne Luehrs.

Prepared Statement of Theodore A. Gustafson, Retired Teacher and Writer of Insurance, Minneapolis

May I say first that I am pleased and delighted to participate as a member of the senior citizens group.

I am reminded of the story which you all will remember regarding the four blind men and who came upon an elephant. After feeling of the elephant, they afterward discussed what the elephant is like. You know the story; one felt of the elephant's leg and said that he was like a tree. Another felt of his side and said that he was like a house, et cetera, et cetera.

We are also happy to live in a country where free speech still prevails. We are also urged to express our convictions on controversial questions. As I have been led to understand, this meeting is for the purpose of letting our leaders hear from the "grassroots" so to speak. So here, after considerable study I have come to certain conclusions:

I assume that you are all familiar with the provisions of the Kerr-Mills bill passed by the Congress of the United States. Under this bill, the U.S. Government will aid the States in a financial way. Minnesota could, or would have, benefited to the amount of $200,000 if the State legislature had acted at its last session. The amount is determined by the services each State elected to provide. This would put the administration of this bill under State control, instead of the U.S. Government at Washington. At present more than half of the States are implementing this bill in some form or other.

On top of all this protection for old-age groups, comes the proposed King-Anderson bill. There was a time in history when a "king" was viewed as a man who could "do no wrong." There seem to be those among us who still persist in this viewpoint, in spite of facts presented to the contrary. After the implementation of the Kerr-Mills bill by so many of the States, which as I have indicated before, comes under the control of the State governments, why should a blanket bill be imposed on top of it, regardless of the needs of the individual? The Kerr-Mills is voluntary while the King bill as written is compulsory in effect. Besides the King bill limits its protection to those on social security.

Let us have a plan which will be available to everybody regardless of membership in any one group and on a voluntary basis. Any direction and administration would come, as I intimated before, from local authorities. We wouldn't need any direction from the Federal Government. The administration costs would naturally be much less when administered locally, as anyone can understand.

It has been estimated that for every dollar received from Washington (and many people look upon this money as gifts) costs us taxpayers back home $1.40. Is this economy? You be the judge. Some say this King plan gives us security, because it would be backed by the Federal Treasury. Yes, possibly so for the time being. But take note of the fact that we as a nation are in debt up to $3 billion. And, moreover the King plan is not fiscally or actuarially sound as any capable economist can tell you. It is not insurance in the sense that it is based on sound principles. And if not, let us not adopt it. These statements can be proven to those interested enough to study the question. Furthermore, it seems rather selfish to accept benefits for which present workers will be paying for. Most of them are already saddled with more plans than they can carry. Why increase this load? Now let me turn to a very agreeable subject, agreeable to me, and many of my friends.

We as an old-age group are pleased, not to say proud in being able to be around and active, despite the years. And if we stop to consider why we are living much longer now than men and women did some 50 to 70 years ago, what is the reason? Or who is responsible?

You know, and we all must admit, it is because of the hard work in study and research that our doctors have unselfishly done for us and are consistently doing for us as the years go by. A doctor deals with the most valuable thing on earth, and that is life itself. We want doctors who have had the 12 years of preparation in preparing for their life work. At present 12 years of hard work and study are required before practicing his profession. How many people today would have the "guts" to tackle such a program? And you well know what some of the discoveries are, such as the Salk vaccine and numerous others, that could be mentioned.

Through research and study, our own State of Minnesota has become the medical center of the world. Doesn't this give you an additional feeling of pride in our State?

When this group suggests that a certain plan is better than another, I am willing to take their advice, backed up with facts as I have found them.

(P.S. Other subjects will likely come up in which we (the senior citizens) are interested, and if time allows I shall be glad to take part spontaneously.)

PREPARED STATEMENT OF ORACE H. HANSON, PRESIDENT, MINNESOTA STATE PHARMACEUTICAL ASSOCIATION

I am representing a current membership of more than 2,000 registered pharmacists.

Recognizing that pharmacy is very closely related to the overall health services of the community, the association has for many years worked closely with

State and community health professions in seeking to determine and fulfill the needs of our medically indigent and aging citizens.

The association has consistently and vigorously maintained the position that the aged and the indigent should receive the same quality of drugs and medications and the same high level of pharmaceutical service as other citizens. And at the same time, it has joined with the other health professions in defending the principle of free choice of health services.

Our attitude toward the King-Anderson bill, H.R. 4222, must properly be based upon conditions in Minnesota, rather than elsewhere in the Nation. Our conclusions are based upon the statistics compiled by the Minnesota State Welfare Department concerning the medical-economic status of persons 65 years of age and over.

This data, published under the title, "Minnesota's Aging Citizens, a County-by-County Statistical Report," indicates, among other things, that only 7 percent of all persons over 65 in this State are medically indigent. This figure represents only 0.7 percent of Minnesota's total population. The needs of these citizens are amply fulfilled by Minnesota's old-age assistance program, which provides complete medical services, including drugs and medical supplies.

This statistical study further indicates that 87 percent of the people interviewed had no unmet medical needs. Only 5 percent could not meet their medical needs because of inability to pay. Further questioning revealed that the persons included in this 5 percent were not aware of the health services available to them through the medical profession and the State welfare programs.

To us it seems apparent that Minnesota's aging and medically indigent are now receiving adequate health service, or have adequate health service available to them. Minnesota's experience illustrates that the medical needs of the aging citizen can be adequately met by the individual States, with the Federal Government fulfilling its responsibility by furnishing funds which are administered by the States.

Since health is a uniquely personal matter, the needs of the individual patient, whether young or old, self-supporting or indigent, can best be determined and fulfilled on the local level by physicians, pharmacists, dentists and welfare officials, who know the patient's needs firsthand. It is questionable whether a nationalized, rather than a localized, program is the answer to the problem of medical aid to the aging.

For these reasons the Minnesota State Pharmaceutical Association feels obliged to state its opposition to the King-Anderson bill (H.R. 4222).

3411 Dupont Avenue South, Minneapolis, Minn.

MESSAGE

What about those not covered by social security? This is a question worrying our aged not on old age assistance. Some have hospital insurance, but as rates increase and their limited income reduces they are unable to cope with the situation. I think this is a very vital subject and satisfactory answers are necessary.

Mrs. B. L. "Goldie" Wienberg,
President, Adath Social Club, South Branch Jewish Community Center.

PREPARED STATEMENT OF WALTER SCOTT, CORRESPONDING SECRETARY, QUINT CITIES CHAPTER, AMERICAN ASSOCIATION OF RETIRED PERSONS, ROCK ISLAND, ILL.

In phone conversation with Dr. Frank Atelsek I was informed that it would suffice if I prepared a paper and mailed it instead of traveling to a distant hearing site and delivering it in person. So I feel privileged to present the following for your consideration.

