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SENATE

REPORT
No. 91-119

DEVELOPMENTS IN AGING
1968

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 223, MARCH 15, 1968

Resolution Authorizing A Study of the Problems of the Aged and Aging

TOGETHER WITH

MINORITY VIEWS

APRIL 3, 1969.—Ordered to be printed

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[1] Five vacancies in committee membership were caused by the departure from the Senate of Senators George A. Smathers (Democrat, Florida), Wayne Morse (Democrat, Oregon), Edward V. Long (Democrat, Missouri), Frank Carlson (Republican, Kansas), and Thruston B. Morton (Republican, Kentucky). With the adjustment early in 1969 of committee party ratio from 13–7 to 11–9, one Democratic vacancy existed and was filled by Senator Hartke. Senators Murphy, Fannin, Gurney and Saxbe were appointed to fill the remaining vacancies.

[2] Senator Williams, Chairman of the Committee on Aging, also served as chairman of its Subcommittee on Consumer Interests of the Elderly until June 20, 1968, when Senator Church became its chairman.

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[1] Senator George A. Smathers (Democrat, Florida), served as chairman of the Subcommittee on Health of the Elderly throughout the 90th Congress. Senator Muskie became its chairman at the beginning of this year.

LETTER OF TRANSMITTAL

MARCH 31, 1969.

Hon. SPIRO T. AGNEW,
President of the Senate,
Washington, D.C.

DEAR MR. PRESIDENT: I have the honor of submitting to you the report of the Special Committee on Aging in compliance with the requirements of Senate Resolution 223, adopted March 15, 1968.

The committee, charged by that resolution "to make a full and complete study and investigations of any and all matters pertinent to problems and opportunities of older people" initiated several new studies and continued several inquiries during 1968.

This report reviews the work of the committee and its subcommittees; and it reports on other developments in aging which have occurred since the last committee report, "Developments in Aging," was filed on April 29, 1968.

Senate Resolution 76, which was passed unanimously by the Senate on February 17, 1969, gives the committee new authority to continue its work on matters of direct importance to 20 million Americans now past 65 and the many millions who are nearing that age. Much of that work, as clearly indicated in the following report, is of considerable urgency. The committee will do all in its power to direct public attention to important areas of concern and to make recommendations for action by appropriate congressional units.

On behalf of the members of the committee and its staff, I should like to extend my thanks to the officers of the Senate for the cooperation and courtesies extended to us.

Sincerely,

HARRISON A. WILLIAMS, *Chairman.*

SENATE RESOLUTION 223, 90TH CONGRESS, 2D SESSION

Resolved, That the Special Committee on Aging, established by Senate Resolution 33, Eighty-seventh Congress, agreed to on February 13, 1961, as amended and supplemented, is hereby extended through January 31, 1969.

SEC. 2. It shall be the duty of such committee to make a full and complete study and investigation of any and all matters pertaining to problems and opportunities of older people, including but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing, and, when necessary, of obtaining care or assistance. No proposed legislation shall be referred to such committee, and such committee shall not have power to report by bill or otherwise have legislative jurisdiction.

SEC. 3. The said committee, or any duly authorized subcommittee thereof, is authorized to sit and act at such places and times during the sessions, recesses, and adjourned periods of the Senate, to require by subpena or otherwise the attendance of such witnesses and the production of such books, papers, and documents, to administer such oaths, to take such testimony, to procure such printing and binding, and to make such expenditures as it deems advisable.

SEC. 4. A majority of the members of the committee or any subcommittee thereof shall constitute a quorum for the transaction of business, except that a lesser number, to be fixed by the committee shall constitute a quorum for the purpose of taking sworn testimony.

SEC. 5. For purposes of this resolution, the committee is authorized (1) to employ on a temporary basis from February 1, 1968, through January 31, 1969, such technical, clerical, or other assistants, experts, and consultants as it deems advisable: *Provided,* That the minority is authorized to select one person for appointment, and the person so selected shall be appointed and his compensation shall be so fixed that his gross rate shall not be less by more than $2,300 than the highest gross rate paid to any other employee; and (2) with the prior consent of the executive department or agency concerned and the Committee on Rules and Administration, to employ on a reimbursable basis such executive branch personnel as it deems advisable.

SEC. 6. The expenses of the committee, which shall not exceed $200,000 from February 1, 1968, through January 31, 1969, shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee.

SEC. 7. The committee shall report the results of its study and investigation, together with such recommendations as it may deem advisable, to the Senate at the earliest practicable date, but not later than January 31, 1969. The committee shall cease to exist at the close of business on January 31, 1969.

FOREWORD

Just about 2 years from now, thousands of delegates can be expected to assemble in Washington, D.C., for a White House Conference on Aging.

That conference, proposed in legislation signed into law last September 28,[1] will enable our Government and its people to evaluate national performance thus far in achieving security and satisfaction in life among our aged and aging population.

More than that, the Conference should help us decide what we as a people hope to accomplish—in terms of well-being for an increasing number of Americans—in the decade that follows it.

(We will begin the 1970's with at least 20 million persons past 65, and we will begin the 1980's with approximately 3.1 million more.)

Two years may seem to be more than adequate for conference preparations, but if we look back 10 years ago—when the 1961 White House Conference on Aging was being planned—we can see that every minute will be needed in the months ahead.

Action should be taken early by individual States, which are expected to conduct their own conferences well in advance of the Washington, D.C., assemblage. State meetings, as well as technical studies, preceded the 1961 White House Conference. As a result, delegates to the national conference had a body of information and recommendations that proved invaluable.[2] Every effort should be made during 1969 to assure that funding this year is at an adequate level to help States get off to a good start.

In addition, the new administration should give early priority to its own preparations, studies, and liaison with States. The Department of Health, Education, and Welfare is charged by law with the responsibility for planning the conference; it should have a plan of action ready for scrutiny at the earliest possible date.

A sense of urgency is needed, not only to head off last-minute hastiness or confusion, but also because so much depends upon the success of the conference.

What is at stake? The following chapters of this report by the U.S. Senate Special Committee on Aging provide part of the answer to that question.

They show:

—That inadequate income is still the major problem facing most older Americans, one-third of whom live in poverty.

—That, even with Medicare and Medicaid, rising health care costs are causing great concern, and some hardships.

[1] Public Law 90-526, declaring that it is the sense of the Congress that a White House Conference on Aging be called by the President in 1971, resulted from legislation introduced by Senator Williams in 1967 and resolutions introduced in the House of Representatives soon after. Text of the law appears in appendix 3, page 223

[2] "The Nation and Its Older People," a report issued to summarize major achievements of the 1961 White House Conference, estimated that at least 200,000 persons participated in preliminary State conferences and other activities. The Washington, D.C., conference was attended by more than 2,500 delegates.

—That grave shortages exist in housing, nursing homes, and other forms of shelter.
—That while there have been some advances and innovations in the delivery of social services to the elderly, gaping deficiencies exist.
—That chronic questions persist in terms of Federal organization of programs for the elderly. The role of the Administration on Aging, for example, is not yet clear cut, even after 3 years of existence.
—That many elderly members of minority groups, in particular, pay a heavy price because of unresolved questions or inadequate action taken to meet needs of the low-income aged.
—That, intensifying all other problems, there is a widespread mood of alienation among the millions of Americans who find that their status and hopes deteriorate when retirement begins. That sense of alienation was measured in a poll late in 1968, and it was found that a large percentage of "older people tend to see themselves as left out of things and have the impression that few think they can contribute anything." [3]

While this annual report of the Committee on Aging must of necessity discuss problems, it also discusses achievements and opportunities that are now taking shape as more Americans live more years in retirement:

—Forty-seven States now have agencies on aging that meet requirements of the Older Americans Act of 1965. A growing number of counties and municipalities have established commissions or offices on aging. More than ever before, government is recognizing that Federal-State-local teamwork is needed to build a network of services and resources for the elderly.
—There is a rising demand for educational and recreational opportunity, as well as other leisure activities that will make retirement a period of continuing personal development and satisfaction.
—As pilot projects have already clearly proven, large numbers of retirees can find new meaning in life by performing—in their own communities or in institutions for the ill and disabled—much needed services not otherwise provided.
—There are signs that government and private organizations can work together in new experiments on behalf of the elderly. The model cities program, for example, is bringing together leaders from all parts of communities for joint action.

Much more could be said about problems and possibilities that should be explored before and during the 1971 White House Conference, but perhaps the following points are already clear:

If it is to succeed, the White House Conference should be far more than just one more occasion for talk about the elderly.

[3] From a report by Louis Harris, special analyst, Dec. 18, 1968.

It should arouse the Nation to more responsive concern about failures in meeting immediate needs and in anticipating long-term problems affecting the elderly.

It should give a plan of action during the 1970's.

The Committee on Aging will do all in its power to help achieve both goals.

HARRISON A. WILLIAMS,
Chairman, U.S. Senate Special Committee on Aging.

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EVERY TENTH AMERICAN

Older Americans—those of age 65 or over—increased in numbers throughout the Nation by approximately 13.5 percent between 1960 and 1967, according to recent Census Bureau estimates. Greatest percentage growth occurred in Nevada, Arizona, Florida, Hawaii, and New Mexico. Florida succeeded Iowa as the State with the highest percentage (12.7), and New York had the largest number, 1.9 million.[1] Our 65-plus population now stands at about 20 million, or 10 percent of our population.

What is every 10th American like, and how does this age group change? The following summary [2] provides some answers:

ON NUMBERS. The older population is comprised of almost 20 million separate individuals whose most commonly shared characteristic is that they have passed their 65th birthday. It's a changing group; in the course of a year, there is a *net* increase of 300,000 but 1.4 million or 7 percent are newcomers to the age group.

ON AGE. Most older people are under 75; half are under 73; a third are under 70. More than a million are 85 and over.

ON LIFE EXPECTANCY. At birth—70 years, 67 for men but 7 years longer or 74 for women. At age 65—15 years; men can expect another 13 years but women can expect another 16 years.

ON SEX. Most older people are women, over 11 million; men are over 8 million. For all those 65 plus, there are 130 women per 100 men; for 85 plus, more than 160 women per 100 men.

ON MARITAL STATUS. Most men are husbands; most women are widows. Of married men, more than 40 percent have under-65 wives.

ON EDUCATION. Half never got to high school. Some 3 million or 17 percent are illiterate or functionally illiterate. Only 5 percent are college graduates.

ON LIVING ARRANGEMENTS. Ninety percent of the men and 80 percent of the women head up their own households, including some who live alone or have taken nonrelatives into their homes.

ON HEALTH. Eighty-two percent get along on their own; only 15 percent have no chronic conditions, diseases, or impairments of any kind but the vast majority of those that do, still get along fine by themselves. Older people are subject to more disability, see their doctors more often and have more and longer hospital stays. Medicare is accomplishing its purpose.

[1] For full information on population of all ages and 65 plus, by State, July 1, 1967, see Item 1, app. 2, p. 215.
[2] Summarized from speech given by Mr. Herman B. Brotman, Chief, Reports and Analysis, Administration on Aging, HEW, at State Conference, Iowa Commission on the Aging, at Des Moines, October 2, 1968.

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ON AGGREGATE INCOME. About $45 billion a year. Almost half from retirement and welfare programs, almost a third from employment, and about a fifth from investments and contributions.

ON PERSONAL INCOME. Older people have less than half the income of the younger. In 1967, median income of older families was $3,928; median income of older persons living alone or with nonrelatives was $1,480. About 30 percent of older people live below the poverty line; another 10 percent are on the border. Many aged poor are poor primarily because of age.

ON EXPENDITURES. Like most low-income groups, older people spend proportionately more of their incomes on food, shelter, fuel, and medical care. They do not necessarily need other things so much less, they just can't afford them.

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1st Session } { No. 91-119

DEVELOPMENTS IN AGING—1968

APRIL 3, 1969.—Ordered to be printed

Mr. WILLIAMS of New Jersey, from the Special Committee on Aging, submitted the following

REPORT

[Pursuant to S. Res. 223, 90th Cong.]

INTRODUCTION AND SUMMARY

Economic problems among older Americans dominated all developments in aging during 1968.

Social security benefit increases granted in 1967 were soon overtaken by the rising cost of living.

Rising health care costs triggered widespread concern; raised questions about the future of the Medicaid program; and caused the outgoing Secretary of Health, Education, and Welfare to decide against raising the $4 monthly Medicare (Part B) premium on the grounds that it would contribute to health costs "inflation."

Poverty among the elderly remained disproportionately high, and a "moderate" couples retired budget issued during 1968 showed that in 1966 even modest consumer needs were far beyond the reach of most persons past age 65.

Faced by such formidable facts, the Senate Special Committee on Aging will devote considerable attention to the "Economics of Aging" during 1969.[1]

I. MAJOR LEGISLATIVE AND ADMINISTRATIVE ACTIONS

Even though the year passed without passage of major legislation directly designed to increase retirement income, progress was made on other fronts:

- The Housing and Urban Development Act of 1968 offered new programs of potential help to middle- and low-income older Americans.

[1] "Economics of Aging: Toward a Full Share of Abundance," issued in March 1969 as a working paper by a Task Force appointed by Senator Harrison A. Williams, Chairman, U.S. Senate Special Committee on Aging. Task Force members are: Dorothy McCamman, Consultant; Juanita M. Kreps, Ph.D.; James H. Schulz, Ph.D.; Harold L. Sheppard, Ph.D.; Agnes W. Brewster.

- Experiments and studies were either ordered or conducted by the Department of HEW with a view toward reducing health care costs. One major proposal: Medicare coverage of certain prescription drugs.
- Candidates for the Presidency of the United States agreed on the need for higher Social Security benefits.
- The Congress enacted a law calling for a White House Conference on Aging in 1971.
- Far-reaching health programs for all age groups were renewed or established.
- Though only partially funded, the Age Discrimination in Employment Act went into effect.
- Planners of Model Cities programs were directed to give adequate attention to the elderly in target neighborhoods.
- The number of projects funded by title III programs of the Older Americans Act reached 700, and the number of States with approved plans reached 47.
- Pilot senior aide programs went into operation; new foster grandparents were enlisted; the green thumb program scored new successes; and additional funds were earmarked for senior service programs.
- A start toward pension law revision was made.
- Extensive surveys of training needs in aging and related fields were completed.
- Proposed amendments to the Older Americans Act—while not passed—could receive early action in 1969.
- Some steps toward higher nursing home standards were taken.