The elderly people have always been a problem to the community and to the younger members of their families. A short time ago the solution to the family's problem was the poorhouse or other institution, or, the family did not realize that the old folks had reached a different status in life. In some cases the family allowed the parents to carry on without any special consideration of this change. Others found a simple solution to their own problems caused by the slowness and lack of agility of the old folks. It was to provide a room

away from the area of work and entertainment, a place of reclusion with a regimented schedule for possible participation in some family activities. These things still persist. Some elderly are retained for the value of their ability to support themselves financially. There is, therefore, a keen need for a broad program for this segment of our people. The U.S. Government should set up an agency similar to the HOLC and the RFC with power to lend or insure loans at a reasonable rate of interest for the proper habitation of these people who are not objects of charity nor are they subject to institutionalization. This agency should be empowered to advise, work with, assist, and help to establish single units of housing or apartments where the condition of living is not too dissimilar from the past. Housing built to satisfy the need for low income families is still a very useful project for a small portion of our elderly. The same idea in higher rent housing is usually in some distant place. Moving is not conducive to the happiness of old folks. Especially for them who have been conditioned to a set of things, places, and people all of their life. Smaller housing projects or houses for the elderly properly situated in all cities would be the ideal solution to the many. Ownership or rental projects which are reasonable in price would protect many a widow against the need to dispose her small financial accumulation of money or property, so as to qualify for needed aid.

Our homemaker women are just as responsible for the status of the men as the men are themselves. Our methods of making provisions for the elderly does not take these women into account. A worker earns a pension which stops when he dies. His social security check is twice the amount of the wife. The two of them may have retirement income of $200 per month. The widower will be protected with $160 while the widow is supposed to get by on half that much or $80. Therefore, the social security laws should be changed to allow the widow at least as much as the widower would draw. This should not be any problem as the participants would have to bear the cost of the plan.

The general attitude of business and professional people about insurance benefits in getting all the policy allows instead of charging a normal fee has caused the cost of everything insured to rise to a point where the insurance will not cover the charges. This method of collecting the full amount of the policy should be curbed the same as other profiteering which borders on fraud. County cases of hospitalization should be the concern of the Federal Government to insure proper treatment and care. Also there is a need of so many people who are not given the proper consideration for their ailments due to the high cost of needed care. Some hospitalization plan should be inaugurated to protect those who can't qualify for ordinary policies.

We in the United States are constantly fighting to prevent socialization of this or that. We keep a vigil to prevent regimentation by the Government. And still it is the tendency of agencies to get complete subjectivity of recipients of their services. Any aid to widows that will not reduce their dignity or cause them to go without aid because they may have a nest egg they had sacrificed to accumulate will be the solution to those who are not paupers and yet not able to completely pay their own way. It is this middle class of senior citizens that need special attention.

SOUTH DAKOTA STATE MEDICAL ASSOCIATION,
711 North Lake Avenue, Sioux Falls, S. Dak., December 9, 1961.

Hon. EDWARD V. LONG,
U.S. Senate, Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: I wish to express my appreciation for being allowed to appear at the Special Committee on Aging meeting in Minneapolis, on December 4.

I realize that my request was late and that the opportunity given to me to appear was done as a considerable favor.

May I also suggest that in any future discussions that the panelists in the afternoon discussion have at least one person who takes a different view of social security medical care. This would make it a much more interesting and intriguing "tug of war" than having the three individuals all in favor of the social security approach to medical care.

Best personal regards,

JOHN C. FOSTER, *Executive Secretary.*

ST. MICHAEL, MINN., *December 20, 1961.*

DEAR SENATOR LONG: Since at the hearing presumably held for facts re nursing home care, retirement income maintenance, housing for the elderly, and Government activities held in the field of the aging held in Minneapolis, December 4, there was a great deal of time allowed to "sob sisters" who apparently had had, and might still, a high standard of living and now want more benefits under the King-Anderson bill at the expense of much more needy taxpayers, as well as other oldsters, regardless of their need, who want more benefits tied onto the Social Security Act which is discriminatory in itself since it does not cover all the people, I will also give you some of my personal background and views on this subject.

I am 55 years old, female, with two children. I came from a laboring class family. My parents and relatives have been in this country since around 1881 or earlier. They were landowners, property owners, voters, and have always paid their taxes on real estate and personal property. I am a niece of a man who was elected in the 1890's on "stickers" to the senate in Bismarck, N. Dak. He was the only Democrat in the senate there at that time. My parents never received any old-age benefits before their death, although they were eligible. It smacked too much of charity. My mother's homestead had to be sold after her death because she got caught in the "rent freeze" for highly paid war workers during World War II with the low rent she had been charging in 1939. She was not allowed to raise her rents to the higher level others had been charging when the rent "freeze" came and was therefore victimized. The rent she received during this time was not sufficient to maintain her in the last years of illness and keep up her property since she received but $70 per month for a modern nine-room home in St. Paul in a good location; whereas her minimum keep was $100 per month, plus the upkeep on the property which increased drastically during the war years. Therefore, we had to contribute (I mean my husband) to her support.

Then I worked for 10 years in industry before marriage, just before the social security law, so I am not covered, nor is my husband. I am now a housewife, living in a "grassroots agricultural town of 716 by the last census. I have seen the town grow from 398 to 716 in 25 years. I could go back to work, no doubt, as many retired farmer's wives (not in need) have in recent years to get on social security to get all the benefits they can, but I feel I would only be taking a job from some young person that really needs a job. Many of these women are working to add to their personal wealth to "keep up with the Joneses."

I believe that all those in real need should be looked after by the Government in some way, such as by the Kerr-Mills bill or some similar plan, but it should not be tied into the Social Security Act, as all are not covered by it and those that are not, of this group there are more indigent. As a matter of fact, I personally know of one woman who got on social security through a position in her husband's business who is eagerly awaiting 62 years so she can get her social security benefits. She and her husband are not in need but well off and driving around in a Cadillac. Should additional health benefits be given to people like this that can pay their way and taken out of our pockets, our young people's pockets that are just getting a start and trying to raise families, and the pockets of future generations? I say "No."

I am mighty sick of the welfare state we are in where many are living at their ease and enjoying life at the expense of the workers. It is destroying the incentive of workers to carry four or five recipients of welfare and unemployment benefits on their back; whereas, they themselves may receive no benefits at all and maybe do not wish them. They value their freedom more.

The question comes to my mind should additional health benefits be given to oldsters how this program could be carried out? The papers and magazines carry stories of the shortage of doctors and this is well borne out by the very few we have in Wright County in relation to population. Where will the help come from to carry on these programs? Would it not be better for Government to build more medical schools and aid needy students that wish to become doctors, etc., so there would be more personnel available to look after the health of all the people, and help people medically indigent or in need so they can go to the doctor or hospital of their choice through low-cost insurance plans of their own selection?

Where Government controls come in, so does the cost of administration rise with loss of freedom to the people. It is easy to see how socialism and commu-

nism is trying to infiltrate into this country. I did not enjoy being handed a copy of a pamphlet published by the National Association of Social Workers at your hearings. Also the "corrupt" labor unions are backing more health benefits. Enough said.

As for the problem of nursing homes, think the Government should set up a plan so there will be decent homes, nursing homes, etc., for the aged to live in that they can afford to pay for from their savings and income, aiding them if necessary. These nursing homes should be properly inspected to see if they are adequate. We have one in this town that is run for profit and, in my opinion, is not up to standards, but it is only inspected about once a year and allowed to continue operating. However, it is all we have here and I suppose they figure it is better than nothing. People come out to it from Minneapolis and St. Paul, as well as from Wright County. Most are on welfare.