II. COMMITTEE AND SUBCOMMITTEE STUDIES

Members of the U.S. Senate Special Committee on Aging were involved in many of the developments listed above. In addition, the following hearings were conducted during 1968:

Full Committee	**Usefulness of the Model Cities Program to the Elderly.** **Washington, D.C., July 23.** **Seattle, Wash., October 14.** **Ogden, Utah, October 24.** **Syracuse, N.Y., December 9.** **Atlanta, Ga., December 11.**
	Availability and Usefulness of Federal Programs and Services to Elderly Mexican-Americans. **Los Angeles, Calif., December 17.** **El Paso, Tex., December 18.** **San Antonio, Tex., December 19.** **Washington, D.C., January 14, 15 (1969).**
(Joint Project)	
Subcommittee on Employment and Retirement Incomes and Subcommittee on Federal, State, and Community Services	**Adequacy of Services for Older Workers.** **Washington, D.C., July 24, 25, 29.**
Subcommittee on Consumer Interests of the Elderly	**Hearing Aids, Hearing Loss, and the Elderly.** **Washington, D.C., July 18, 19.**
Subcommittee on Health of the Elderly	**Costs and Delivery of Health Services to the Elderly.** **Los Angeles, Calif., October 16.**

III. CONCLUSIONS AND RECOMMENDATIONS

Chapter	Conclusion or Recommendation	Page
I	There is danger that the "fact" of low income among the elderly could become accepted as an inevitable component of life, just as the probability of dying before age 50 once was. Close attention must be paid now to the many related problems that produce inadequate retirement income if we are to realize that the Nation is faced with a problem far more intricate, pervasive, and potentially dangerous than is commonly recognized.	9
I	The prevalence and persistence of poverty among elderly Americans raises forceful arguments for insisting that the next major increase in Social Security be directed primarily at the substantial raising of minimum payments as a prerequisite to more general increases.	12
I	Old-age assistance, along with other forms of public welfare, stand in need of searching re-evaluation both as to objectives and standards. The Senate Special Committee on Aging, recognizing that widespread evaluation and reform of the entire welfare system is imminent, urges that inadequate OAA payments receive careful attention.	12
I	Recognizing that careful consideration must be given to far-reaching issues related to income maintenance of the elderly, the Senate Committee on Aging renews its recommendation that an Institute on Retirement Income be established to provide a continuing, problem-solving mechanism that could assist the Congress and the executive branch in formulating policy or subjects for debate and national analysis. In addition, the committee recommends that the Institute take on as an early assignment a study of the many possible indices that could be employed in establishing automatic cost-of-living increases under the OASDHI social insurance program. Every effort should be made to arrive at an index that gives adequate weight to the special problems of low-income Americans in particular, including inadequate minimum payments.	13
I	Prompt enactment of the changes recommended by Secretary Cohen (in his report to Congress entitled "The Retirement Test Under Social Security") should be the minimum action Congress should take toward the goal of enabling social security recipients to earn enough to supplement retirement benefits which are frequently inadequate.	15

Chapter	Conclusion or Recommendation	Page
II	Rising medical care costs are causing demands for Medicare revisions, such as: elimination of co-insurance and deductibles; at least partial coverage of non-hospital prescriptions; financing of Part B through the payroll tax spread over the rising earnings of workers rather than through monthly premiums paid by the aged; and imposition of tighter cost controls.	23
II	Such demands should be considered in comprehensive congressional and administrative reviews of Medicare intended to make that historic program an even more valuable component of a concerned society.	23
II	Medicaid, imperfect and costly as it is, could become a highly effective program to provide assistance to Americans who stand in greatest need of health services or care now beyond their reach. The national commitment expressed in the Medicaid legislation of 1965 should be honored, but the Federal-State dialog on needed reforms should be broadened and put on a high-priority level of action, if funds meant to help the needy and medically needy are to be put to the best possible use.	
II	The committee renews its recommendations for action that will promote preventive medicine, implement a broad educational program for consumers of health services, and broaden services provided by OEO Neighborhood Health Centers. In addition, the committee recommends that all cost-cutting research or experimental projects be so designed as to simultaneously upgrade the quality of services rendered. Useful findings from this and other research should be implemented at the earliest possible date.	33
III	The BLS budget should receive sustained attention and—where necessary—criticism intended to arrive at the most accurate, acceptable standards possible for moderate consumer requirements of the elderly. In addition, the use of consumer price indexes as a measure of need for adjustment and amount of adjustment in retirement benefits should also receive careful attention.	38
III	The growing awareness of difficulties encountered by elderly and others in low-income areas should lead to more intensive scrutiny of such problems as: effect of shutdowns of retail stores on elderly shoppers, especially those whose mobility is limited; usefulness of the food stamps program for the elderly in such areas; experiments in making shopping facilities more readily accessible; and the need for additional information for individual shoppers and Government officials responsible for consumer protection.	40

Chapter	Conclusion or Recommendation	Page
III	The meal service and nutrition projects sponsored by AoA funds can be significant in terms of information gathered, people served, and the channels they open to other services needed by the elderly. These projects should receive careful evaluation by the AoA, other governmental agencies, and appropriate congressional units.	41
VII	The soundness of the concept of community service by older Americans—either as paid participants or as volunteers—has been amply demonstrated in many promising pilot programs. The committee renews its recommendation that advantage be taken of the lessons learned within recent years, and that a comprehensive national program—using all available resources at Federal, State, and local levels—be considered by the Congress and enacted into law at the earliest possible date.	76
X	Goals for the Model Cities Program—as established by Federal officials and by those private and public citizens now seeking to establish projects at the local level—are ambitious, and it is well that they are so, because the need is great. The elderly population in target areas stand to benefit, in particular, if such ambitions are fulfilled. Every effort should be made during 1969—a critical period in the evolution of a complex program—to assure that the model cities effort succeeds in developing and implementing much-needed innovations and combinations of programs in neighborhoods of great need.	97
XIV	Preretirement counseling can be of great significance and assistance to men and women about to make far-reaching adjustments to an entirely new role in life. The Federal Government should take the lead in providing action programs within its own agencies to serve as models for application elsewhere.	113
XIV	There is room for much additional experimentation by the Federal Government in terms of new work arrangements that could counter ill-effects of arbitrary retirement ages. Close attention should be given to this subject by Federal officials in the near future.	114

CHAPTER I

THE FUNDAMENTAL PROBLEM: INADEQUATE RETIREMENT INCOME

American men and women—while working on a full-time job—can claim a direct share in rising productivity: their earnings usually rise along with output or work effectiveness.

And, within recent years, productivity has increased at about four percent annually.

Older Americans in retirement find that—while work force incomes of younger persons rise at a substantial rate each year—their incomes remain fairly constant.

Worse yet, retirees' purchasing power is diminished by several erosive forces. Part-time job opportunities disappear as years go by. Costs go up on health services not covered by Medicare or Medicaid. Homeowners pay higher property taxes. Inflation takes its toll.

I. THE DIVISION DEEPENS

Consoling as it would be to hope that the sharp division between incomes of the old and the young is narrowing, a new Administration on Aging analysis shows that quite the contrary is true.

A reading of the tables on this and the next page forces us to face the following facts:

TABLE 1.—*Trend in median money income of families and unrelated individuals, 1960–67*[1]

Period	Families			Unrelated individuals		
	Heads 14 to 64 (amount)	Heads 65-plus		14 to 64 (amount)	65-plus	
		Amount	Percent of 14 to 64		Amount	Percent of 14 to 64
1960	$5,905	$2,897	49.1	$2,571	$1,053	41.0
1961	6,099	3,026	49.6	2,589	1,106	42.7
1962	6,336	3,204	50.6	2,644	1,248	47.2
1963	6,644	3,352	50.4	2,881	1,277	44.3
1964	6,981	3,376	48.4	3,094	1,297	41.9
1965	7,413	3,514	47.4	3,344	1,378	41.2
1966	7,922	3,645	46.0	3,443	1,443	41.9
1967	8,504	3,928	46.2	3,655	1,480	40.5
Percent change:						
1960–67	+44.0	+35.6	----	+42.2	+40.6	----
1962–67	+34.2	+22.6	----	+38.2	+18.6	----
1960–61	+3.3	+4.4	----	+.7	+5.0	----
1961–62	+3.9	+5.9	----	+2.1	+12.8	----
1962–63	+4.9	+4.6	----	+9.0	+2.3	----
1963–64	+5.1	+.7	----	+7.4	+1.6	----
1964–65	+6.2	+4.1	----	+8.1	+6.2	----
1965–66	+6.9	+3.7	----	+3.0	+4.7	----
1966–67	+7.3	+7.8	----	+6.2	+2.6	----

[1] See footnote, table 2.

Source: Bureau of the Census.

TABLE 2.—*Distribution of families and unrelated individuals by money income in 1967* [1]

Income	Families				Unrelated individuals			
	Distribution		Cumulative		Distribution		Cumulative	
	Heads 14 to 64	Heads 65 plus	Heads 14 to 64	Heads 65 plus	14 to 64	65 plus	14 to 64	65 plus
Total:								
Number (thousands)	42,764	7,070	----------	----------	8,048	5,066	----------	----------
Median income	$8,504	$3,928	----------	----------	$3,655	$1,480	----------	----------
Percent	100. 0	100. 0	----------	----------	100. 0	100. 0	----------	----------
Under $1,000	1. 8	3. 7	1. 8	3. 7	16. 0	25. 0	16. 0	25. 0
$1,000 to $1,499	1. 2	5. 8	3. 0	9. 5	8. 3	26. 0	24. 3	51. 0
$1,500 to $1,999	1. 5	9. 2	4. 5	18. 7	6. 3	15. 0	30. 6	66. 0
$2,000 to $2,499	2. 1	10. 2	6. 6	28. 9	6. 1	9. 3	36. 7	75. 3
$2,500 to $2,999	1. 8	8. 0	8. 4	36. 9	5. 2	5. 6	41. 9	80. 9
$3,000 to $3,499	2. 6	7. 7	11. 0	44. 6	6. 6	4. 2	48. 5	85. 1
$3,500 to $3,999	2. 5	6. 4	13. 5	51. 0	4. 9	2. 7	53. 4	87. 8
$4,000 to $4,999	6. 0	9. 5	19. 5	60. 5	10. 2	3. 5	63. 6	91. 3
$5,000 to $5,999	7. 9	7. 3	27. 4	67. 8	10. 0	2. 4	73. 6	93. 7
$6,000 to $6,999	8. 6	6. 3	36. 0	74. 1	8. 0	1. 5	81. 6	95. 2
$7,000 to $7,999	9. 5	5. 1	45. 5	79. 2	5. 7	1. 1	87. 3	96. 3
$8,000 to $8,999	9. 0	4. 1	54. 5	83. 3	3. 6	. 8	90. 9	97. 1
$9,000 to $9,999	7. 7	3. 2	62. 2	86. 5	2. 2	. 5	93. 1	97. 6
$10,000 to $14,999	24. 8	7. 7	87. 0	94. 2	4. 8	1. 3	97. 9	98. 9
$15,000 to $24,999	10. 4	4. 3	97. 4	98. 5	1. 5	. 8	99. 4	99. 7
$25,000 plus	2. 6	1. 5	100. 0	100. 0	. 6	. 3	100. 0	100. 0
Head year-round, full-time worker:								
Percent of total [2]	76. 4	15. 4	----------	----------	52. 6	8. 0	----------	----------
Median income	$9,368	$7,418	----------	----------	$5,390	$3,859	----------	----------

[1] By age groups (14 to 64 and 65 plus). Data are estimates derived from the March 1968 survey of a national probability sample of households; they are subject both to sampling variability and to errors in response and nonreporting.

[2] Excluding Armed Forces.

Source: Bureau of the Census.

—While the income of older persons has been rising—largely because of fitful improvements in retirement payments—the rise has not been as rapid as for the younger group.

—As a result, the median income of older families which was 50.6 percent of that of younger families in 1962, was only 46.2 percent of the median income of younger families in 1967.

—Single elderly individuals have fared even worse. Their median income dropped from 47.2 percent of that of younger individuals in 1962 to 40.5 percent in 1967.

Additional evidence about the seriousness of the situation is readily available.

—One 1968 study [1] showed that the social security increases voted in 1967 momentarily restored most beneficiaries' purchasing power to the amount received at the time they came on the rolls. But as this study points out: "Unless statutory benefit increases more than just match upward price movements from the time of one benefit increase to the next, inflation will continue to adversely affect retirees' purchasing power because the value of their fixed benefits deteriorates as prices rise steadily between the passage of amendments to the law."

—Most retirees have incomes far below the "Retired Couple's Budget for a Moderate Standard of Living," autumn 1966,[2] issued by the U.S. Bureau of Labor Statistics in mid-1968.

—Projections indicate that by 1980 there will still be long-term deficiencies in private and public pension payments.[3] There is no reason to believe that these projections are unduly pessimistic.

—Even though only one in five older persons is in the labor market, and most are in part-time or low-pay jobs, their total earnings add up to almost a third of the aggregate income of all older people. Any threat to this earning power—such as the trend toward earlier retirement ages or decreased employment opportunities after age 65—could have serious effects upon the total income structure of the elderly.

—Out-of-pocket medical expenses, even for those covered by Medicare or Medicaid, are on the increase.[4]

For the reasons given above, and for others now under study, the Senate Committee on Aging will give extensive attention in 1969 to income and other problems related to the economics of aging. Broad public exploration of issues [5] related to retirement income is essential at an early date, because:

There is danger that the "fact" of low income among the elderly could become accepted as an inevitable component of life, just as the probability of dying before age 50 once was. Close attention must be paid now to the many related problems that produce inadequate retirement income if we are to realize that the Nation is faced with a problem far more intricate, pervasive, and potentially dangerous than is commonly recognized.

[1] "OASDHI Benefits, Prices and Wages: Effects of 1967 Benefit Increase," Research and Statistics Note, Social Security Bulletin, December 1968.

[2] Additional discussion of the BLS budget appears in ch. 3.

[3] For discussion of these projections, see "The Economic Status of the Retired Age in 1980: Simulation Projections," Social Security Administration Office of Research and Statistics *Research Report* No. 24, 1968.

[4] See pp. 19–24, *Social Security Bulletin*, August 1968, for additional information about the effects of medical costs, and ch. 2 of this report.

[5] See pp. 1–23, "Developments in Aging—1967," U.S. Senate Special Committee on Aging, Apr. 29, 1968, for additional discussion of these issues; see also footnote 1, p 1.

II. THE SPECIAL PROBLEM OF POVERTY

All that has been said thus far in this chapter deals with problems faced by most retired people. Mention has been made of medians, and of course there are highs and lows involved. At one end of the scale are about 950,000 older families with incomes of $10,000 or more. At the other end, however, are those elderly Americans who live in poverty; and they are not moving out of poverty as rapidly as those in other age groups.

Measures for poverty.—Social Security Researcher Mollie Orshansky recently gave this description of the SSA criteria for determining poverty:

> A husband aged 65 or over with his wife, not living on a farm would be poor with an income less than $1,975 in 1966; he would be near poor with an income of more than $1,975 but less than $2,675.[6]

She added:

> In 1966, a considerable number of elderly families were poor. Of the 4.2 million elderly husband-wife couples not on farms, 1.9 million or 2 out of 5 had less than $2,675 for the year.

For elderly persons living alone, to be poor is to have an income of less than $1,565. To be near-poor means to have an income near but less than $1,900. Two out of three unrelated aged individuals not living on farms were poor or near-poor.

Number of aged poor: 1966.—As the following table shows, there was a decline between 1959 and 1966 of 7 percentage points in the proportion of the elderly who were poor.

(See table on following page:)

[6] "Living in Retirement: A Moderate Standard for an Elderly City Couple," Social Security Bulletin, October 1968.

Trends in poverty: Percent of persons with income below the SSA poverty index, by age, 1959–1966

[Numbers in millions]

Age	1959			1964			1966		
	Total persons, number	Poor		Total persons, number	Poor		Total persons, number	Poor	
		Number	Percent		Number	Percent		Number	Percent
All ages	176. 5	38. 9	22. 1	189. 7	34. 1	18. 0	193. 4	29. 7	15. 4
Under 18 [1]	63. 7	16. 6	26. 1	69. 4	14. 9	21. 4	69. 8	12. 5	17. 9
Families with male head	58. 2	12. 6	21. 7	62. 3	10. 5	16. 9	62. 5	8. 0	12. 9
Families with female head	5. 5	4. 0	72. 6	7. 1	4. 4	62. 6	7. 4	4. 5	60. 6
18 to 64 [2]	96. 8	16. 4	16. 9	103. 0	13. 8	13. 4	105. 7	11. 9	11. 2
65 or over	15. 9	5. 9	37. 2	17. 4	5. 4	30. 8	17. 9	5. 4	29. 9
In families	12. 1	3. 4	28. 4	12. 8	2. 6	20. 5	13. 0	2. 7	20. 5
Unrelated individuals	3. 8	2. 5	68. 1	4. 6	2. 8	59. 3	4. 9	2. 7	55. 3
Men	1. 1	. 6	59. 9	1. 3	. 6	47. 9	1. 3	. 6	44. 0
Women	2. 6	1. 8	71. 5	3. 3	2. 1	63. 7	3. 6	2. 1	59. 3

[1] Never married children in families.
[2] Includes never-married persons under age 18.