In conclusion, since your hearing seemed to turn out political, I hope that Minnesota will eventually adopt the Kerr-Mills bill and the King-Anderson bill proposed at this time will definitely be beaten, or any similar bill tied onto social security.

Thank you.

ISABEL S. THIELEN.

MINNESOTA WELFARE ASSOCIATION,
15th and Washington Avenues SE., Minneapolis, Minn.,
December 4, 1961.

The need for assistance to our older people in obtaining adequate medical, hospital, and nursing home care is admitted by every one. Our only disagreement is how this may best be accomplished.

For many years we have felt that health insurance is the most logical and the least burdensome way in which to make sure that the aged get the medical services they require. This could be provided either through voluntary plans or through Government, e.g. an extension of the social security system. Since we know that most people over 65 are not in a position to purchase an adequate amount of private health insurance coverage, we then have three alternatives: (1) To provide a system of public health insurance. (2) Continue meeting medical care costs of the aged from tax funds—which we are now doing under the old-age assistance program. (3) Meet such costs under the Kerr-Mills law, which would require financing from tax funds.

Following are arguments for providing medical care for the aged under an extension of the OASI system:

(1) For 25 years the people of this country have subscribed to the principle of a compulsory insurance system designed to build a fund out of which the normal maintenance needs of the aged will be met after their retirement (OASI).

(2) An aged person is just as certain to need medical care as he is food and shelter. Therefore, there seems no logical reason why this should not be provided for through a system of contributory insurance.

(3) It makes more sense to finance medical care for the aged from an insurance fund to which most of them have contributed during their 35 or 40 years of productive effort than it is to pay for it from tax funds at the point when they need the care.

(4) The principle of insurance as a means of providing protection against the vicissitudes of life is well established in this country—on a voluntary basis There seems no reason why a compulsory plan (which OASI already is as to maintenance needs) under governmental auspices should be regarded as coercion.

(5) If deductions from an employee's salary on a compulsory basis is regarded as improper, then it is just as improper to compel people to pay taxes to support a medical care program. In both cases the payment is compulsory.

(6) Voluntary insurance programs cannot do the job, for several reasons. There is very incomplete coverage of the population; the aged at the time they need the care are the least able to buy insurance because they are without income to do so; and the cost is considerably higher than OASI coverage because the risk is spread over a much smaller group of people.

(7) To meet medical needs through the MAA plan (Kerr-Mills) is nothing more than an extension of public assistance to a larger group than we now have. It is time we got away from the "means test" and established the principle of insurance coverage. In this way people get the care they need from a fund they

have helped create, and as a matter of right, regardless of their financial circumstances at the time they are eligible for it.

While these arguments apply to all types of medical care, we suggest they have particular application (at least in Minnesota) to the provision of nursing home care, since that constitutes such a high percentage of our medical costs for OAA recipients.

MYRTLEMAE PLEBUCH,
Executive Secretary.

3146 WEST CALHOUN BOULEVARD,
Minneapolis, December 14, 1961.

TO THE EDITOR,
The Minneapolis Star.

An article in the December 11 issue of the Star (p. 2–B) states that the American Hospital Association (AHA) may break with the American Medical Association (AMA) on the issue of health care for the aged, according to Medical World News, which states that the hospital group "may be on the verge" of endorsing the Kennedy approved plan for financing medical care for the aged through social security. The article goes on to say that the AMA is outspokenly opposed to the social security approach charging it would be a costly service, covering everyone over 65, regardless of need or lack of it, and would interfere with a person's right to free choice of physician and hospital.

Why does the AMA persist in making statements like this? If they have read the King-Anderson bill, which was before the Congress at its last session, and which will undoubtedly be brought up again at the next session, they must know that the bill specifically states that the patient has the right to choose his hospital and his doctor. If they have not read the bill, they should not make such charges that are not based on facts.

The AMA claims this King-Anderson bill would be a step toward socialized medicine. They favor the Kerr-Mills bill. In my opinion, the Kerr-Mills bill could more properly be characterized as a step toward socialized medicine because that definitely is paid for out of taxes. The plan under the proposed King-Anderson bill is that it will be paid for out of the contributions of every person under social security during his working years, and until his retirement at age 65. It is distinctly an insurance plan. The contribution during his working years is only one-fourth of 1 percent of his earnings up to $5,200 per year. In other words, an employee who earns $5,200 in a year would contribute $13 during the year to this fund to provide hospital and health care benefits when and if he needs them after 65. This is a contribution, not a tax. The employer would contribute a like amount. A self-employed person would contribute three-eighths of 1 percent of his earnings up to $5,200.

Of course this is a compulsory plan for everyone under social security. To that extent, it perhaps might be called regimentation. But the social security system to provide pensions after retirement is also compulsory. I do not hear very many objecting to social security now. As a matter of fact, social security payments to retired persons has been a godsend to thousands, yes millions of our senior citizens, and has actually been a stabilizing force in our national economy.

The actuaries of the Social Security Administration have figured that the contribution of one-fourth of 1 percent from the wages or salary (up to $5,200) of every employed person during his earning years, plus a like amount from the employer will be adequate to provide a fund to take care of hospital and health care benefits paid to persons over 65, when and if they need it. Recipients can accept such benefits with dignity and without any sense of shame and without having to sign any pauper's oath—because it is insurance that they have paid for. They are not accepting charity. The needs test is repugnant to every American.

The hysterical charges made by some opponents of the King-Anderson bill are simply ridiculous. For instance, here are some:

"If the administration programs aren't halted, we will have: Federal control of factory location; Federal control of wages; Federal control of school systems; Federal control of city development; Federal control of hospitals and medicine; and Federal control of the marketplace."

I shouldn't think that such extravagant charges as these would influence anyone.

E. B. RINGHAM,
President, Senior Citizens Council of Minneapolis.

MINNEAPOLIS, MINN., *December 4, 1961.*

DEAR SENATOR LONG: The Senate and Congress had best put forth their efforts toward granting medical care to the aged through social security. They, the aged, have already earned all that will ever be done for them along the welfare line, and why not be graciously considerate of the aged, rather than to first follow the dictates of the AMA and their frustrating treatment. I make no threat, but a united 17 million votes can and eventually will put a lot of faces, new to Washington, there to represent each and every one of us. Past 77 years I hold no brief for exploitation of worthy people or a nation. Look what the Scandinavian people have done and still do; and hold our heads in shame.

RAY M. CLARK,
5701 West 42d Street.

1506 LAUREL AVENUE NORTH,
Minneapolis, Minn., December 28, 1961.

DEAR SENATOR LONG: I am on old-age assistance, county of Hennepin, Minneapolis, Minn. Born March 1, 1875. Have worked all my life but am unable to care for my own needs. I get $74.75 a month to live on from the Hennepin County welfare plus doctor bills and drugs. The welfare treats me fine but I do not have enough money for rent, food, clothing, and laundry.

OSCAR ANDERSON.

MINNEAPOLIS MINN., *December 22, 1961.*

DEAR SENATOR LONG: I think the enacting of this bill through social security is the only solution for senior citizens.