Source: Derived by the Social Security Administration from special tabulations by the Bureau of the Census from the Current Population Survey.

Herman B. Brotman, Administration on Aging Chief of Reports and Analysis, points out, however, that the elderly—at least in 1965 and 1966—were not moving out of poverty proportionately as quickly as the under-65 population. He reported:[7]

> The 65+ population, continuing the modern trend of faster growth than the under-65 group, increased between 1965 and 1966 by approximately 300,000 or 1.6 percent to 17.9 million (non-institutional). But the aged who were poor also increased, from 5.3 million to 5.4 million, up 1.8 percent. Thus, while the proportion of all under-65 persons living in poverty fell from 16 to 14 percent, the proportion of the aged who were poor remained about the same, 30 percent. *People aged 65+ made up 9.3 percent of the total non-institutional population but 18.1 percent of the poor.* (Emphasis added.)
>
> Another 2.3 million or almost 13 percent of the 65+ population were on the borderline between poverty and low income, *making a total of 42.5 percent of the aged living below the low-income level.* (Emphasis added.)

EFFECT OF THE 1967 AMENDMENTS

Approximately 800,000 older persons were moved out of poverty by the Social Security increases voted by the Congress in 1967. That legislation raised the minimum to $55 and the special 72+ benefit to $40 and provided a general increase of 13 percent to others. As Brotman points out:[8]

> If the Congress had enacted the same 13-percent increase for the above-the-minimum beneficiaries but had raised the minimum to $70 and the special benefit for 72+ persons to $50, the number of 65+ persons moved out of poverty would have been 1.3 million. The change in the minimums would have lifted an additional half-million older persons out of poverty.

The prevalence and persistence of poverty among elderly Americans raises forceful arguments for insisting that the next major increase in Social Security be directed primarily at the substantial raising of minimum payments as a prerequisite to more general increases.

Poverty perpetuated by OAA. Old-age assistance payments averaged $80.30 in February 1967 for all individuals dependent upon such payments as virtually their sole means of income. For those receiving social security and OAA, the average OASI (old age and survivor's insurance) payment was $52.95 and the OAA money payment was $56.75.[9] Total income was, at best, at minimum poverty levels. In June 1968 more than 2 million persons 65 and older were receiving old-age assistance.[10]

> **Old-age assistance, along with other forms of public welfare, stands in need of searching re-evaluation both as to objectives and standards. The Senate Special Committee on Aging, recognizing that widespread evaluation and reform of**

[7] Useful Facts number 37, issued by the Administration on Aging, May 8, 1968.
[8] Useful Facts number 34, March 11, 1968
[9] See "Aged Persons Receiving both OASDI and OAA, Early 1967" Social Security Bulletin, April 1968.
[10] For Social and Rehabilitation Service report on old age assistance see appendix I, p. 162.

the entire welfare system is imminent, urges that inadequate OAA payments receive careful attention.

III. PROPOSALS FOR CHANGE

Republican and Democratic candidates for the Presidency of the United States argued in 1968 for major changes in social security payments [11] and there were other indications that the time for a major overhaul of the 33-year-old social insurance system was due. Among the signs were:

—A Brookings Institution report [12] proposed widespread social security revisions including automatic cost-of-living increases, sharp increases in widow's benefits; benefits geared to a uniform percentage of past earnings.

—A Senate subcommittee report called Toward Economic Security For The Poor," [13] listed as one possibility for future action the setting of minimum social security benefits equal to the poverty line. This, the report added, "would require the transfer of general revenue funds to the social security system."

—Departing HEW Secretary Wilbur J. Cohen, in his final report, issued several recommendations,[14] one of which would raise social security minimum benefits to $100 per month.

—Suggestions were heard for "guaranteed annual incomes" of one kind for all age groups, including the elderly.[15]

Recognizing that careful consideration must be given to far-reaching issues related to income maintenance of the elderly, the Senate Committee on Aging renews its recommendation that an Institute on Retirement Income be established to provide a continuing, problem-solving mechanism that could assist the Congress and the executive branch in formulating policy or subjects for debate and national analysis.

In addition, the committee recommends that the Institute* take on as an early assignment a study of the many possible indices that could be employed in establishing automatic cost-of-living increases under the OASDHI social insurance program. Every effort should be made to arrive at an index that gives adequate weight to the special problems of low-income Americans in particular, including inadequate minimum payments.

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[11] See appendix 10 for details on campaign statements.

[12] "Social Security: Perspectives for Reform," by Joseph A. Pechman, Henry J. Aaron, Michael K. Taussig. November 1968.

[13] Prepared by the Subcommittee on Employment, Manpower, and Poverty of the Committee on Labor and Public Welfare, October 1968.

[14] Secretary's Introduction, "Annual Report of the Department of Health, Education, and Welfare, Fiscal Year 1968", issued January 17, 1969, for the Secretary's discussion of Social Security, see appendix 4, p. 227 of this report.

[15] The Joint Economic Committee, Congress of the United States, issued in 1968 part 6 of its "Compendium of Papers and Problems and Policy Issues in the Public and Private Pension System," called "Abstracts of the Papers," the latest publication gives helpful summaries of papers discussing widely varying income maintenance proposals and other matters.

* On Oct. 1, 1968, Senator Harrison Williams introduced S. 4115 to establish an Institute on Retirement Income. It would be a "think tank" agency, modelled after The Urban Institute, and designed to conduct comprehensive and intensive studies of all aspects of retirement income and make recommendations to solve the increasing urgent and complex problems associated with income maintenance. Since it was introduced too late for action by the 90th Congress, Senator Williams reintroduced the bill as S. 869 in the 91st Congress on Feb. 4, 1969.

IV. PUBLIC CONCERN ABOUT THE "RETIREMENT TEST"

Under present law, social security recipients under age 72 who earn more than certain annual and monthly amounts forfeit portions of their benefits. Since the Social Security Amendments of 1967 (Public Law 90–248), these earnings limitations, or "retirement test," have provided that:

1. A recipient can earn up to $1,680 each year without loss of benefits.
2. One dollar in benefits is withheld for each $2 of annual earnings between $1,680 and $2,880 and for each $1 of earnings above $2,880.
3. Regardless of annual earnings, the recipient can receive benefits in full for any month in which he neither works for wages of more than $140 nor renders substantial services in self-employment.
4. Beginning with the month in which a recipient reaches age 72, full benefits are payable to him (and to his eligible dependents) regardless of the amount of his earnings.

The complexities of these limitations have perplexed many older persons. Some may even decide that the intent of the law is to discourage them from seeking employment.

The Committee on Aging has long been aware of the hardship of these limitations upon social security recipients under age 72 who need income from earnings to supplement inadequate retirement benefits, and who are able to work, at least part time.[16] There has been strong sentiment in Congress and throughout the Nation in favor of liberalizing or removing the limitations. Congress, seeking information upon which to base future legislation on this subject, inserted in the Social Security Amendments of 1967 a provision[17] directing the Secretary of Health, Education, and Welfare to conduct a study and to report his findings and recommendations on or before January 1, 1969. Accordingly, Secretary Cohen transmitted to Congress a report entitled, "The Retirement Test Under Social Security."[18]

Secretary Cohen, in explaining why he favored retention of a retirement test, pointed out:

> Repeal of the retirement test would increase the cost of the social security program by $2.5 billion a year now, and more in the future years. In order to finance this additional cost it would be necessary to increase social security contributions for employers and employees by a total of 0.70 percent of taxable payroll or by 0.35 percent of taxable payroll each for employers and employees. Most of this additional cost would be incurred in order to pay benefits to people who are fully employed and earning as much as they ever did. I do not believe that this would be the best use of the income available to the social security program and therefore do not recommend repeal of the retirement test.

[16] "Increasing Employment Opportunities for the Elderly," report of the U.S. Senate Committee on Aging, p.4, August 1964.
[17] Sec. 405, Public Law 90-248, Jan. 2, 1968, 90th Cong., 1st Sess.
[18] Excerpts of the report appear in app. 4, p. 238.

The Secretary's report further states:

> Any test of retirement for social insurance purposes must be a compromise between two conflicting goals. The principle that social insurance benefits should be paid only to those suffering a loss of work income must be balanced with the need to avoid creating disincentives for those who wish to work. The retirement test, then, must be a compromise between these two objectives. While preventing payment of benefits to people with relatively substantial earnings, the amount of earnings allowed without any withholding of benefits should be high enough to allow those beneficiaries who can work at low paying or part-time jobs to do so and still get part or all their benefits.

Secretary Cohen made the following recommendations for liberalizing the test:

1. That the amount a social security beneficiary can earn in a year and still get all of his benefits, be raised from $1,680 to $1,800, to bring this restriction up to date with the increase in earnings levels that have occurred since the $1,680 figure was adopted.
2. That there be a corresponding increase from $140 to $150 (one-twelfth of the annual exempt amount) in the monthly exempt amount—the amount of wages which, regardless of his annual earnings, a beneficiary can earn in a given month and still receive his benefit for that month.
3. That the band within which $1 of benefits would be lost for every $2 of earnings be raised to $1,800—$3,000 (from the present $1,680—$2,880).
4. That there be a loss of $3 of benefits for every $4 earned over $3,000 a year, in lieu of the present requirements that $4 of benefits be forfeited for each $4 earned above the 2 for 1 band.
5. That there be provision for automatically adjusting the exempt amount to rises in earnings levels.

The Secretary estimated the cost of this entire package as 0.07 percent of payroll.

Prompt enactment of the changes recommended by Secretary Cohen should be the minimum action Congress should take toward the goal of enabling social security recipients to earn enough to supplement retirement benefits, which are frequently inadequate.

V. CONGRESSIONAL ATTENTION TO PRIVATE PENSIONS

A new phase in congressional interest toward private pension legislation began in 1968, with the consideration of comprehensive bills intended to protect pension rights of workers and to provide more satisfactory coverage. While no major new enactments resulted, it appeared that early action would be sought in 1969 on similar proposals.[19]

[19] See app. 4, p. 228 for additional information on the pension bills and hearings during 1968.

CHAPTER II

COSTS AND DELIVERY OF HEALTH SERVICES

Steadily rising health care costs during 1968 raised far-ranging policy questions about Medicare, Medicaid, and overall organization of services. By year's end it was clear that the $50 billion health industry would receive searching scrutiny during the 91st Congress, and it was equally clear that older Americans would stand to benefit perhaps more than anyone else if the cost trend could be reversed or slowed, and if high quality health care services could be made more readily available.

While much attention turned to problems, the year also brought positive developments. Medicare was making a major contribution to the economic security [1] of older Americans: the program paid $5.1 billion for health care expenses during fiscal year 1968, and enrollment rose to almost 19 million.[2] In addition, major health legislation was enacted, including extension of the regional medical program.[3] Finally, within the Social Security Administration and the U.S. Public Health Service, studies and experiments were under way on projects intended to provide higher quality health care with built-in cost controls.

I. COSTS AND THE ELDERLY

Heavy health care costs for the elderly—though alleviated by Medicare—nevertheless remain a cause of growing concern.

For all age groups, the price of medical services has risen far faster than the prices of other consumer goods and services, as the following table [4] shows:

	Consumer Price Index (1957-59=100)	
	June 1966	December 1968
All items	112.9	123.7
Medical care	127.0	149.1
Hospital daily charge	164.2	239.3
Physicians' fees	128.0	149.1

Seen from a different perspective, it is equally clear that the medical care charge rise is accelerating. A Bureau of Labor Statistics survey [5] shows that the medical care index rose at a rate of 4.7 percent a year during the 1950's, dropped during the early 1960's to 2.6 percent annually, but then increased to 6.6 percent in 1966 and 6.4 percent in 1967.

[1] In a memorandum on January 3, 1968, HEW Secretary John Gardner said that the average dollar value of social security payments was increased by 12 percent by the addition of Medicare.
[2] A report by the Social Security Administration on the Medicare program appears in app. 1, p. 167.
[3] A summary of major health laws for 1968 appears in app. 5, p. 241.
[4] U.S. Bureau of Labor Statistics.
[5] "A Closer Look at Rising Medical Costs," by William F. Berry and James C. Daugherty, *Monthly Labor Review*, November 1968.

From the end of World War II to the end of 1967, the medical care index increase was 125 percent, compared to only 71 percent for all consumer items. The biggest increase in that period occurred in hospital daily services charges, which rose 441 percent. The rise in physicians' fees was 107 percent.

Effect on Older Americans.—Milestone that Medicare is, it nevertheless was not meant to pay for all health care expenditures of the aged. That fact becomes clear when we look at the chart opposite, which shows that during the first full year of Medicare, Federal expenditures on behalf of the aged rose markedly, but private payments by aged individuals were still substantial.

Translated into more personal terms, this means that medical expenditures still take a significant portion of a retiree's budget. One 1968 study[6] estimated that the annual out-of-pocket cost for Medicare enrollees at 1966 prices was $150 in metropolitan areas and $145 in smaller cities.

A. Charges Under Medicare

One reason for the large out-of-pocket costs is simply that Medicare coverage does not pay all bills. Part B of Medicare—which applies to physicians' charges and other services—requires a monthly premium—now $4.00, or $48 a year. Enrollees also pay the first $40 of hospital bills and the first $50 of doctor bills, plus 20 percent or more of the rest of the physician's bill. If Medicare has led them to see a doctor more readily than in the past, there are bills for laboratory work, X-ray, etc., on which they must pay a portion of the cost, as well as prescriptions they must pay out-of-pocket.

To illustrate, suppose that Mr. Jones, who lives in a large city, used to see Dr. Smith nine times a year in his office at $5.00 a visit. Once a year he had an X-ray and some lab tests costing $20—or $65 in all.

Under Medicare, Dr. Smith charges $8 for an office visit[7] and has placed the charges for the tests given annually at $40. Mr. Jones charges come to $112; his Medicare benefits equal $49.60 because the first $50 is deductible and only 80 percent of the remainder is covered. Mr. Jones pays out $62.40, in addition to $48 in premiums.

Perhaps in a nearby rural area Dr. Smith's $8 fee would be considered above the prevailing fee for routine office visits. Dr. Smith does not "take assignment"[8] of Medicare benefit payments, so Mr. Jones would pay Dr. Smith the full $112 and collect less than $49.60 from Medicare, $9 less if only $7 per visit were allowed.

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[6] "Retired Couple's Budget for a Moderate Living Standard". (See ch. 3 for additional discussion.)

[7] For additional discussion of pressures causing increases in physicians' fees under Medicare, see "Costs and Delivery of Health Services to Older Americans," Washington, D.C., June 22-23, 1967, testimony by Dr. William A. Nolen, Litchfield, Minn., pp. 36-51.

[8] *Pamphlet SS 1-50* May 1968, p. 22 "Your Medicare Handbook" which SSA made available to beneficiaries after the 1967 amendments to Public Law 89-97 explains "assignment" of the benefit as follows:

"I. Payment to your doctor or supplier:

"(*a*) Complete and sign part I of the 'Request for Medicare Payment' (form SSA-1490). Often your doctor's office or the supplier will complete part I as a convenience to you.

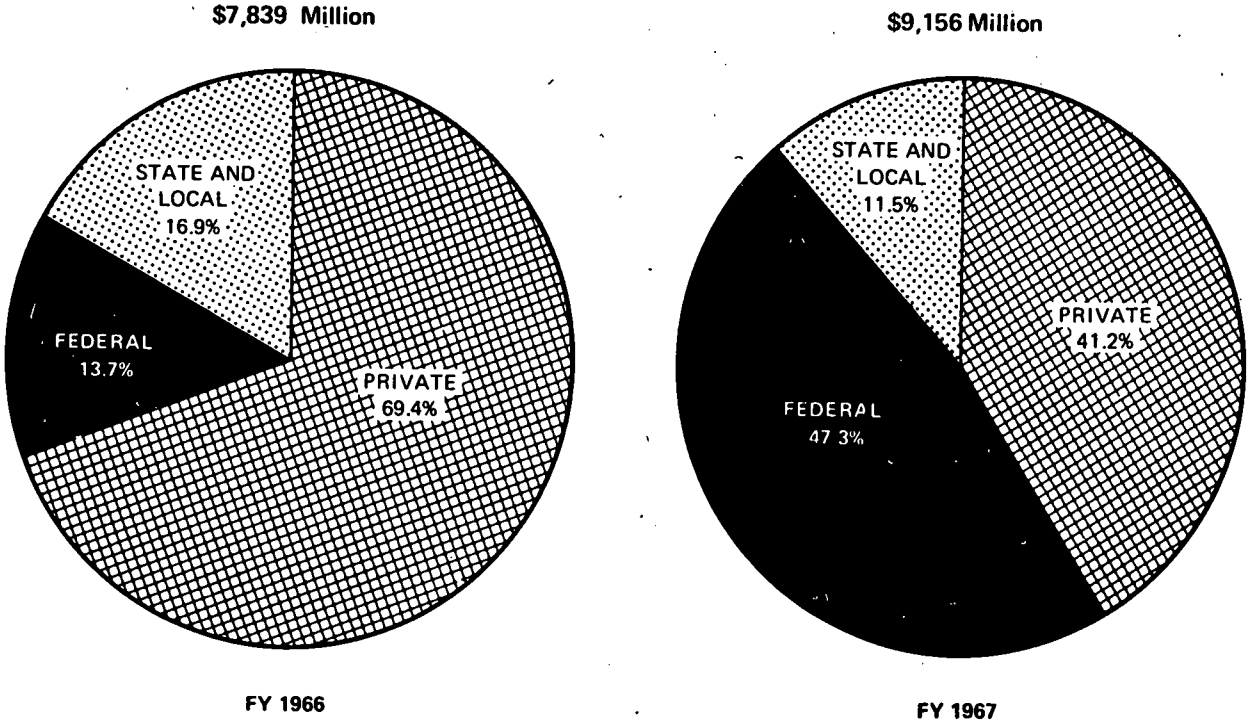
"(*b*) Your doctor or supplier completes part II of the form.

"(*c*) Your doctor or supplier sends in the 'Request for Medicare Payment' form.

"When your doctor or supplier accepts assignment, he agrees that his total charge will not exceed the reasonable charge. This means that you are responsible only for any of the $50 deductible not yet met, plus 20 percent of the balance of the 'reasonable charges'."

If unwilling to take "assignment," as just described, the doctor is not limited in his charges by the carrier's determination as to a "reasonable charge" for the service he has rendered. In such situations, which in fact comprise the majority of Medicare claims volume, the physician is free to price his services at his own estimate of their worth; the Medicare beneficiary must then pay not only the 20-percent coinsurance, but must also pay the difference between the physician's charge and the carrier's determination of a reasonable charge for the particular service.

CHART 1.—Percentage distribution of personal health care expenditures for the aged, by source of funds, fiscal years 1966 and 1967



Source: August 1968 Social Security Bulletin.

Such situations occur every day. It is estimated that only about 45 percent of physicians' bills are rendered on an assignment basis, and the proportion is even less if hospital-based physicians' and welfare recipients' claims—paid to the vendors—are omitted. The disadvantages of nonassignment to the aged person are twofold: he must pay the doctor's charges, whatever their level, without such deterrents as are imposed by screening for reasonableness and relation to other doctors' charges; and in addition he must complete forms, submit claims, and perform other paperwork.

Gaps in coverage and other difficulties inherent in Medicare,[9] however, are only part of the story. Older Americans face other unique problems. It is commonly recognized that the onset of chronic disease in later years causes a rising need for health care expenses, but perhaps the extent of the increase is not widely understood. The fact is, however, that the average health care expenditure per aged person is much more than double that of younger persons. (In fiscal year 1967, it equaled 2¾ times that of persons under 65.) The chart opposite gives additional information about the health cost differences between the elderly and those in younger age groups:

For the "elderly" aged—those far beyond age 65—the need is especially great for the types of health care not covered by Medicare, notably long-term nursing care (as distinct from posthospital extended care) and drugs. One recent study [10] showed that more than 50 percent of nursing home patients were age 80 or over. For the patient who cannot qualify for welfare or for Medicaid (even though living in a State that provides nursing home care for welfare recipients), nursing home costs can mean a sustained and severe drain on the financial resources that keep him from qualifying for welfare.

B. Medicare and Prescription Drugs

An HEW task force on prescription drugs, after completing 18 months of work on a review of methods of meeting drug needs of the elderly by broadening Medicare coverage, called for an out-of-hospital drug insurance program under Medicare.[11]

Dr. Philip R. Lee, Assistant Secretary for Health and Scientific Affairs, gave the following arguments for the task force action:

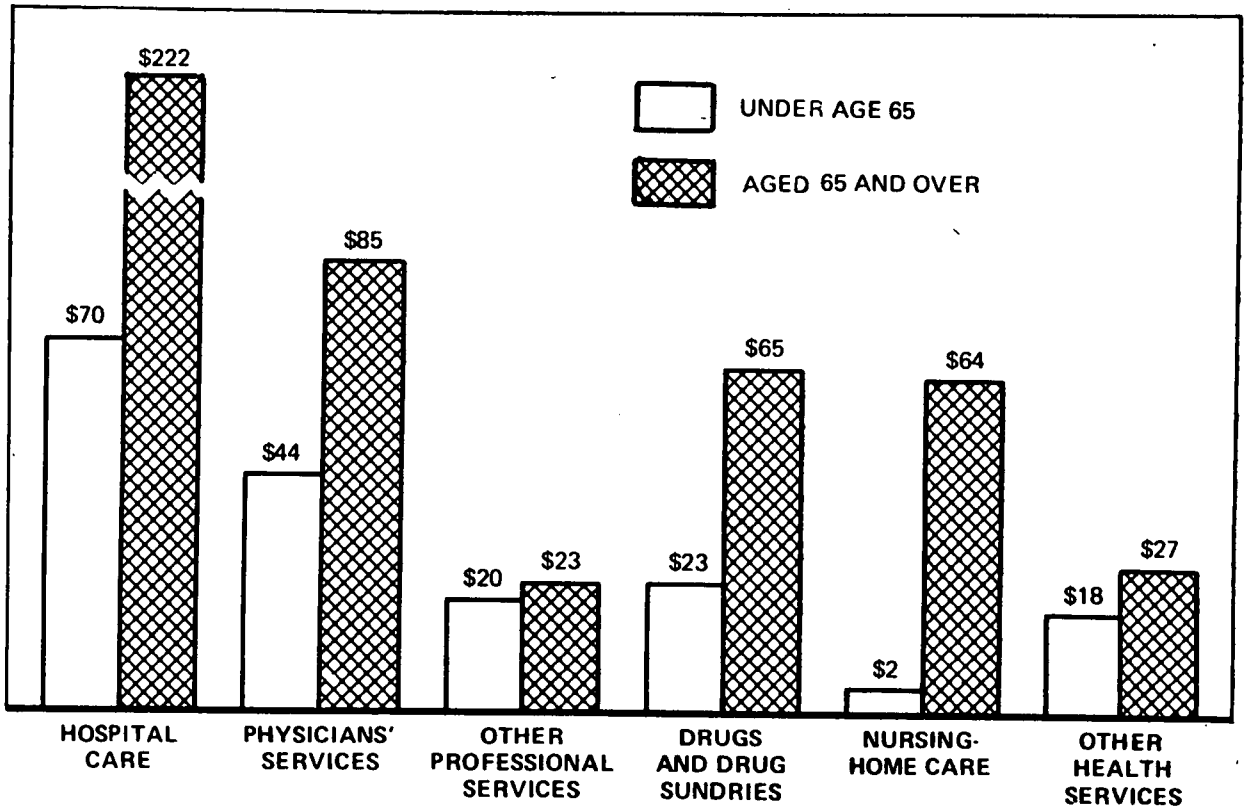
> Since the advent of Medicare, prescription drugs have represented the largest single personal health expenditure that the aged must meet almost entirely from their own resources—some 20 percent of their personal health expenditures. *Although the elderly represent less than 10 percent of the population, they account for nearly 25 percent of all prescription*

[9] One problem in implementing medicare has been the extent to which medicare benefits should be paid for care in substandard health-care facilities. The dilemma posed is whether to adopt strict policies of withdrawing medicare approval for facilities which fail to meet standards (thus forcing beneficiaries in those communities to seek care in distant communities) or to be more tolerant (thus risking loss of opportunities to upgrade standards). Two somewhat divergent views on the problem have been taken by the General Accounting Office and the Social Security Administration. In a report (B-164031(4)) issued on Dec. 27, 1968, Comptroller General Elmer B. Staats concluded that the Social Security Administration had been slow in resolving the status of 42 hospitals that the Texas State Department of Health had determined were deficient in meeting medicare standards. The Texas State Department of Health had therefore recommended that their participation in the program be terminated. The Comptroller-General's report expressed the opinion that the Social Security Administration should require the establishment of reasonable time limits within which the hospitals would be required to take corrective action. On the other hand, the Social Security Administration took the position—in a report to committee Chairman Harrison A. Williams—that greater flexibility and latitude than that is needed, to take into consideration the good faith of the institution and obstacles it encounters in seeking to upgrade its standards.

[10] Center for Health Statistics, Series 12, No. 2.

[11] For additional details see: "Task Force on Prescription Drugs," Third Interim Report, Dec. 31, 1968.

CHART 2.—Estimated per capita personal health care expenditures, by type of expenditure and age, fiscal year 1967



Source: August 1968 Social Security Bulletin.

drug costs, and their annual per capita expenditure for drugs is more than three times that of persons under age 65 (emphasis added).

Further, Dr. Lee commented, "these expenditures fall upon a group which is among the most impoverished in our Nation," and he added that the extent of aid the group receives from private insurance, existing public programs, and tax relief is insufficient.

TASK FORCE RECOMMENDATIONS

Recognizing that comprehensive drug coverage of all prescription drugs for the elderly under Medicare would be expensive and complex, the task force recommended that the scope of benefits should be restricted primarily to those drugs needed in the treatment of serious long-term illness, or, alternatively, that comprehensive benefits should be provided only after a considerable portion of the annual personal drug expense had already been met from private funds. The beneficiary would also probably be required to pay some part of the prescription payment through co-payment or co-insurance, to hold down the costs of the program.

C. Overall Impact of Rising Costs on Medicare

Perhaps the most dramatic statement on the potential effects of rising costs was provided by HEW Secretary Wilbur J. Cohen on December 31, 1968. The Secretary was required by law to decide by that date whether to raise the monthly premium paid by almost 19 million Americans enrolled in Medicare's supplementary medical insurance plan (pt. B of title XVIII).

On that date, the premium stood at $8 a month—$4 paid by the beneficiary and $4 by the Federal Government (an increase of $2 over the $6 monthly rate set in 1965). If the Secretary had heeded actuarial advice given to him from the Social Security Administration, he would have asked for a premium increase to a total of $8.80 monthly ($4.40 each). Instead, the Secretary took no action at all. Among the reasons for his decision: [12]

—A 40-cent monthly increase in premiums would increase the cost to aged beneficiaries by about $100 million during fiscal 1970. And—since 5.8 million social security beneficiaries have incomes below the poverty line and about 3 million more are "near-poor", "any increase without an increase in social security benefits would be a hardship for many senior citizens."

—"Any increased premium based on an assumption of as much as a 4½-percent increase in physicians' fees [13] is likely to act as a further inflationary factor. *Any such estimate is likely to be viewed as a minimum prediction of increase—one which the Federal Government has approved* (emphasis added). No one can say with any reasonable certainty what the effect of any proposed increase would be on other parts of the $50 billion medical care industry . . . I want to avoid further fanning of the flames of inflation throughout our entire medical care system."

[12] For the Secretary's complete statement of Dec. 31, see app. 5, p. 244.

[13] The 4½-percent increase in physicians' fees was estimated by Social Security Administration Actuary Robert J. Myers, who was quoted by Secretary Cohen as saying he believes that physicians' fees will rise about 5 percent in calendar year 1969 over 1968 and 4½ percent in 1970 over 1969.

The Secretary urged physicians of the country "to show unusual restraint in setting their fees in the coming months." He also charged the Social Security Administration and Medicare carriers to make every effort to keep payments for services in line with premium income. Secretary Cohen's stand also raised the probability that the Congress or the new administration would have to formulate new policy either (1) to find ways of paying for costs that may rise despite his admonitions, or (2) to impose new procedures intended to reduce costs while maintaining high standards.[14]

Rising medical care costs are causing demands for Medicare revisions, such as: elimination of co-insurance and deductibles; at least partial coverage of non-hospital prescriptions; financing of part B through the payroll tax spread over the rising earnings of workers rather than through monthly premiums paid by the aged; and imposition of tighter cost controls.

Such demands should be considered in comprehensive congressional and administrative reviews of Medicare[15] intended to make that historic program an even more valuable component of a concerned society.

II. CONCERN ABOUT MEDICAID

Medicaid—as Title XIX (of the same law that created the Title XVIII Medicare Program) is comonly called—is meant to provide medical assistance for low-income people of all ages. For the elderly, the program is of special importance. Seventy-nine percent of the population over age 65 reside in the 38 States and four jurisdictions[16] operating Medicaid programs in 1968 under a Federal-State cost-sharing plan. In 15 States, only the "needy" aged or those receiving public assistance payments, are included. In 27 States, however, the Medicaid programs include both the "needy" and the "medically needy"—or those who have enough income for daily needs but not enough for medical bills. Thus, the Medicaid program is of considerable importance to many older Americans including those who, while

[14] See pp. 45-46, "Developments in Aging—1967" for additional discussion of cost controls. Hospital Administrator Dr. Martin Cherasky—quoted in that report—also spoke out in 1968 upon the need for quality standards at a hearing on "Health Care in America" before Senate Subcommittee on Executive Reorganization (p. 21): "Equally disturbing and certainly more dangerous is the total lack of quality standards for physicians treating Medicare patients. Here Congress should act and act quickly. For example, provisions for payment could require that major surgery only be paid for if carried out in an institution fully accredited by the Joint Commission on Accreditation and carried out by a surgeon who is either Board qualified or Board eligible.