JOHN C. JOHNSON,
2529 Hennepin Avenue.

MINNEAPOLIS, MINN., *December 11, 1961.*

DEAR SENATOR LONG: In answer to my inquiries about the passage of a law providing for medical care for the aged citizens, our Representatives in Congress from Minnesota complained that the American Medical Association is doing everything possible to forestall any such legislation. This sounds to me like a strong hint to me that the American Medical Association is more powerful than both Houses of Congress, that they can prevent any legislation not to their advantage. But these coldhearted medics have said not a word of protest against the lawmakers raising their paychecks, also raising the ex-Presidents' widow's pension to double the amount, and providing for $25,000 a year pension for well-to-do ex-Presidents. This is what I call adequate protection against the ravages of old age. I would not begrudge the lawmakers getting their pay boost if they were as generous to us who are in pressing need, as they are to themselves and to those who are able to help themselves and ask for nothing. But everytime we, the people, who are not in a position to help ourselves, ask for the passage of legislation designed to help us financially in our declining years, when the gates to employment are slammed shut to us, we are met with a chorus of excuses. Such as: "It is too expensive. Who is going to pay for it? Or a group of prosperous, rugged individualists are blocking it because it is regarded as socialized medicine, and creeping socialism designed to make this land a welfare state."

My dear Senator, the name "welfare state" is nothing ominous. It is inspiring. It suggests an idea of a state where the welfare of all is the first and foremost concern of every citizen. Where there is no one too rich and too powerful, and no one too poor and neglected. Indeed, the striving for human welfare in every land should be the religion of every citizen. I would like to see this land of the free and the home of the brave, to be a model of social justice for other nations to take example from, not a laggard. If you are "sold" on this idea I want you to get up on the floor of the Senate at the next session of Congress and speak up for us. Let us know that Senator Edward V. Long is a real friend of the "forgotten men." Let me add this too, that whatever you are able to accomplish for us, we do not want any pauper's oath attached to such provision.

LOUIS PROSZEK.
3723 Queen Avenue N.

MINNEAPOLIS, MINN., *Aug. 5, 1961.*

DEAR SENATOR LONG: After attending the meeting at the Coffman Memorial Hall I shall try to list a few remarks which I would like to make. We were not informed that our suggestions were to be put into writing and we were wholly unprepared. We of the Old Timers Union Club, AFL–CIO, sponsored by the labor movement of Minneapolis are solidly behind the move to attach health and medical bill to social security and we all resent the implications by the medical profession that this bill is socialistic. It is a bill to help the unfortunate men and women that have given the best part of their lives to making our Nation a strong and respectable force for solidarity.

Our wish is that this statement shall not be misconstrued to mean that we stand for organized labor alone. We are interested in humanity at all times. Sisters Myrtle Harris and Marie Hoaglund and myself came as previously stated unprepared as well as the 20-odd more of our members of our club. Due to being unprepared I beg to cite an incident that has come to my attention. A lady in our block had the misfortune to fall and break a bone in her hand. Her doctor did not set the bone or give her any medication and was told it would mend by itself. The following day her husband, a carpenter, had an accident while at work. A flying object struck his glasses and smashed bits of glass were lodged in his one eye. The company doctor that attended him removed a few particles of glass and discharged him and it developed that he still had more glass. She called the doctor and was refused help. She called several other doctors who also refused. As a last resort she had to take him into our general hospital where the remaining glass was removed. I have always thought that a doctor was a man with a heart. I have my doubts now.

I wish to further state that our forefathers immigrated to the United States, fought and died for these United States. We the old-times of today. Many have worked for and shed their blood to make our country one the powers of the world and now the miserly doctors come and claim that giving aid to the men and women that have served the Nation are socialistic—a bitter pill to swallow by these dedicated people.

NELS R. JOHNSON,
411 14th Avenue S.E.

APARTMENT 2, 1801 SECOND AVENUE SOUTH,
Minneapolis, Minn., December 6, 1961.

Senator EDWARD V. LONG,
Washington, D.C.

DEAR MR. LONG: I'm herewith enclosing the testimony I had prepared to give at Coffman Hall at the University of Minnesota in Minneapolis on December 4. I'm sorry not to have been able to attend that meeting. Had a long way to go by bus, which requires considerable transferring. I have trouble with arthritis, and since the day was chilly and damp, I didn't feel it would be wise to stand and wait for bus, as is necessary most of the time.

Thanking you for any help you can give us on this legislation.

Yours truly,

(Mrs.) AMELIA TANNER.

PREPARED STATEMENT OF MRS. AMELIA TANNER, MINNEAPOLIS

I would like to give this testimony in support of the King bill, H.R. 4222, now pending in the House Ways and Means Committee in Washington, D.C. I understand it will provide some payment toward hospital, nursing home, and home health services for persons 65 and over who are beneficiaries under the social security law. I am much in favor of the passage of such a bill as I feel our retired citizens do not wish to be charity patients but prefer this setup which is in the form of an insurance plan.

Because of increasing costs of hospital and health care, many of our retired citizens are unable to pay for the care they need and should have.

As testimony in favor of this bill, I will tell some of my personal experiences. I am a retired citizen over 65 drawing a small social security check of $52.80 per month. I also draw a small check of about half that amount from teachers' retirement. But I find such income will not stretch enough to cover present living expenses; rent ($75 per month) and such high hospital and medical bills. I am having a lot of eye difficulties. I had surgery on both my eyes some years ago. More recently, my eye specialist told me that I had cataracts coming on

both eyes, which would require surgery; and one eye would probably require two operations. Consequently I had surgery on one eye May 17, 1961, for removal of cataract with approximate cost as follows:

7 days in a hospital	$250
12 days in a nursing home	100
Surgeon's and physician's fees	300
Traveling expense, glasses, home help, etc	100
Total	$750

In the near future, I will have to have another operation on this same eye for an eyelid condition, and at some later date removal of a cataract from my other eye.

So with raises in rent and living expenses, together with much higher hospital and medical bills, I feel our retired citizens drawing social security would be greatly benefited if they can be given some help toward hospital expenses, which seem to come to us sooner or later, especially with advancing years.

You will see from what I have said that my two small pensions give me an income of about $80 a month or $960 a year. The rent on my apartment is $75 a month, and if I spend $25 a month or more for other living expenses it makes a total of over $1,200 a year on an income of $960. That gives me an annual deficit of $240 or more. How do I do it? Years ago while I was teaching, I saved and invested part of my teachers salary, chiefly Government savings bonds, and these I have been cashing in as they become due and in that way I am able to meet the expenses that are in excess of my income from pension payments.

But this $750 expense for eye surgery and hospital expense in 1961 was in the nature of a catastrophe and I was able to meet it only by disposing of more of my bonds and trying to pay a part of the bill in installments. But now I face another major expense of the same nature. How long will my savings bonds hold out? And what will I do when they are all gone? That is a question that haunts me, as I dread to contemplate going on relief or old age assistance.

I hesitate to make this disclosure of my personal affairs in public, but I feel that our legislators should know what elderly people are experiencing and how badly we need the relief that this proposed legislation will give us.

Your support is needed to help senior citizens to better health and more happiness. I wish to express my thanks for your support in our behalf.