"In other words, major surgery should not be paid for by the Government except in unavoidable circumstances unless the surgeon has evidence of the qualifications he should have.

"And, you know, Senator, this is not an insistence upon standards which are meaningless. Cancer of the cervix is a very dangerous and deadly illness. When early cancer of the cervix is operated on by qualified Board-certified gynecologists, there is 80 percent cure rate. When it is operated on, as it often is, by people who don't have these qualifications, there is a 50 percent cure rate. The difference between insisting upon qualifications and no qualifications is the difference between 50 and 80. We are talking about human lives, not about money or anything else.

"Where a Medicare patient has a major medical problem, a consultation with a qualfied specialist should be required."

[15] In his letter of transmittal of the "Second Annual Report of the Medicare Program," January 17, 1969 Secretary Cohen offered the following recommendations for improvement of the Medicare program: (1) Extend Medicare protection to disabled social security beneficiaries; (2) Cover certain maintenance drugs under Medicare; (3) Finance both hospital insurance and supplementary insurance through payroll contributions and general revenues; and (4) Coordinate Federal reimbursement to health care facilities with State health facility planning.

[16] See app. 1, p. 162, for report on Medicaid by Social and Rehabilitative Services.

just above welfare levels, nevertheless have health care bills not covered by Medicare or private insurance.[17]

As 1968 ended, however, it was clear that the Medicaid program while providing much-needed help to millions of Americans [18] is undergoing a period of critical evaluation at all levels of government.

One fundamental question about the program was raised at a congressional hearing by Dr. Lester Breslow, former director of the State Department of Public Health in California and now professor of Health Services Administration at the University of California. While praising part A of Medicare for requiring high standards of care and utilization review, he said: [19]

> Medicaid, on the other hand—the welfare medical care program—has tended to bolster the poorest kind of medical care. This has occurred because the basic legislation gave no attention to the matter of quality. Contrary to the Medicare legislation, which established a framework for quality standards, especially in part A, the Medicaid legislation ignored this critical problem. State and local welfare administrators have tended to purchase and pay for more of the same kind of care that poor people were obtaining previously. The personnel and facilities in neighborhoods where poor people obtained care were often inferior and, most important, Medicaid offered no inducement to improve. It simply financially supported what was present.

Dr. Breslow acknowledged that in some States, including California, attempts have been made to link up Medicaid with the quality standards of Medicare.

"To the extent that this has been possible, Medicaid patients have benefited from the Medicare standards," he added.

In California and in other States, however, other questions have arisen about the costs of the program, threatened cutbacks, and ultimate objectives and relationships with other government health programs.

A. Complaints About Costs

At earlier hearings,[20] the Subcommittee on Health of the Elderly, U.S. Senate Special Committee on Aging, received complaints about rising costs of the Medicaid program. Additional reason for concern arose during 1968 with reports from several States about major increases in medical assistance costs. The New York Times of November 20 reported, for example, that in Massachusetts, "medical assistance payments increased from $74,849,290 in 1963—an entire year—to $129,341,214 for the first seven months of 1968." The same news story gave examples of alleged profiteering by medical practitioners, including one dentist said to have grossed $164,000 in seven months of 1968 for treating welfare patients. Similar complaints were reported

[17] Approximately 48 percent of the aged have private health insurance coverage of hospital care, according to the *Social Security Bulletin* of February 1969. Such coverage, however, may be out of financial reach of those who need it most.

[18] HEW Secretary Cohen, in the introduction to the annual departmental report, described Medicaid "as the tip of the iceberg opening our eyes to the terrible need for health care among the poor."

[19] Hearing on "Costs and Delivery of Health Services to Older Americans," in Los Angeles, Oct. 16, 1968, U.S. Senate Special Committee on Aging.

[20] Hearings on Costs and Delivery of Health Services to Older Americans, Washington, D.C., June 22, 23, 1967, and New York City Oct. 19, 1967, and "Developments in Aging—1967," annual report.

in the press from other States, and in particular from Maryland, Ohio, and New York.

California's Medicaid program—called Medi-Cal—has been the center of considerable controversy; and it received attention in 1968 from the California State Legislature, the attorney-general of California, and the Health Subcommittee of the Senate Special Committee on Aging.

COSTS IN CALIFORNIA

Speaker of the California Assembly Jesse Unruh, testifying before the Subcommittee on Health of the Special Committee on Aging in October [21] told of some physicians who "collected as much as $70,000 each simply from treating Medi-Cal patients." He added:

> . . . we have been told by people in the medical profession that this is considerably more than the average doctor makes, and we estimate that some of them are making somewhere between $35,000 and $60,000 net profit out of this program each year.
>
> It is obvious that the most direct method of controlling costs is through the imposition of fee schedules on doctors and the other providers of medical services. Yet, despite pleas from members of the legislature, the administration which we gave the authority to has refused to set such limits, and in my opinion that refusal, or the threat of using that, is almost totally responsible for those soaring, runaway costs which have occurred.

Speaker Unruh—who, with other members of the California Legislature has questioned many policies and practices related to Medi-Cal [22]—said in a letter to this committee that a report made by the California Department of Justice later in the year "completely bears out my comments that some physicians and other providers of health care services in California are making exorbitant and unjustified profits from the Medi-Cal program."

The Attorney-General's Report.—Ordered on February 8, 1968, by the State attorney-general, the California Department of Justice investigation of the Medi-Cal program led to a report that on November 6 declared:

- Our investigation indicates that illegal and unethical activities of persons providing services under Medi-Cal are siphoning millions of dollars annually from the program. Poor administration of the program has contributed to further needless expenditure of money by Medi-Cal.

* * * * * * *

[21] Hearing on "Cost and Delivery of Health Services to Older Americans," in Los Angeles, Oct. 16, 1968.

[22] A different view about physician's fees was expressed at the October hearing by Dr. Malcolm Todd, President of the California Medical Association. He said

"Too much attention has been directed toward the physician's fees. Figures can be made to mean anything that they want to. But in an effort to achieve solutions to medical services for the aged, and to cut medical care costs, there are some things that I would like to mention.

"It is interesting to note that the Medi-Cal budgeted in 1967–68, $159,500,000 for physicians' services. But they actually paid out only $122,100,000.

"I would also like to state that over the overall health care cost dollar in the Medi-Cal program, the physician's fees amount to just 19 to 20 percent of the entire health care cost dollar. But it is that extra day in the acute hospital that we must not allow to be abused, because this is where the cost of this program centers."

- The primary abuses of the program involve submission of false claims, kickbacks and overservicing. (Chief Deputy Attorney General Charles A. O'Brien later informed the committee that "*minimally* $8 million is being bilked annually from the Medi-Cal program by medical practitioners.").

* * * * * * *

- In addition to the violations of the laws and regulations of Medi-Cal by the vendors, the investigation disclosed that an effective enforcement program to cover, investigate, and deter such activities does not exist.

Special attention was given in the report to problems in nursing homes and long-term care facilities.[23] Attorney General O'Brien gave the committee this evaluation of the situation:

> Medicare provides greater reimbursement to nursing homes than Medi-Cal. Therefore, the potential for transferring a nursing home patient from Medi-Cal to Medicare may determine the patient's admittance to a nursing home. Special arrangements between hospitals and nursing homes exist solely for the purpose of maximizing Government payments to nursing homes.

A major part of the problem, in the view of Attorney General O'Brien is the "sheer bigness" of the program. He recommended that smaller regional administrative offices be established to help "reduce the management of the program to a scale which may be encompassed by the mind of man." He added:

> Aside from conquering the immensity of the program through some effort at localization, another broader concept may also be seen in the problems which we have uncovered. A major contributor to these problems was the pressure on the State of California to take advantage of the funds made available by the Federal Government through title XIX. Better coordination between local governments, the State and the Federal Government would certainly have resulted in a better program. As we note in our report, peril accompanies prosperity when Federal funding rushes the States into adopting hastily conceived programs.

NATIONAL IMPETUS FOR REFORM

Three major analyses of the Medicaid program were underway in 1968. One, conducted by the Advisory Commission on Intergovernmental Relations,[24] was culminated by a report which stated as one of its major conclusions:

"Policy makers at all governmental levels were largely unprepared for the magnitude of the fiscal impact of Medicaid that soon became apparent soon after the program's initiation in 1966," but that the goal expressed in the Medicaid legislation of "comprehensive care for 'substantially all' of the needy and medically needy" should be met. The Advisory Commission also proposed far-reaching Federal-State action to strengthen the Medicaid program, improved procedures for

[23] The California Association of Nursing Homes, Sanitariums and Homes for the Aged took sharp exception to several conclusions in the Attorney-General's report and charged that the report indicated "a shocking lack of knowledge . . . of the professional relationships in the health care field."

[24] "Intergovernmental Problems in Medicaid," September 1968.

establishing Medicaid eligibility, and public support of private health insurance as one means of reducing Medicaid costs.

Another evaluation of title XIX was provided by the Medical Assistance Advisory Council established in the 1965 Medicaid legislation. Early in 1969 that 21-member body was preparing to issue a report offering recommendations intended to reduce costs and make the program more effective.

A third report, issued in November by an HEW State-Federal task force on the costs of medical assistance and public assistance, called for tighter budgeting procedures intended to make cost estimates more accurate. The need for such action is "obvious and pressing," said the task force report, which also noted that Federal costs for Medicaid and other public assistance programs in fiscal year 1968 were understated by $1.1 billion, or approximately 27 percent.

B. Concern About Cutbacks

Concern and confusion about Medicaid are compounded by the fear of sharp reductions in the Federal commitment to the program. As the Inter-Governmental Advisory Commission observed:

> The legislative history of section 1903(3) of title XIX requires all States to provide comprehensive care to "substantially all" the needy and medically needy by July 1975, and congressional attitudes toward further cost escalation of the Medicaid program, raise doubts about the strength of the Federal Government's real commitment to this goal.

The impetus for cutbacks [25] is provided partially by estimates of future cost. The Advisory Commission cites one report indicating that total program expenditures would rise by 1975 to $6–$7 billion or more, from the $4.2 billion estimated for fiscal year 1969.

Uncertainty about Federal intentions leads to special anxiety in States such as California and New York, each of which had acted quickly to implement elaborate, expensive Medicaid programs. Anxiety at the State level in turn leads to additional pressures for cutbacks.

At the Los Angeles hearing, Malcolm C. Todd, president of the California Medical Association, said that new Federal cutbacks in title XIX programs would be a "deterrent to the provision of health care to the needy."

Speaker Unruh was critical of State or Federal cutbacks on the grounds that:

> Those actions have been aimed at control of the symptoms by reducing expenditures at the governmental level they are trying to protect. These actions have been in the form of either service cuts as here in California or recipient cuts by the Congress. In neither case has there or will there be any meaningful effect upon the total costs of health care; there will merely be a shift of costs to some other governmental level—in California, to the counties.

[25] On Sept. 24, 1968, Senator Russell B. Long (D.-La.) offered a Medicaid amendment to a tax bill then under Senate floor consideration. His amendment was intended to reduce the Federal outlay for Medicaid by (1) reducing the Federal share of Medicaid payments from the 50–83-percent range to a new range of 25–69 percent, (2) providing that the Federal Government would not participate in matching the cost of medical assistance to persons whose incomes exceeded 150 percent of the eligible income level of Old Age Assistance, and (3) permitting States to require the medically needy to pay part of their medical bills. Later that day, the amendment was added to the pending tax measure by a vote of 44 yeas to 25 nays. However, before the tax measure was passed, the Long Medicaid amendment was deleted.

Medicaid, imperfect and costly as it is, could become a highly effective program to provide assistance to Americans who stand in greatest need of health services or care now beyond their reach. The national commitment expressed in the Medicaid legislation of 1965 should be honored, but the Federal-State dialog on needed reforms should be broadened and put on a high-priority level of action, if funds meant to help the needy and medically needy are to be put to the best possible use.

III. NEW DIRECTIONS IN ORGANIZATION OF HEALTH SERVICES

Study groups of all kinds—"task forces," advisory councils, special purpose commissions of one kind or another—have repeatedly examined health care resources of this Nation within recent years. Typical of their findings was this declaration in 1968 from an HEW task force on hospital effectiveness:

> The key fact about the health service as it exists today is disorganization. Unlike industry, the health service lacks most of the controls that are imposed in the free enterprise economy by the forces of supply and demand, competition, and the drive for profits.[26]

What is needed at this point—declared another study group, the National Commission on Health Facilities—is an "integrated or comprehensive approach" in which "health facilities can contribute effectively to the object of their efforts: the care of people."

Commission Chairman Boisfeuillet Jones said that the Hill-Burton Planning amendments, regional programs, neighborhood health care centers, and the partnership for health program[27] are pointing the way to the goal of comprehensive care. The existence of such programs, he added, "indicates that the transition to comprehensive health care systems now warrants priority in national health policy."

To the elderly American, who stands in special need of high-quality health services both within reach of his pocketbook and convenient to transportation, the prospect of such a transition is certainly appealing. But while the need for comprehensive care is recognized, the progress toward such a goal is gradual rather than dramatic, as indicated by the following significant events which occurred in 1968.

A. Problem-Solving Research and Experiments

The National Center for Health Services Research and Development, established in May 1968, has been charged with responsibility for performing and supporting research, demonstration, and evaluation of the organization of health services for the total population.

"Significantly," says a report from the U.S. Public Health Service,[28] "top priority has been placed by the Center on finding ways to increase the availability of high quality medical care to the disadvantaged in inner cities and rural areas, and the aged are included in the category of the disadvantaged."

[26] See p. 9, "Report of the Secretary's Advisory Committee on Hospital Effectiveness, 1968".
[27] See footnote 3.
[28] See app. 1, pp. 148–154 for full text of the Public Health Service report.

Another hopeful development is the implementation of cost-cutting experiments authorized under the Social Security Amendments of 1967. The experiments are to develop "incentives for economy while maintaining or improving quality in the provision of health services" in connection with reimbursements under such programs as Medicare.

Toward the end of 1968, the Department of Health, Education, and Welfare announced that four such experiments had been authorized:

—Uniform "target" budgets for components of care will be set by the Connecticut Hospital Association. Incentives will be offered to hospitals for staying within or below the model budgets.

—In New York City, the Greater New York Hospital Association and the Blue Cross Plan of New York will offer similar incentives for participating hospitals that keep total inpatient costs within specified bounds.

—A flat per capita rate will be charged by the Health Insurance Plan of Greater New York to provide coverage for all costs of medical, home care, and institutional services covered by Medicaid and Medicare. The prepaid group practice mechanism is expected to achieve several purposes, including more efficient use of medical manpower and facilities.

—A quasi-public hospital cost analysis firm will analyze departmental costs of voluntary hospitals in Maryland. [29]

B. Mounting Interest in Health Maintenance

Earlier studies by the Subcommittee on Health of the Elderly have resulted in emphatic recommendations for action that will speed development of "health maintenance" or "preventive medicine" programs. Senator Harrison A. Williams, chairman of the Committee on Aging, has received widespread support for his proposal to establish regional multiphasic screening centers to promote early detection of illness.

Among other signs of mounting interest in preventive medicine in general were these developments in 1968:

—Increasing support of a Presidential Commission charged with the responsibility of studying national goals for preventive medicine.

—Operation of four pilot multiphasic screening projects funded through the Public Health Service. Plans were underway for opening the first public structure in the Nation expressly designed for multiphasic screening.[30]

The overall importance of preventive medicine was expressed at the Los Angeles Health Subcommittee hearing by Dr. Austin B. Chinn, former director of the Gerontology Branch, U.S. Public Health Service:

> These hearings have been directed toward the principle of cost. It seems to me that if we are thinking of increasing cost of medical care, as it presently exists, we can think only in terms of building increasing numbers of hospital beds, of educating increasing numbers of physicians, nurses, and other professional people and of increasing efforts directed to the care of the already sick.

[29] An informative article in the Wall Street Journal in November 1968 gives additional details on the experiments. See app. 5, p. 247.

[30] The Center, in Providence, R.I., was to be dedicated Mar. 10, 1969. It is a joint project of the U.S. Public Health Service, the Rhode Island Health Department, and the University of Rhode Island.

We will thus have increasing costs of hospital beds—and these other services for the sick for the foreseeable future. Where do we wind up? The Nation is increasing at the rate of millions of people every decade, and all that we can expect is to increase the number of beds and doctors and professional people to take care of them.

The cost, on the other hand, of early identification of these diseases, which are filling the hospitals, causing morbidity and mortality, must be looked at in comparison.

I think that the cost of this, though substantial initially in the effect to find the disease, and in the event the disease is found, to move the individual into the receipt of health care, is minuscule compared to the management of that same individual months or years later following the development of an advanced stage of the disease with the prospect of long periods of hospitalization, or other institutionalization, physician services, nursing services, and on and on and on.

It seems to me, Mr. Chairman, that we are at the point wherein we must face the issue of whether we want to do what we are doing now, or whether we are willing to sponsor the support and development of this type of health service as we did with biomedical research some 25 years ago.

C. Education as a Force for Overall Improvement

This committee, in last year's report, recommended "educational programs to apprise the elderly of their rights, privileges and opportunities under Medicaid, and other health programs for the elderly, of the procedures which must be followed to take advantage of these programs, and of their opportunities for the prevention and early detection of illness and ill health in old age."

Strong support for such an effort was indicated by HEW Secretary Cohen on December 31 when he issued a report[31] calling for the following:

> It is recommended that a national, cooperative, voluntary effort directed at health education for the aged should be initiated by the department in cooperation with medical societies, women's auxiliaries, voluntary agencies, advertising groups, consumer groups, senior citizen's organizations, community hospitals and other providers of services, public health agencies, insurance companies, news media and other groups interested in and capable of providing local leadership, initiative and effective action. To accomplish this, it will be necessary that:
>
> (*a*) Congress provide appropriations for the activity;
>
> (*b*) The Department provide an effective focal point for the coordination of health education efforts in the Office of the Assistant Secretary for Health and Scientific Affairs;
>
> (*c*) Federally funded programs, and public and voluntary organizations, place more emphasis in their programs on supporting effective educational activities which

[31] "Feasibility Study on Preventive Services and Health Education for Medicare Recipients", a report to Congress; Department of Health, Education, and Welfare; Wilbur J. Cohen, Secretary; December, 1968.

encourage sound health practices among the aged; and

(*d*) Governmental, voluntary, and private agencies finance evaluation of different types of educational activities for the aged and for other age groups, and determine the relation of costs to effectiveness in reducing illness among Medicare beneficiaries.

It is recommended that the Social Security Administration expand its activities directed at informing beneficiaries about availability and utilization of services under Medicare, and that wherever possible these activities be coordinated or integrated with general community information and referral services.

The Secretary's proposal—calling as it does for broad public and private action—could be an important force for improving organization of health services if it is implemented with full understanding of all its implications and potential scope. Early action is called for, and this committee will do all possible to advance the proposed program.

D. Lessons To Be Learned From OEO Centers

As reported in "Developments in Aging—1967," [32] the elderly could be among the major beneficiaries from the Office of Economic Opportunity neighborhood health centers.

In 1968, this committee conducted a survey of OEO health center directors and received information indicating that such possibilities do indeed exist, but that additional attention should be given to them.

An analysis of questionnaire returns indicated:

—With few exceptions, aged patients are underrepresented in the centers, possibly because of the great emphasis placed on services for the young.

—There is some support, however, for the idea of a geriatric clinic as a working component in such centers.

—Training and consultation for improved services to the aged should be provided.

The centers are important to the development of comprehensive health services because in many urban neighborhoods, they have been called upon to provide care that has been almost nonexistent or inaccessible. One reason for the problem was given at this committee's Los Angeles hearing by Dr. Clarence G. Littlejohn, chairman of the Health Committee of the Urban League of Greater Los Angeles:

> The Medi-Cal program as presently administered actually promotes the exodus of medical resources from the ghetto. More and more health care vendors are becoming disgusted with the program and phasing it out as an economic hazard. More and more recipients, frustrated in their attempts to obtain health care near their homes, have returned to the county corridors and/or neighborhood emergency rooms for disjuncted, crisis-type medical care.
>
> Why is this so? As a black physician, a product of the ghetto and as chairman of the Health Committee of Greater

[32] See pp. 59–62.

Los Angeles Urban League, I have been intimately involved in health care of our community and discussions of the same. The above observation continues to prevail in spite of the numerous efforts of the health care vendors of the black and brown communities, individually, and in groups, locally and in Sacramento, to rectify the inequities in the program so that they might continue to take care of their people. Considerable sacrifices of time and money have been made by these vendors with only minimal progress.

Dr. Elsie Georgi, assistant professor of medicine, University of Southern California, described many shortcomings or problems she encountered from first-hand experience with OEO centers. Nevertheless, she warned against wholesale discontinuance of such projects and made suggestions for modifications intended to broaden their effectiveness:

. . . there is a definite danger of further frustration and distrust should these health centers be discontinued. However, before they proliferate further, I would think it mandatory to have a complete evaluation as to their efficiency, per capita operational costs, etc. I do not believe this has been done to date.

I do not think that OEO health programs—as they are now designed—can effect coordination and unification of health care services—both of which are sorely needed. As a matter of fact, should they continue to expand before proper evaluation, the end result may well be a shift of inequities through further dilution of funds and resources.

At the same time, I wish it clearly understood that I approve of the basic philosophy of the total health concept, and the war on poverty, and the use of health care with relation to both. The concepts of consumer perspective and participation; health care teams; dynamic health education; peer-related multipurpose workers as informed family advocates—all of these are of proven value not only to the poor but to all of us. There is no reason why these cannot be incorporated into a coordinated and unified system rather than through creation of plans which enforce rigid geographic and economic eligibility standards, and are still in reality "medicine for the poor".

We are indebted to OEO for its energetic approach toward promotion of these concepts. It is now time to move on to a broader and more complete plan—one which addresses itself to the total problem of better health and health care to all with the least amount of threat to existing institutions. This can be accomplished if we are mindful of the fact that truly successful planning usually carries with it that which is good from the past; is pertinent to the present; and has some meaning for the future.

At this point in time, with relation to health care services, I feel that experience has taught us that the preference of both recipients and providers of services leans heavily toward a one-to-one relationship in connection with the very

"personal" services. Comprehensiveness, and reasonable cost as well as the other factors described can still be achieved through pooling of the less "personal" aspects of health care such as clinical tests, other special paramedical and ancillary services, and the administrative and managerial components—all of which traditionally lend themselves much more readily to grouping.

E. New Emphasis Through Reorganization of Public Health Service

Reorganization within the U.S. Public Health Service resulted in the establishment of a new Community Health Service in October 1968. Dr. John W. Cashman, Assistant Surgeon General and Director of CHS has reported[33] to this committee that the reorganization has provided CHS with:

> A significant program commitment to the health needs of the aging, especially because of its responsibilities in the professional health aspects of Medicare. The Division of Medical Care Administration (one of the units absorbed by CHS) was particularly active in the areas of standards development for providers, certification of health service providers, and assistance to providers to enable them to meet Medicare standards.

Dr. Cashman acknowledges that "many individual activities which formerly would have been developed as free-standing programs for the aged are now incorporated into comprehensive health programs for wider populations."

The Senate Special Committee on Aging, which has in the past examined individual health maintenance programs for the elderly, is concerned about program consolidations that tend to reduce the visibility of problems faced by the elderly.

Apparently recognizing the need for specialized attention, the new CHS has provided for overall review of aging activities. In the words of Dr. Cashman:

> To coordinate, stimulate, and provide a focal point for the diverse Public Health Service efforts and resources in health services for the aged, a position has been established for a Coordinator of Aging in the Division of Health Care Services. The Coordinator for Aging has responsibility for keeping constantly aware of all the health and health-related activities for the aged conducted by operating units within the Department of Health, Education, and Welfare and by other Government agencies.

The committee renews its recommendations for action that will promote preventive medicine, implement a broad educational program for consumers of health services, and broaden services provided by OEO Neighborhood Health Centers. In addition, the committee recommends that all

[33] For the full text of his report, see app. 1, pp. 148–154.

cost-cutting research or experimental projects be so designed as to simultaneously upgrade the quality of services rendered. Useful findings from this and other research should be implemented at the earliest possible date.

CHAPTER III

THE ELDERLY AS CONSUMERS

Older Americans—the 65-plus generation—have a buying power of about $45 billion, a fact which won increasing attention within recent months.[1]

But, while the total income is large, nearly one-third is from earnings, a source not enjoyed by the overwhelming majority of all older people. For the average older person, income is modest. For this reason, the elderly have a major interest in new legislation intended to protect all consumers,[2] in new information provided about the elderly as consumers in 1968, and in new efforts to provide information needed to help them make moneysaving decisions in the marketplace.

I. THE RETIRED COUPLE'S "MODERATE" BUDGET

Problems related to poverty and near-poverty have been discussed earlier, but what about those older Americans whose income is relatively more adequate? How much do they need to live comfortably, if not luxuriously?

The Federal Bureau of Labor Statistics gave the most authoritative answer available when it issued its "Retired Couple's Budget for a Moderate Living Standard, autumn 1966." [3]

Its major finding: a self-supporting, retired couple in U.S. urban areas required an annual expenditure of about $3,869.[4] For elderly persons without a spouse, an estimated $2,130 would be needed.[5]

As shown on the chart opposite, the major expenditure was for housing. For urban homeowners with a mortage-free house, the U.S. average for a couple was $1,232. Couples in rental units averaged about $179 more, or $1,411 in all.

Even with Medicare coverage, out-of-pocket expenses for medical care were $288 in metropolitan areas and $274 in smaller cities.

The BLS Budget provided much other useful information, including a list of cost variations in cities throughout the Nation (see chart opposite.) Clearly, however, the long-awaited Budget still leaves unanswered many urgent questions about appropriate standards to use in assessing the adequacy of income of various groups in the aged population.

[1] In an article called "Our Place in the Market" carried in the December 1968 issue of *Harvest Years*, Prof. John Kerr of the Florida State University wrote that merchandisers are becoming more aware of the fact that older Americans have special needs and wants. The January 15, 1965 issue of *Forbes* made much the same point in an article called "The Forgotten Generation," stating that the elderly have twice as much money to spend as teenagers, but are getting scant attention from the marketing men. Another indication of growing interest in consumer problems of the elderly was the selection of "The Older Person as a Consumer" for the theme of the 22d Annual Conference at the University of Michigan, June 8–11, 1969.

[2] A list of consumer interest legislation enacted in 1968 appears in app. 6, p. 251.

[3] Bulletin No. 1570-4, U.S. Department of Labor, BLS, June 2, 1968.

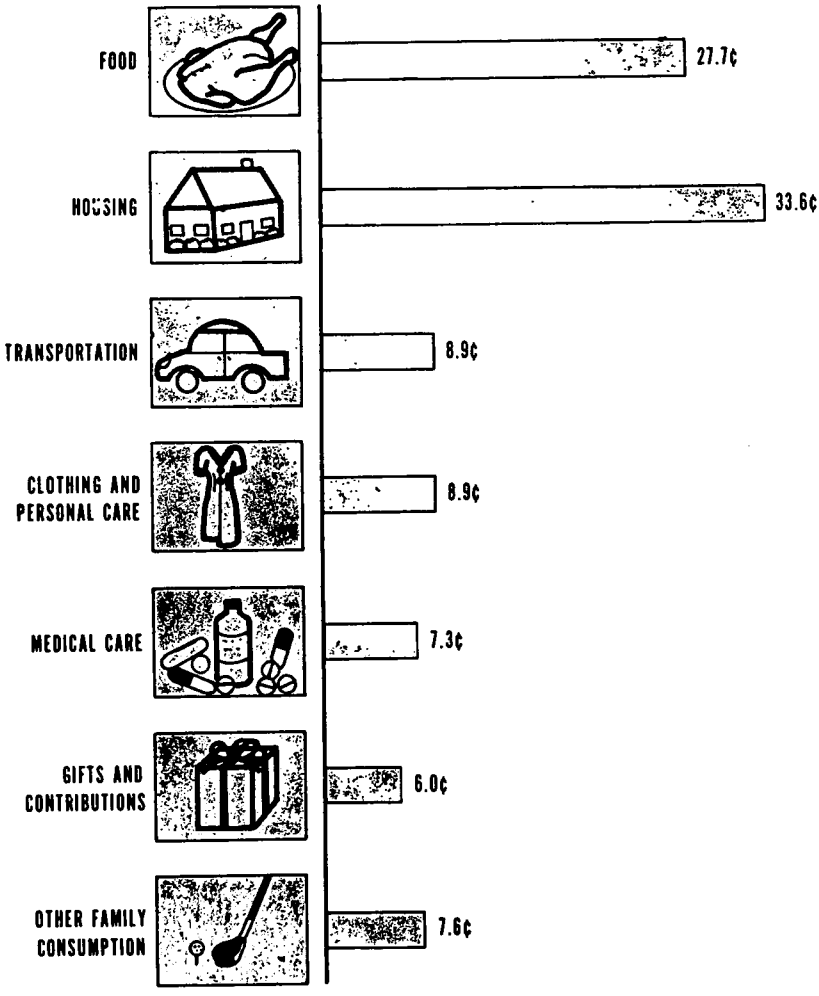
[4] The budget is neither a model nor a minimum. According to BLS the list of goods and services making up the Retired Couple's Budget is based on criteria of adequacy translated into pricing lists that reflect the buying practices of retired couples * * * the budget figure is above the subsistence level, or what would be necessary to carry families through a limited period of stringency. On the other hand, it is not a luxury budget, and does not represent an ideal way of living. For additional information about methodology and findings, see app. 6, p. 252–256, which reprints the introduction to the report and its major tables.

[5] No budget for single elderly persons was developed by BLS but an equivalent scale developed by the Bureau suggests that an elderly person living alone in a city would need approximately the amount listed above.