St. Paul, Minn., *December 5, 1961.*

To the Honorable Senator Edward V. Long,
Washington, D.C.:

I hear you have been in Minnesota, and regret that I did not have an opportunity to meet you; however, a letter will serve the purpose just as well.

In regard to the King-Anderson bill or health care under social security it comes next in importance after national defense. This measure has been discussed and neglected for too long and it should be made into law at once.

The Kerr-Mills law is no solution at all, and is only evidence of Republican inefficiency.

There are no reasons why the administration's medical care plan should not be made into law at once. The many objections raised against the plan by the AMA and others have no foundation in fact. In fact, it is a matter of justice and right.

The Kerr-Mills aid to aged health program passed with President Eisenhower's backing is the worst kind of fiscal irresponsibility, and is stalled in most States because they cannot or will not put up the matching money. It would be variable and the most expensive plan one can envision. It takes a national problem and makes or treats it as if it were the problem of only one or a few States. It is not worthy of consideration at all.

Countless retired persons can get along to meet the requirements of food and clothing but cannot pay health insurance premiums under any circumstances.

The Blue Shield is the only dependable one, but out of reach of countless retired people because they cannot afford to pay the premiums.

The commercial or private insurance companies have never shown any interest in the retired people, and most of them are not dependable at all, because they can cancel the policy for various reasons. The people will be watching the

Congress in the coming session and will remember. The great majority are in favor of health care under social security which is the only sensible and rational solution of the problem. It is for the benefit of all the people. Anyone against it is either confused, ignorant, or mistaken in some way.

Very respectfully,

ALFRED M. ODEGAARD,
Traveler's Hotel, 441½ St. Peter Street.

AUSTIN, MINN., *December 4, 1961.*

DEAR SENATOR LONG: The King-Anderson bill, if passed would be a waste of some of our tax moneys, because some of the older citizens who would receive these benefits would not need financial help in time of illness. At the same time some of the senior citizens who would need help would not get it because they would not be eligible for social security benefits.

The Kerr-Mills law, where implemented, could adequately provide for the health needs of all who need help, and only for those who need help.

I do urge you not to support the King-Anderson bill.

Thank you.

Sincerely yours,

MRS. INMAN HESLA,
501 19th Street, SW.

PREPARED STATEMENT OF RUTH M. HARVEY, DIRECTOR, UNITED CHURCH WOMEN OF GREATER MINNEAPOLIS

Twelve years ago, in November 1949, our nursing home volunteers program was organized in cooperation with the University of Minnesota hospitals and the Twin City Nursing Home Association. The need for such a service had been established as a result of careful study over a period of time.

University hospitals had a very real concern for the patients they placed in nursing homes who were far away from home; the nursing home operators realized the loneliness and the need of patients who had no relatives, or if they had them, were, seemingly forgotten. The interest and support of informed and responsible citizens was important to the operators. Visiting in nursing homes by church people and other interested citizens was nothing new but there had never been sponsoring groups, nor any definite organization.

United Church Women of Greater Minneapolis, a department of the Greater Minneapolis Council of Churches, has as one of its functions the direction of social service projects in the community which can be better accomplished by churches and denominations working cooperatively than by individual church or denomination. We were looking for a new area of service. It was felt that volunteers needed in the nursing homes must have not only a desire to be of service to others, but a large measure of real dedication, and as the director of the social service department of university hospitals put it "a sparkle in their souls." This project appealed to us and we entered into it as pioneers with much enthusiasm because we felt that here was a real unmet need in the community.

The efforts of the three groups were coordinated. United Church Women have the responsibility for recruiting, selecting, and supervising the volunteers. University hospitals acts as the coordinating agency and provides the training for the volunteers and for a number of years the president of the nursing home association selected the homes for volunteers to visit, contacted the operators, and served as a liaison between the operators and the other cooperating agencies.

The purpose of this volunteer project as given in the manual is "This corps of nursing home volunteer visitors was organized to provide a measure of human contact between the patients who must remain permanently in private nursing homes and the outside world. Therefore, in order to break the necessary routine of the day and to provide these people with interest, you are requested to visit them, be a friend to them and to perform such courtesies as will add to their happiness."

The volunteers visit the nursing home to which they are assigned as a unit, and at a time mutually agreeable to the operator and the volunteers. It is a 2-hour visit each week, usually from 2 to 4 p.m. All volunteers are re-

quired to take the orientation given by university hospitals before being assigned to a home.

The aim of the visitor is to become a friend of the patient and to bring him in contact with the outside world—to make him feel a part of what is happening there. They may visit, read or play games, or look at pictures. Birthday and holidays provide opportunities for bringing happiness to the patients through small remembrances, tray favors, refreshments, or special programs for a group of patients.

Patients look forward to the coming of the "Tuesday" or "Thursday" ladies as they call them, and are dressed in their best waiting anxiously for the coming of their "friend" at 2 o'clock. Many volunteers have interested their "circles," church school classes, youth groups and men's clubs in their particular home and in some cases, a church has "adopted" a particular nursing home in which its women are serving as volunteers.

During these 12 years over 400 people have been trained. In this as in all such programs there is a tremendous turnover and currently over 100 are active in 24 homes. During this period we have worked in 41 homes; some have gone out of business and a number are now boarding homes. Our volunteers have given over 40,000 hours of service and 107 of them have been awarded the volunteer service pin of the American Hospital Association for 100 consecutive hours of service. Some volunteers have given from 5 to 10 years of faithful service and one has been a volunteer in this program for 12 years.

We feel that as a project in which we have cooperated with university hospitals we have demonstrated that a real need in the community has been met. We know the need is still here. We are now reevaluating our program—recognizing the growing population of older people, and are gearing it in accordance with the many new developments in the field of geriatrics and new plans for caring for the aging.

2937 41st Avenue South, Minneapolis, Minn.,
December 6, 1961.

Special Committee on Aging,
U.S. Senate,
Old Senate Office Building,
Washington, D.C.

Gentlemen: As a senior citizen, I am very much interested in the passage of a medical aid bill for the aged, based on social security.

While it is the contention of the opposition that most of the senior citizens already carry hospitalization insurance, this is true, but it is insurance we are compelled to carry but cannot afford on account of the ever-increasing rates. Furthermore, this insurance offers no positive security, because it is the practice of a great many insurance companies to send the policyholder a rider, after it had paid a claim, eliminating this particular coverage, which, in the majority of cases, is the coverage which is most needed. Then, again, in cases where a senior citizen happens to carry a policy with a noncancellable clause, many insurance companies "neglect" to send a premium notice, thus allowing the insurance to lapse and then refusing to reinstate the insurance when the insured discovers that the policy has lapsed. This happened to my sister-in-law.

The Kerr-Mills bill is very unsatisfactory from several standpoints. I read an article in a Denver newspaper this past summer that they were having considerable difficulty in that State and that it was not working out. Furthermore, this is charity because it has to be paid out of taxes from a local government; whereas, under a social security bill, the premiums would be prepaid during the productive years of a worker's life when he can afford to make the payments, and not be a drain on the resources of an older person, who has to pay private insurance companies a higher rate for the "privilege" of being over 65 years of age.