WHERE THE BUDGET DOLLAR GOES

RETIRED COUPLE'S BUDGET (Moderate Living Standard, Autumn 1966)

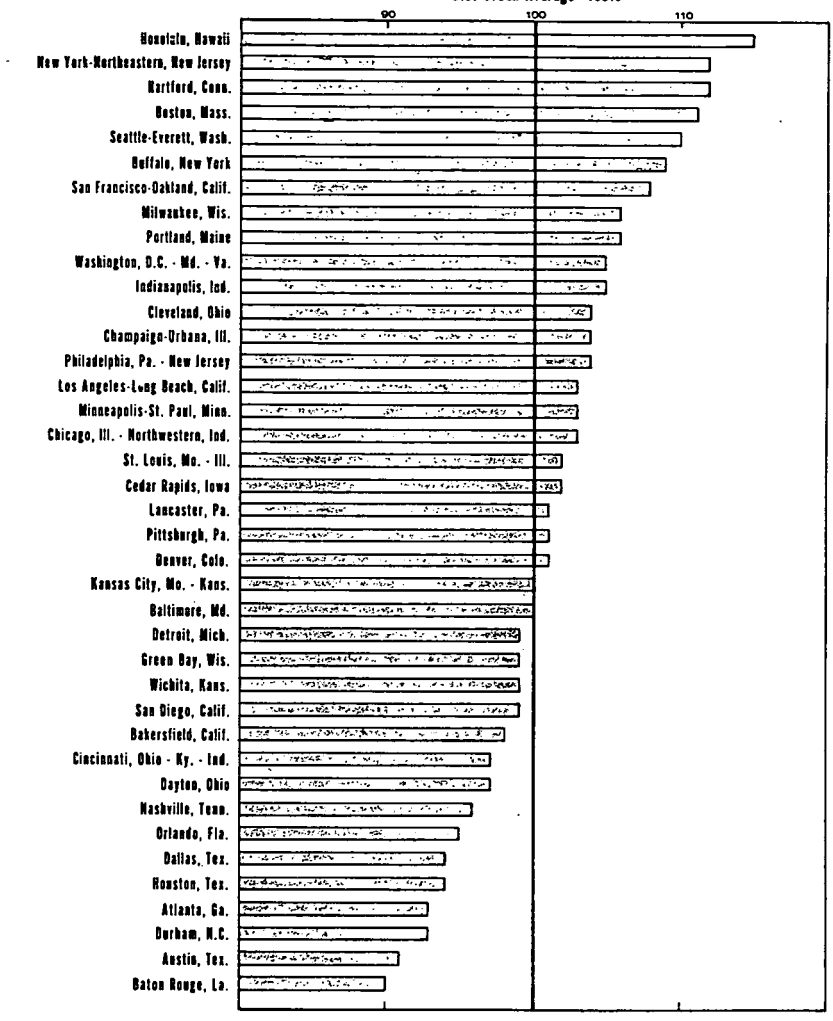
U.S. AVERAGE $3,869



Source: Bulletin No. 1570-4, BLS, June 2, 1968.

COMPARATIVE LIVING COSTS

MEASURED BY RETIRED COUPLE'S BUDGET (Moderate Living Standard, Autumn 1966)



Source: Bulletin No. 1570-4, BLS, June 2, 1968.

Miss Mollie Orshansky of the Social Security Administration, Office of Research and Statistics, for example, made the following observations in a recent article: [6]

—Although the moderate standard was worked out by BLS for an urban couple, barely half of all persons aged 65 and over, as of March 1967, were married and living with a spouse.

—The budget is for a couple residing in a city, but a fourth of the aged persons living in families resided in a community that would be classified as rural.

[6] "Living in Retirement: A Moderate Standard for an Elderly City Couple," *Social Security Bulletin;* October 1968, vol. 31, No. 10.

—Although the vast majority of homes owned by aged couples are mortgage-free, the BLS has yet to determine the standard to apply in those instances where the house is not yet fully paid for.
—The budget standard raises questions about a fundamental concept—the appropriate point of reference. As Miss Orshansky puts it:

> With income in retirement markedly reduced by withdrawal from the labor force and the days of accumulating savings largely past, will the consumption standards of the aged reflect the level of living their pre-retirement income made possible, or will they be tempered to reduced current income? If the latter, what assumptions will be made as to the amount and depletion rate of savings and other resources? Or should the standard for the retired worker and his family reflect rather the idea of modest but adequate living prevailing among those still working full time, with appropriate adjustments—such as altering outlays related to employment to take account of lower transportation and clothing costs, as well as those more strictly termed occupational expenses, and deleting those incurred for raising children?

The BLS Budget should receive sustained attention and—where necessary—criticism intended to arrive at the most accurate, acceptable standards possible for moderate consumer requirements of the elderly.[7]

In addition, the use of consumer price indexes as a measure of need for adjustment and amount of adjustment in retirement benefits should also receive careful attention.[8]

II. UNIQUE PROBLEMS OF THE ELDERLY CONSUMER

Rising costs of health care are discussed elsewhere in this report, as are other cost increases that have their impact upon the budgets of elderly consumers. Cost increases, however, are not the only problems faced by retirees with fixed incomes. Some difficulties arise simply because of advancing years and the place of the elderly in today's society.

A. "Susceptibility" Takes Its Toll

This committee has already given much attention to frauds and misrepresentations affecting the elderly [9] and seven Federal agencies are now working toward a report to study the reasons for susceptibility

[7] The Subcommittee on Consumer Interests of the Elderly of the U.S. Senate Special Committee on Aging, has tentatively scheduled a hearing on "Consumer Aspects of the Economics of Aging" on June 8, 1969, at the University of Michigan Conference mentioned in footnote 1. The BLS Budget is among the subjects under consideration for that hearing.

[8] Use of the Consumer Price Index is an issue in a suit filed on Jan. 16, 1969, against the California State Social Welfare Director. State law requires an annual increase based on the Federal cost-of-living index. Last year, the State dropped the cost of medical care from the index on the theory that welfare recipients do not have to meet medical expenses since they are eligible for Medi-Cal (the State's Medicaid program). Part of the issue revolves around the question of whether Medi-Cal meets all medical needs.

[9] Frauds and quackery affecting the older citizen: Pt.1. Washington, D.C., Jan. 15, 1963: Pt. 2. Washington, D.C., Jan. 16, 1963; Pt. 3. Washington, D.C., Jan. 17, 1963.
Health frauds and quackery: Pt. 1. San Francisco, Calif., Jan. 13, 1964; pt. 2. Washington, DC., Mar. 9, 1964; pt. 3. Washington, D.C., Mar. 10, 1964; pt. 4(a). Washington, D.C., Apr. 6, 1964 (eye care); pt. 4(b). Washington, D.C., Apr. 6, 1964 (eye care).
Interstate mail-order land sales: Pt. 1. Washington, D.C., May 18, 1964; pt. 2. Washington, D.C., May 19, 1964; pt. 3. Washington, D.C., May 20, 1964.
Preneed burial service: Washington, D.C., May 19, 1964.
Deceptive and misleading practices in sale of health insurance: Washington, D.C., May 4, 1964.

to quackery and worthless "health products." The survey is expected to yield new information about the elderly, as well as consumers in other age groups. Whatever the survey findings are, it is to be remembered—as pointed out in a recent article by Research Psychiatrist and Gerontologist Robert Butler, that many influences cause vulnerability among large numbers of the elderly. He observed: [10]

> It is not age alone that makes certain older consumers susceptible to medical quackery and other fraudulent practices. People do not automatically lose their intelligence with age. A variety of factors influence susceptibility, including past history, current medical status, presence of organic brain damage, loneliness, grief and depression, fear of aging and death, pain and anxiety, educational level and cultural characteristics, poverty, and lifelong relationships with physicians.

Reports from the Federal Trade Commission [11] and from the U.S. Postal Inspector [12] for 1968 confirm that susceptibility takes its toll. The Postal Inspector, for example, said that the "soaring cost of medical care" is but one of the reasons that the elderly fall prey to the medical quack. He added:

> By their nature, medical frauds probably affect the elderly more than any other segment of our populace, and postal inspectors completed 244 investigations in this area during Fiscal Year 1968.

Among the examples of effective prosecution:

—A New York City practitioner who collected more than $1.3 million from low-income and welfare families by advertising the services of a spurious "medical" clinic on radio, telephone, direct mail, and in newspapers.

—A Texas mail order testing laboratory that collected $10 each for more than 15,000 mail order "tests" for cancer.

Both the postal inspector and the Federal Trade Commission gave examples of other schemes with special appeal to the elderly. FTC Chairman Paul Rand Dixon provided this information about one area of concern:

> The regulation of insurance lies principally with the States. Nevertheless the Commission has continued to receive numerous complaints involving insurance matters. Many came from the elderly. They generally related to dissatisfaction with cancellations or settlements under health, life, and automobile policies rather than mail-order insurance promotions into States where such companies were not licensed and regulated as was the prior case. Perhaps this was due to the Commission's drive against these latter promotions and its issuance of the public bulletin warning of "Pitfalls to Watch for in Mail Order Insurance Policies." Because of the nature generally of the more recent complaints it has been neces-

[10] "Why are Older Consumers so Susceptible," by Robert N. Butler, M.D., Geriatrics, vol. 23, pp. 83-88, December 1968.
[11] See app. 1, p. 133.
[12] See app. 1, p. 144.

sary for the Commission to explain to the complainants that these were matters which were subject from a regulatory standpoint to consideration by State insurance authorities. The Commission is cooperating with the Department of Transportation in the investigation of certain phases of the automobile insurance industry which the Congress authorized that Department to make.

B. Elderly Shoppers in Low-Income Urban Areas

Testimony taken at hearings on the model cities program [13] indicates that a large number of single elderly persons live in central urban neighborhoods. They therefore share in consumer difficulties encountered by all in such areas. Such problems received considerable attention in 1968 from the Federal Trade Commission [14] and from the U.S. Senate Committee on Government Operations. The committee's report [15] dealt only with findings from Washington, D.C., New York, and St. Louis; but it apparently concurred generally with the theme that the "poor pay more."

The growing awareness of difficulties encountered by elderly and others in low-income areas should lead to more intensive scrutiny of such problems as: effect of shutdowns of retail stores on elderly shoppers, especially those whose mobility is limited; usefulness of the food stamps program for the elderly in such areas; experiments in making shopping facilities more readily accessible; and the need for additional information for individual shoppers and government officials responsible for consumer protection.

C. Nutrition and Meal Patterns

Independence is highly prized among the elderly as among all age groups in this Nation. But, as family patterns change and as more and more elderly persons find that "independence" sometimes means isolation even the daily provision of sustenance itself can become difficult to the point of producing discouragement and even passiveness about meals and their preparation.

The problem is by no means limited to the homebound or to low-income individuals. The Chicago Commission for Senior Citizens gave recently this poignant summary of the problem:

> The experience of agencies providing group or individual services for the elderly in a large urban center such as Chicago substantiates the proposition that poor nutrition is a common denominator for many older persons in our society. Inadequate income, isolation, widowhood, lack of dental care, misconceptions about foods or diminished activities are only some of the frequently identified causes of the poor eating habits of the elderly.

[13] Usefulness of the model cities program to the elderly: Pt. 1. Washington, D.C., July 23, 1968; pt. 2. Seattle, Wash., Oct. 14, 1968; pt. 3. Ogden, Utah, Oct. 24, 1968; pt. 4. Syracuse, N.Y., Dec. 9, 1968; pt. 5. Atlanta, Ga., Dec. 11, 1968.

[14] The Federal Trade Commission conducted public hearings on National Consumer Protection on Nov. 16 to explore problems encountered by low-income consumers. An FTC statement which appears in appendix 1 reports: "The data and views received were under intense study at year's end."

[15] "Consumer Problems of the Poor: Supermarket Operations in Low-Income Areas and the Federal Response," Thirty-eighth Report by the Committee on Government Operations, Aug. 7, 1968.

Clearly, many of the questions suggested above cannot be answered until more hard facts become available. A successful attack on the social and personal problems underlying inadequate, poor diets among older people must be based upon objective data and informed insights. For this reason, the Administration on Aging is acting on a "first priority" basis to make title IV (Research and Demonstration) funds available for projects related to nutrition and meal patterns.

"These projects," says the AoA report on the program,[16] "attack such problems as loneliness, inability to market and prepare meals on the part of the homebound, lack of motivation for eating, and inadequate knowledge of food purchasing and meal preparation."

More than $2 million has been made available for 29 nutrition grants, including three in rural areas.

The meal service and nutrition projects sponsored by AoA funds can be significant in terms of information gathered, people served, and the channels they open to other services needed by the elderly. These projects should receive careful evaluation by the AoA, other governmental agencies, and appropriate congressional units.[17]

D. Automobile Insurance and the Elderly

Automobile insurance coverage is of special importance to older Americans because public transportation services in many urban and rural areas are unavailable, costly, or inconvenient. But the fear of losing that coverage is apparently widespread, as indicated by Executive Director William R. Hutton of the National Council of Senior Citizens in a report to this committee:

> Millions of elderly drivers live in fear of losing their car insurance. They are entitled to definite and specific legal guarantees as their right:
>
> - To renew where a company arbitrarily refuses to renew although it has not cancelled a policy.
> - To buy insurance without regard to arbitrary and capricious rules (such as blacklisting in the case of an applicant rejected by another car insurance firm).
> - To rules that define faulty driving when this is alleged as a reason for cancelling car insurance. The rules should say what constitutes faulty driving.
> - To an easy and inexpensive appeal process to insure the right of elderly with good driving records to keep their car insurance.

Similar concern was expressed to this committee by the National Retired Teachers Association—American Association of Retired Persons. Summarizing replies from 4,154 individuals who responded to an "Auto Insurance Questionnaire" printed in NRTA–AARP publications, Legislative Representative Ernest Giddings reported the following:

[16] See app. 1, pp. 126–127, for details.

[17] Senator Frank Church, chairman of the Subcommittee on Consumer Interests of the Elderly, U.S. Senate Special Committee on Aging, announced early in 1969 that the subcommittee will give intensive attention to the AoA projects as an important component of a study on nutrition and the elderly.

1. Experience with auto insurance in 1967 and/or 1968:	
A. Satisfactory	2,360
B. Unsatisfactory	1,794
2. Treatment reported by the 1,794 whose experience was unsatisfactory:	
A. Cancellations	606
B. Non-renewals	795
C. Transfers to assigned risk plans	924
D. Refusal of coverage	404
E. Policy limit reductions	773
3. Reasons given:	
A. Age	1,134
B. Frequency of accidents	187
C. Other	251

It appears from this sampling that a substantial number of older drivers believe that age is the major reason for insurance company decisions about reduction or cancellation of coverage.

The Older Driver in Perspective.—Sherman G. Finesilver, District Court Judge in Denver, Colo. and a member of the Law College faculty at the University of Denver, is working with the Administration on Aging funds on a study of the licensing, accident involvement, and insurability of the older driver. Among the tentative conclusions he forwarded to this committee in 1968 [18] were the following:

—Although there are obvious problems in underwriting the senior driver, such as declining health and slowing reflexes, these seem to be outweighed by other factors which tend to make him a more desirable risk. Older drivers tend to limit their driving, put few miles on their cars. They are not nearly as likely to be driving in the more hazardous time periods—night time, rush hour weekends, bad weather, etc. Generally speaking, older drivers do not *have* to drive at any particular time. They can drive when they please. Older drivers tend to drive conservative cars in A–1 condition.

—Perhaps the greatest need for the senior driver is public awareness of his capabilities and a demand for greater research on the subjects. The results so far produced would seem to indicate that future research would be generally an acceptable and worthwhile risk for the insurance industry.

—Judge Finesilver also cited individual State studies indicating that senior drivers have a lower accident involvement than other age groups.

Considerable attention to automobile coverage problems of older drivers was given by the Anti-Trust and Monopoly Subcommittee of the Senate Judiciary Committee during its 1968 hearings on automobile insurance rates.[19]

III. HEARING AIDS, HEARING LOSS, AND THE OLDER AMERICAN

For its major project in 1968, the Subcommittee on Consumer Interests began the study identified above. The fundamental question

[18] A more complete report, The Older Driver: A Statistical Evaluation of Licensing and Accident Involvement in 30 States was issued by Judge Finesilver in January 1969. It reports that accident involvement by the elderly is far less frequent than commonly assumed. Similar conclusions were reached by the National Safety Council in "Research Report: An Investigation of the Problems and Opinions of Aged Drivers." Report No. 5168, December 1968.