Furthermore, the Kerr-Mills bill, as I understand it, places a very nominal limit on the amount of money or personal property which can be possessed by any person receiving benefits under this bill. We older citizens have to have more cash reserve than the Kerr-Mills bill allows. My home is old and I have had to spend a considerable amount of money for repairs; had to put in a new heating plant this fall and there are other major repairs needed. My major appliances are old and will soon have to be replaced. With today's high prices,

I cannot live on my monthly income and have to augment this from my savings account. We also need money in reserve for funeral expenses. This situation would certainly apply to thousands of senior citizens, now and in the future. If we had a reasonably long stay in the hospital, the doctor and hospital bills would deplete our cash reserve and then what? Charity?

Medical aid, under social security law, would enable elderly persons to remain in their own homes, to participate to some extent in community affairs and to receive special care, when required, without considerable worry, which would be the case if we did not have this protection.

Respectfully,

ETHELYN C. GOSSLER.

P.S.—I was 68 last July.

MINNEAPOLIS, MINN., *December 4, 1961.*

To the Senate Committee:

I am a senior citizen of a strong organization in Minneapolis, Minn., that meets once a week. I am very much concerned for the passing of the social security health bill.

My husband was an older man when the social security was passed, consequently we only get $79.50 a month. This is all that we have to live on. We own a five-room bungalow and have a small savings in the local bank. We have to use some of the savings to pay taxes with and for winter gas heat. Last summer my husband became very ill and my son took him to the general hospital. He was there 2 weeks and they charged us $32 a day and pressed us for it. That left us with very little. My husband worked hard all his life and went through a depression and war. We have always paid our bills and don't owe anyone any money. Just lately he went to the clinic on Lake Street and it cost us $20 for that one call and you take $20 from $79.50 and we didn't have too much left for food. What we so badly need is the social security health bill. I worked my way through school and taught school in the State of Wisconsin and also Washington.

Respectively,

KLARA K. WEINKE.

MINNEAPOLIS, MINN., *December 4, 1961.*

DEAR SENATOR LONG: On page 254, "Goals for Americans" report plainly states that the President's Commission were all in favor of health care for the aged though social security.

I am asking you, Senator Long, will you please see that every lawmaker in Washington reads the President's Commission's "Goals for Americans" report.

I have asked quite a number of young men: Are you willing to have deducted from your paycheck one-fourth cent to help finance health care for the aged? And every one was very much in favor of paying. Most of them said that "it is good insurance; I expect to get old some day."

ARTHUR HANSON,
3046 Blaisdell Avenue.

PREPARED STATEMENT OF ARTHUR C. HANSON, PRESIDENT OF LEGISLATIVE GOALS FOR SENIOR CITIZENS CLUB, MINNEAPOLIS, MINN.

The year 1960 President Eisenhower appointed a Commission of 11 U.S. citizens to investigate the conditions in the United States. This Commission appointed 100 citizens to help with the investigation. They found quite a number of things that were needed very much.

One report was medical aid for senior citizens. They recommended that medical aid should be financed through social security. All members voted in favor of this bill.

The Kerr-Mills bill is unjust to all senior citizens. An applicant for help by sickness must sign a pauper's oath. Every man or woman would resent this very much as they would be forced to admit to themselves that they were destitute in life through no fault of their own.

The names of the President's Commission:

Edward D. Canham, president of U.S. Chamber of Commerce.
James B. Conant, president of Harvard University.
Colgate Darden, Jr., Governor of Virginia.
Crawford H. Greenewalt, president of E. I. du Pont de Nemours & Co.
Alfred M. Gruenther, president of American Red Cross.
Learned Hand, judge of U.S. Court of Appeals for the Second Circuit.
Clark Kerr, president of the University of California.
James R. Killian, special assistant to the President of the United States for science and technology.
George Meany, president of AFL–CIO.
Frank Pace, Jr., Secretary of the Army, 1950–53.
Henry Wriston, chairman, president of the American Assembly, Columbia University.

The President's Commission report is called "Goals for Americans."

Medical care for the aged is needed badly and all senior citizens urge the passage in Congress of the King-Anderson bills, H.R. 4222–S. 209, at the next session of Congress.

U.S. Senate Special Committee on Aging.

1316 Clinton Avenue,
Minneapolis, Minn., December 13, 1961.

Dear Senator Long: My complaint is in regards to the inadequacy of my old-age pension check which is for $77.75 per month.

Over a year ago I was living in an apartment that was renting for $32.50. Then the Central Lutheran Church bought the land and put in a parking lot. The cheapest rental I could find was across the street and so I moved there. At first the landlord charged $40 per month and after the first month he raised it to $45.

I am 79 years old and able to do my own work and am still active. However, I have been on an ulcer diet for many years and have to have cream every day. This alone costs $12 per month.

In order to meet expenses I have had to sell my washing machine, sewing machine, and piano. I have nothing more to sell and am getting very nervous since I do not know how I will be able to keep paying for all my living costs. Prices for the base minimum living esentials keep going up but the amount of check I receive has been the same since 1957. I am not able to buy any clothes on the amount received and can buy only the cheapest food which does not give me a balanced diet.

Due to the various redevelopment projects going on, and the condemnation of land for freeways, low-price housing is becoming even more scarce. The landlords are taking advantage of this situation and are charging more than we can afford to pay. There should be ceiling rates on housing and room rentals.

About 4 years ago I put my application for low-price efficiency apartment (public housing) but as yet it has not been accepted. I cannot afford to live in a foster home since they charge $150 per month. Nursing homes are much more expensive. Why then, can we not get a little more to meet our bills and not have to worry ourselves sick. The worrying does not help my ulcer stomach. I need additional help now since one of my friends who was helping me is over 80 and is now sick so he cannot help me to make ends meet.

Marie Johnston.

My expenses are as follows:

Rent	$45.00
Phone	2.00
Paper	1.70
Cream	12.00
Laundry	2.00
Total	62.70
Check	77.75
Expense	−62.70
Balance left for food, clothing, and necessary items	15.05

Marie Johnston.

MINNEAPOLIS, MINN., *December 8, 1961.*

U.S. SENATE, SPECIAL COMMITTEE ON AGING.

DEAR SENATOR LONG: Granted, there are problems in caring for the health of the aging. But, the King-Anderson bill does not really take care of these problems nor does it try to do so in the right manner. If this bill became a law, it would create a far greater evil than that which it supposedly seeks to remedy. Being federally administered, it would surely involve unnecessary Federal expense. It would not give help to many who might really need it. It would enable many to get financial aid for their medical care when in fact they could well take care of it by themselves and would take pride in doing so. It would most assuredly take away one's freedom, eventually, to choose one's own physician. Have you ever seen a situation in which Federal power and regulation did not eventually mean Federal control?

I firmly believe that the Kerr-Mills law must be given a chance to prove that it can be a big step toward giving financial aid to those aging people who need aid in providing for their medical care. And this help would be administered on the local level, which is only right.

It is a real thrill to me to see and hear elderly people give their opinions which show their personal pride in making every effort in caring for themselves so long as it is possible.

My father is 74 years old. He was hospitalized for 23 days this fall, having had surgery. Don't think for 1 minute that he would have wanted others to pay for his medical bill through social security when he could do so himself. And, more important, his children would surely have helped him in his need.

Is not that sort of attitude worth something? Is it not worthwhile to teach our children that freedom of the individual to be responsible for himself is a good thing? That is what makes people a strong people—they are mentally and physically far healthier than those who sit back and let others work and provide for them.

Why should we put our children and grandchildren unnecessarily in debt? Let us give the Kerr-Mills law a chance to take care of the problem of the medical care of the aging—for those who need it—handled on the local level. Let us not tamper with that heritage which we have received from those who left all security for that which they felt was far more important—personal freedom.

Please give this your personal consideration.

Thank you.

MRS. HAROLD J. ANDERSON,
400 19th Street SW., Minneapolis, Minn.

MINNESOTA RETIRED STATE EMPLOYEES ASSOCIATION,
596 SOUTH CRETIN STREET,
St. Paul, Minn., December 7, 1961.

U.S. SENATE, SPECIAL COMMITTEE ON AGING.

DEAR SENATOR LONG: Some provision for at least help with major medical or hospital expenses is desirable, in fact necessary. I am making no suggestion as to what bill, if any of the present bills provides this help the best.

Equally important—or more so—is some plans for more income to the aged. More jobs, less discrimination because of age, more pension. This might include some provision for buying additional coverage under social security.

Persons who have given a major part of their working years to an organization or to a government are due consideration for so-called, or in fact, cost-of-living increases. This is their due as much as it is proper for present employees to receive such increases. I believe when one gets an increase the other should get an increase, probably not as much by considerable. But some increase.

Specifically I want to call attention to two bills before the present Congress for an increase in the pension of retired Federal employees. This will give some needed help for part of the retired populace.

Thank you for this opportunity to express myself. I realize this is not exactly the subject of your hearing.

WAYNE E. WATSON, *Secretary-Treasurer.*

1320 La Salle Avenue,
Minneapolis, Minn., December 8, 1961.

U.S. Senate Special Committee on Aging.

Dear Senator Long: On behalf of senior citizens like myself, I would like to see the bill passed that provides for medical care through social security.

Since my operation for cancer a year ago, I have not been able to work because I am still sick, and cannot secure proper medical care, and the Blue Cross keeps going up all the time so I have to drop it, so I have nothing to pay for hospital care.

I get $60 social security a month, and out of that I pay $45 a month rent for one room, no running water, and no bathroom. I have $15 left for food and clothes, and nothing to pay medical care with.

I need a better place to live, but I am not able to work and earn money and pay higher rent, since this operation for cancer it left me so weak.

Mrs. Ella Fisch.

F-A-M, Inc.,
3149 Hampshire Avenue South,
Minneapolis, Minn., December 21, 1961.

Hon. Edward V. Long,
Special Committee on Aging,
Washington, D.C.

Honored Sir: This is a very important committee for now the number of those 65 and over constitutes about one-tenth of our entire population. I do not believe that anyone on social security would favor any other form of medical care and hospitalization except the King-Anderson bill, but very preferably the Forand bill. The CIO-AFL favors rightly the Forand bill. The medical care and hospitalization amendments put over by the American Medical Association is a monstrosity as it is revolting in its pauper's approach and subjecting the American citizen to that indignity when it is and should be an insurance system which the beneficiary will have paid for in his working days. Certainly when it is a benefit which he himself pays for and does not cost the taxpayer anything, there should not be any objection from any source any more than were one to buy the same protection from a life insurance company on the annuity plan. The reason the AMA opposes it is a purely selfish one. They fear their charges will be controlled and that it will build up competition as against them. They have always been involved in suppressing the entry of new doctors into the profession, as well as other medias of healing. They are the most powerful trust in the United States as they reach into every community dictatorially. And their charges and especially that of hospitals are confiscatory and many who need that help cannot afford it, so become victims of chronic conditions that might have been averted.

And what about the opposition by the Blue Cross and Blue Shield? In the last years the costs over a 10-year period have gone up 96 percent and are still rising while their coverage is shrinking. Unless you are in a group, people cannot get that coverage after 60. They write group coverage which includes for those so favored in the higher age brackets where the costs are the greatest. They want to cover people when the chance of illness is the least. Now, why are they concerned? It would lessen their costs and they could increase the coverage for that selected period.

Were the King-Anderson bill or the Forand bill put to a vote of the general public, it would pass overwhelmingly. I begin to think that we are living under the delusion that this is a democracy. Or has it become an autocracy of special interests who are enabled by their collective pressure selfishly benefiting themselves? The pressure of the average citizen not so situated is building up. All you have to do is to see what is happening all over the world. They are shedding from their backs all mercenary or political mercenaries. We have such an example only 90 miles from our own shores and the controlling groups are fearful of what may become a showplace and are trying to suppress it by indirect means as a blind. It is a dangerous suppression never led to progress. The American people are not what they were like years ago. They are more informed. Through all the media of information, foreign and domestic, they are becoming more critical of what is being done. And they are getting more cognizant of what is going on in the world. They believe that the abundance showered on the favored few also has come from the sweat of their own brow and they want more equitable adjustment in our own society. They are

beginning to seriously doubt slogans which have been so effectively used in the past. They are beginning to see through, and not at, conditions. They are beginning to ask, "Why?" They want to know why their sharing in this credit-inflated prosperity sheds so few benefits on them individually. They wonder whether this lush largess to foreigners in other countries bears any relation to the benefits to be derived by this country—a largess which they have to pay for in increased taxes and debit balances which will be inherited by generations to come. For whose benefit is this done? There are many cogent questions which have not yet been answered and probably will not. They wonder why and for whom all this furor in international diplomacy is for and in whose interests it is done. Most people do not feel that their own interests are a part of it. This is digressing from its own personal problem domestically, but has a relation in its deterrence to the critical requirements on the domestic front. Is it to be an alibi from not doing what should be done on the domestic front and that bogies are purposely built up for that purpose?

Again referring to the 10 percent of our population which conforms to the forgotten men, the oldsters.

The two items that loom the heaviest in expense are housing and medical care and hospitalization.

The housing situation can be corrected by building apartments for senior citizens at low rental as they are now starting in Minneapolis.

The medical care and hospitalization can be corrected for those on social security by the King-Anderson or Forand bills.

The Social Security Act should be amended so that the minimum would be $75 a month instead of, as now, $40. This would take a big part of the load from the welfare departments of each State just as the two other foregoing proposals would do.

However, the Government should take over the financing of such apartments at no interest by a bonding issue where new currency is sent out in payment of such bonds, thereby avoiding the payment of any interest. New legislation would have to be passed and possibly even a constitutional amendment made. The Government cannot loan money but is doing it through other devious methods of guaranteeing such loans as they are doing with the FHA.

If the above were done, it would ease up the critical situation a great deal, for storm clouds are gathering. Make democracy work and no fear need be had of foreign ideologies.

Sincerely yours,

GILBERT A. BRATTLAND.

5138 LOGAN AVENUE NORTH,
Minneapolis, Minn., December 29, 1961.

DEAR SENATOR LONG: Thank you for the opportunity to express my convictions re the attempts to legislate for the care of the aged. In connection with the meeting at the University of Minnesota, there was circulated, purportedly, from the National Council of Senior Citizens from 200 C Street SE., on Capitol Hill, Washington, D.C., a folder giving reasons why the King-Anderson bill should be enacted into law. However, there are so many erroneous conclusions made that are not based on fact, that it is beyond my comprehension that people (the old age group) will swallow without any question. Certain citizens have evidently trained to work with the aged, to gain their good will by promises, and thus win their votes at the next election. In other words, it has become a political football, which is deplorable.

The meeting referred to above was filled with the proponents and some of the speakers at the so-called townmeeting had been coached and lined up. Those opposed were allowed very little time, and one of them, a doctor, was booed when he concluded his speech. And this at a State university, owned by all of us in Minnesota.

Now for a few misstatements:

The King-Anderson bill would aid only those on social security. (This is unfair.) If so—it is not equitable,

More than half have less than $1,000 income. (As a matter of fact married women in general, have no income.)

One-third of aged live with their children. (Seventy percent of the aged on social security own their own homes, 87 percent mortgage free.)

People over 65 have twice the medical bills of younger people. (Statements show that this is a false assumption.)

Hospital costs are double that of 12 years ago. (Yes, but so has everything else. Twice better care is also given. And besides, no one is ever turned down, due to lack of funds.)

Less than half of the aged have health insurance. (Recent reports indicate a greater percentage than that. Besides the King-Anderson bill would hand it out to those who do not need it.)

Older persons are not getting adequate medical care now. (My personal inquiries as regards Minneapolis and State of Minnesota, shows this to be a questionable statement.)

The Kerr-Mills is already a law in operation in most of the States. It allows the States to accept or reject its provisions. It also is controlled by the State, where it should be. This means low administrative costs compared with what it would be if directed from Washington, D.C.

This plan, the Kerr-Mills, is also fiscally sound. That cannot be said of the King-Anderson bill. Those competent in the actuarial field will tell you so. And this differs from what the proponents tell us, who are mainly politicians.

Finally: The one main reason that we as oldsters are here today is because of the tremendous advance in medical care given by the medical profession during the last three generations. Research and discoveries are the background of the care given us all now, thus enabling us to live beyond 65, 70, or 80 years old.

I'll take my hat off to these people for their accomplishments.

And further, when the medical profession supports the Kerr-Mills bill, I am quite sure that we can rely on their judgment to give us what is best, and the most practical approach to the problems of old age.

A senior citizen, age 78, and in fair health.

T. A. GUSTAFSON.

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751 EAST 17TH STREET,
Minneapolis, Minn., November 27, 1961.

DEAR SENATOR LONG: Thanks so much for holding your hearing in Minneapolis, Minn. It was both interesting and informative.

I was 50 when social security started in 1937. Women's wages are always low and my earnings from 50 to 65 years old, did not build up much reserve so my present social security benefits are $40, the minimum.

Men's wages are always higher so widows whose benefits are based on their husband's wages get more.

Educating my two children and caring for my senile mother made it impossible to save anything so I am receiving $71 a month from the State.

These days of high rents and other living costs make living a struggle. I hope our legislators raise the ceiling in the next legislative session.

The Minnesota O.A.A. medical plan works very well for me. I see my doctor often enough to prevent any serious illness.

But many of my friends who have retired on social security with small or no other savings would be wiped out by a serious illness which required a hospital stay.

So I hope the medical plan you present is passed by Congress. There was much opposition to social security when it was started. I believe if this bill is passed the opposition will vanish. Some people are too selfish to want anything that does not help himself.

I hope something can be done to provide employment for young people. My grandson would like to study radio announcing but the Brown School is too expensive and he hasn't found anything else. It is most discouraging for him.

Thanks again for a very pleasant afternoon.

I have a palsied right hand so please excuse my poor writing.

Sincerely,

MARY N. LANGDON.

P.S.—Housing is also a problem, unless one has priority. Public housing here is not much help.

BOX 63, VERNON CENTER, MINN.,
December 26, 1961.

Senator PAT MCNAMARA.

DEAR SENATOR: I just read your article entitled "Big Crusade Launched for Aged Health Care," which is of my opinion one of the most essential needs in the United States today. The living costs since 1952 has grown so out of proportion with the amount social security is paying, that many people over 65 can hardly live on it. Not only that, but hospital cost have gone up beyond the reach of most people living on social security.

I am 73 years old. I have worked as an engineer and machinist until I had to quit because of a heart condition on November 29, 1945. I was 57 at that time. I started drawing social security in 1953 and am now drawing $55 per month. However since 1952, under the Republican administration, they fixed things so the farmers, regardless of how much they are worth, can buy themselves into social security with one lump sum and draw full amount of the pension plan. On the other hand, as I understand, it was set up for the laboring person, and as I look at it, it was set up for a vote getter. I can point out not one, but several farmers that are well to do, some of them still farming and drawing their monthly payments from social security. I also can point out where many farmers were exempt from Army duty because they produced food products and those same farmers became wealthy from it.

What I cannot understand is, we elect men by vote, to represent all the people. Why should the doctors and insurance companies have anything to say about it, when they have hiked their prices out of range of the person that has to live on a limited amount like the laboring man, because no farmer or businessman can make money if the laborer does not make it for him. So every one that hires men makes a profit off the laborer, but now he is too old to work, so they want him to go hungry, and without medical care because the costs are beyond his capacity to pay.

It is time that the men and women that worked all their lives, until they are no longer able to work, are taken care of with respect as American citizens, in my opinion, it is a must.

Our Government is spending billions of dollars for war preparedness, etc., so why do all this spending and forget the very people that have helped build this great country, by letting them go hungry and unable to pay the cost of the doctors and the hospitals? Final note, as Harry Truman would say "give 'em hell."

Yours truly,

FRANK W. LEEMAN.

MINNEAPOLIS, MINN., *December 4, 1961.*

DEAR SENATOR LONG: I am 100 percent in favor of the health bill through social security as with the rising cost of Blue Cross senior citizens with only their social security benefits are unable to keep it up.

Mrs. CLARA JOHNSON,
2529 Hennepin Ave.

MINNEAPOLIS, MINN., *December 26, 1961.*

DEAR SENATOR LONG: I, too, would like to go on record in favor of the administration favored plan on medical aid to the aged.

I am not a senior citizen; but I am very much interested in the geriatric field. As former volunteer worker with the Council of Jewish Women in the field of golden age work, I decided to enter the University of Minnesota to earn a degree in sociology. I am 47 years of age. You can see, therefore, that I, too, shall be in the class of senior citizens.

I was very much interested in the hearing which I attended. It seemed to me that the general concensus of opinion was that the majority of the people

there felt that medical care should be a part of the social security office. I am in firm agreement with the statement uttered by Abraham Lincoln that "this Government of the people, by the people, and for the people." And when a large segment of our population is in favor of such a program that our duly represented legislators hearken to the voice of the people.

Thank you.

Yours very truly,

ESTHER H. S. HAMMERMAN,
2612 Plymouth Ave. N.

Senator LONG. Thank you so much for being here.

(Whereupon, at 4 p.m., the committee adjourned.)