[19] Senator Harrison A. Williams of New Jersey in a statement to the U.S. Senate Antitrust Subcommittee on July 24, declared that many difficulties with automobile insurance coverage "spring from certain highly questionable attitudes about aging and the aged in this nation. Those attitudes should be challenged at every opportunity."

before the subcommittee, as expressed by Chairman Frank Church, was:

> What more should be done in this Nation to help older Americans—those most vulnerable to deafness and near-deafness—to save themselves from the isolation, demoralization, and hazards that occur when hearing deterioration becomes severe?

Senator Church also said that the subcommittee inquiry will focus primarily on the following areas: [20]

> (1) What more can be done to improve delivery of services needed by the elderly and others who suffer from hearing loss? Experiments and research now being conducted by the Public Health Service indicate a need for using all available resources—and perhaps some new ones—if we are really serious about overcoming the fundamental deficiencies in our present testing and service resources.
>
> (2) We should recognize the fact that the elderly are prime victims for the minority of unscrupulous, fast-moving salesmen who are apparently still very active. I want to make it clear that it is not the prime purpose of this subcommittee to investigate scattered complaints about sharp practices. And yet we cannot ignore evidence of widespread door-to-door activity by salesmen who obviously ignore all standards sought by responsible organizations and individuals.
>
> * * * * * * *
>
> Once again, we must ask ourselves: If present services are dismally inadequate for the present population of people in or near retirement, what will the situation be as the number of older persons increases every year, particularly if hearing disorders increase, too?
>
> (4) What kind of consumer education will be helpful to individuals of all ages in need of facts about hearing aids and hearing services? As already noted, hundreds of hearing aid models are available from a wide variety of sources, and the advertising for many of those products is quite often hazy on essential details. In addition, there seems to be a built-in resistance on the part of many persons to any thought of correcting hearing loss. We need new ideas about consumer education. I am sure this hearing will produce some of these ideas.

The subcommittee study was to continue in 1969, but several points emphatically made at the opening hearing can be discussed in this brief interim report:

—Hearing loss in the upper age ranges appear to have increased within recent years.[21] Eighty percent of all adults with bilateral hearing loss are 45 years or over, and 55 percent are 65 years or older.[22]

[20] "Hearing Loss, Hearing Aids, and the Elderly," a hearing by the Subcommittee on Consumer Interests of the Elderly, U.S. Senate Special Committee on Aging, July 18-19, Washington, D.C.
[21] Ibid. p. 5, Testimony by Surgeon General William Stewart.
[22] Ibid. p. 15, Testimony by Dr. Joseph Stewart, Consultant to Public Health Service.

—The major problem in achieving a preferred system of hearing aid selection on the basis of competent professional advice is the shortage of adequately trained persons to provide the service.[23]

—Criticism of the industry and the dealer system, itself, orginate from the actions of a relatively small population of the manufacturers and dealers.[24]

—Some 300 models of hearing aids are on the market and one study shows that they range in price from as low as about $100 to a high of almost $400.[25]

—The initial cost of the hearing aid does not represent the entire expenditure to be expected. In addition to routine maintenance and repair, there is rapid depreciation on the instrument; we have no figures to contradict the generally accepted average life figure of a hearing aid of 3 years. . . . Batteries, of course, are a continual expense as well." [26]

Representatives of hearing aid manufacturers and dealers associations appeared and discussed standards of ethical performance and overall organization of the industry. A representative of Consumers Union asked for public announcements by the Veterans' Administration of findings from tests conducted for the VA on hearing aid performance.[27]

U.S. Surgeon General William H. Stewart provided the subcommittee with an outline of public policy issues involved in the study when he gave the following list of several ideas now in the discussion stage in the Public Health Service: [28]

1. The drafting and promulgation of model State laws covering the dispensing of hearing aids.
2. The establishment of an ongoing program for the testing of hearing aids and audiometers and the publication of the results of such tests.
3. Comprehensive, long-range planning for noise control.
4. Short-term training courses for commercial dispensers of hearing aids.
5. The determination of the most effective system for the organization and delivery of hearing services.

IV. INFORMATION FOR THE ELDERLY CONSUMER

Through the Administration on Aging Food Service and Nutrition programs mentioned earlier in this chapter, elderly persons in many communities are receiving practical information on consumer matters.

Another AoA project during 1968 was the publication of a 16-panel, folding wallet card called "Consumer Guide for Older People." [29] More than a half million guides were distributed in response to requests within 2 months; and a third printing of 250,000 was ordered. The AoA also published a 28-page booklet called "The Fitness Challenge in the Later Years", which presents three levels of exercises intended to

[23] Ibid. p. 17, Testimony by Dr. Joseph Stewart.
[24] Ibid.p. 144, Testimony by Kenneth Johnson, executive director. American Speech and Hearing Association.
[25] Ibid. p. 16, Testimony of Dr. Joseph Stewart, citing a 1966 survey by Consumers Union.
[26] Ibid. p. 16, Testimony by Dr. Joseph Stewart.
[27] Ibid. pp. 119-138, Testimony by Colston E. Worne, president, Consumers Union of the United States.
[28] Ibid. p. 6-7, Testimony of Surgeon General William Stewart.
[29] Single copies may be obtained from the Administration on Aging, 330 Independence Ave. SW., Washington, D.C. 20201.

help older people begin an exercise program at the level suited to their physical fitness.[30]

Project Moneywise—Senior: This is a consumer education program launched in April 1968 by the Social Security Administration Bureau of Federal Credit Unions in conjunction with the AoA. The basic objective is to train small groups of elderly individuals to conduct education programs among their friends and neighbors on such matters as: how to prepare a budget, good buying habits, identification of deceptive practices, and group efforts to combat financial problems. Regional staffs of the Department of Health, Education, and Welfare were at work during 1968 with State offices on aging to arrange for training programs. In the latter part of the year, several 1-day consumer education programs were given in several cities. The first full-scale Project Moneywise—Senior was scheduled in Hawaii for early 1969.[31]

Office of Education Survey: The U.S. Office of Education announced late in 1968 that it is conducting a nationwide survey of consumer education programs. Commissioner Harold Howe II said that modifications in existing educational resources may result from the study. He added:

> Those in greatest need of consumer education are individuals and families with limited incomes, the elderly, and a great number of middle-class working people who find it difficult to maintain a decent standard of living or meet unforeseen emergencies with average incomes.

[30] For information on AoA activities, see app. 1, p. 131.

[31] For additional information, write to Project Moneywise—Senior, Office of State and Community Services, Administration on Aging, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, Washington, D.C. 20201.

CHAPTER IV

TOWARD MORE AND BETTER HOUSING

The Housing and Urban Development Act of 1968—most comprehensive and potentially far-reaching housing legislation ever enacted into law—set new national goals that could be of direct usefulness to millions of elderly Americans for years to come.

Passage of the act, together with widespread planning for model cities [1] and the successful implementation of several innovations related to housing, made 1968 a notable year of achievement.

I. EXISTING PROGRAMS

Under programs administered by the Department of Housing and Urban Development, cumulative commitments through September 1968 increased to about 260,000 units for the elderly under several programs: [2]

—Low-rent Public Housing continued to be the largest program, accounting for nearly 174,000 dwellings.

—The FHA housing for the elderly program had made commitments for nearly 43,500 units.

—Direct loans for the lower middle-income groups accounted for 41,600.

—FHA's 221(d)(3) market interest rate program—combined with formal rent supplement reservations or contracts provided about 2,000 of the 260,000.

In terms of units placed under construction, the cumulative total was nearly 194,000.

Mrs. Marie C. McGuire, Assistant for Problems of the Elderly and Handicapped at HUD, earlier summed up [3] the situation as it stood at the end of the 1968 fiscal year:

> Completed units among these programs as of the end of fiscal 1968 amounted to nearly 140,000, with over 80,000 completed under our low-rent program. It is estimated, that these completed dwelling units provide good housing—specially designed—for approximately 190,000 senior citizens. It is important to note that our low-rent program, of course, provides decent housing for low-income senior citizens in its regular housing, too; and altogether it is estimated that 340,000 elderly persons were living in public housing as of the end of June 1968.

[1] See ch. 10, pp. 91–98 for discussion of the model cities program.
[2] See app. I, p. 179, for report from HUD on programs, including tables showing State-by-State project grants.
[3] In a speech given October 31, 1968, at the 21st Annual Meeting of the Gerontological Society, Denver, Colo.

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Sizable as the accomplishments are, Mrs. McGuire added:

> Yet, given the huge size of the need and potential market, we in HUD are not satisfied and recognize that all of us have a great challenge ahead if the needs for our senior citizens for better housing are to be met.

Congregate housing needs.—Many elderly persons, though capable of meeting most of their needs, may require some help in preparing meals, caring for living quarters, and for minor services. They are almost independent, but not quite. HUD is experimenting with several approaches for the provision of practical help in such cases, but present law does not permit the use of Federal annual contributions in one essential area: to cover deficits in food service operations for tenants in public housing. Attempts to involve outside agencies have not generally been fruitful.

"If local authorities were authorized to cover such deficits," said Mrs. McGuire, "I am quite convinced that the congregate program would move forward very rapidly."

With additional adaptations, Mrs. McGuire added, existing public housing programs could be made to provide for other congregate housing needs.

Innovations underway or contemplated.—HUD is experimenting with pilot projects or specially designed programs that could have far-reaching effects in providing suitable shelter and services to the elderly. Among them:

—At Glendale Terrace in Toledo, Ohio, nonpsychotic elderly persons—released from the Toledo State Mental Hospital—live among other senior citizens. The provision of certain services and facilities has made possible their return to the community.

—With the help of the Department of Agriculture, HUD is studying possible development of housing for the elderly in rural non-farm areas using HUD programs where feasible.

—Studies of the European "day hospital" is underway. Similar to some community centers in this Nation, the "day hospital" usually includes more services, staff, and equipment.[4]

—Alternatives to "single occupancy room"—or skid row quarters—are recognized as areas for study.

—"Scattered site" projects—providing low-cost apartments for the elderly—were under construction in California and Massachusetts.

II. THE 1968 HOUSING ACT

Once again, the Congress—in passing the 1968 Housing Act—declared that enjoyment of "a decent home and suitable living environment for every American family" is a major national goal. Furthermore,

"The Congress . . . declares that 'the programs authorized by this act are designed to give the highest priority toward meeting the housing needs of those for which the national goal has not yet become a reality.'" [5]

[4] For additional discussion of "day hospitals," see p. 31, "Usefulness of the Model Cities Program to the Elderly," Washington, D.C., July 23, 1968, hearing before the U.S. Senate Special Committee on Aging.
[5] P. 6, Rept. No. 1123, U.S. Senate Committee on Banking and Currency, May 15, 1968.

Among the programs authorized by the law are several of direct meaning and prospective helpfulness to the elderly. Here is a brief summary:[6]

236 PROGRAM: Is intended to open new opportunities for developing rental and cooperative housing for the elderly at low cost. The relationship of this new program to existing ones—and its potential importance to the elderly—are expressed in this excerpt from the Senate Banking and Currency Report on the Housing Act:

"The 221(d)(3) program, has been successful in providing much-needed rental and cooperative housing for these families. However, it, too, has the limitation, as does the 221(h) program of homeownership for low-income families, of depending on direct Federal lending from the special assistance funds of FNMA to support its 3 percent mortgages. The limited availability of these funds will not permit the production of the large volume of rental and cooperative housing for lower income families needed to meet the goals contemplated by this bill. It is therefore necessary to obtain financing from the private mortgage market. This would be done under the new section 236.

"The new 236 program is intended to replace the 221(d)(3) BMIR program, as well as the program of direct 3-percent loans for the elderly and the handicapped authorized under section 202 of the Housing Act of 1959, *but only after the new program is fully operational and adequately funded.* (Emphasis added.)

"It will be better able to serve lower income tenants because the rents attainable under it will be lower than those possible under the other two programs. This is possible because the mortgagor could make monthly payments for principal and interest under the mortgage as if it bore an interest rate of 1 percent. The difference between this amount and the monthly payment due under the mortgage, which will bear a market interest rate, for principal, interest, and mortgage insurance premium will be paid to the mortgagee on behalf of the mortgagor by the Federal Government."

The word of caution about maintenance of the 202 program is noteworthy, particularly in light of reports early in 1969 that the transfer could cause problems for nonprofit sponsors of housing under 202.

SECTION 235: Is a mortgage subsidy program which can promote homeownership for the elderly, as well as for younger persons.

PUBLIC HOUSING: Authorization of funds for low-rent housing was increased, and HUD also was authorized to make grants to local housing authorities to improve management procedures and to provide new services such as counseling on household management, housekeeping, budgeting, and social, health, and other community services. Unfortunately, no

[6] For additional details, see HUD report, app. 1, p. 179.

funds were appropriated to make it possible for this new program to begin during this fiscal year.

PRECONSTRUCTION LOANS: Permit HUD to make interest-free loans of up to 80 percent of such costs to nonprofit sponsors under various programs including:

202 DIRECT LOANS: Now permits loans to limited profit sponsors for the first time. Only nonprofit sponsors, cooperatives, and certain public agencies had previously been eligible.

HOME REHABILITATION—LOANS AND GRANTS: Now available in areas other than urban renewal and concentrated code enforcement areas under certain conditions. Maximum grants have been increased from $1,500 to $3,000.

RELOCATION PAYMENTS: Additional relocation payments to assist families of all ages and elderly single persons were authorized. Maximum payments were raised, and may be paid over a 2-year period instead of five months. A new program of payments of up to $5,000 was authorized for displaced owner-occupants of residential property to enable them to purchase replacement dwellings.

II. ARCHITECTURAL BARRIERS

On June 3, 1968, President Johnson transmitted to Congress the report of the National Commission on Architectural Barriers to Rehabilitation of the Handicapped.[7] The report, the product of 2 years of work by the Commission, reflects throughout a realization that the aged constitute a sizable proportion of Americans whose accessibility to public buildings is restricted due to physical incapacity.

In his letter, the President commented:

* * * * * * *

> In the next 30 years, more buildings will be constructed in this country than have been built in the past 200 years. And as we go about this tremendous task, we must make sure that the needs of the handicapped are not overlooked.

In his letter transmitting the report to the President, Secretary Wilbur J. Cohen of the Department of Health, Education, and Welfare had stated:

> The Commission's findings and proposals are based upon special studies and surveys, testimony from many groups and individuals, and site visits by the Commission to several communities in different parts of the country.
>
> They found that about one out of every 10 Americans is in some way physically handicapped. These include . . . millions of older citizens with impairments of age . . . .
>
> They found that in almost all communities, virtually all of the buildings and facilities most commonly used by the public have features that bar the handicapped . . . .
>
> * * * * * * *

[7] House Document No. 324, 90th Cong., second sess. (June 3, 1968).

They found that with relatively little cost and no loss of beauty or function most new buildings and many existing structures and facilities can be made usable by disabled people.

Of the recommendations in the report, the Commission designated six as "priorities for action," as follows:

1. Enactment of Federal legislation requiring that all new public buildings and facilities which are intended for use by the public must be designed to accommodate the elderly and the handicapped if any Federal funds are used in their construction.

2. Issuance of an Executive order to apply accessibility standards to new construction and directing all Federal agencies to plan and budget for feasible changes in their existing buildings and facilities.

3. Enactment or revision of State legislation to require that State and local buildings constructed with public funds meet accessibility standards and to include strong enforcement provisions.

4. Revision of all building codes so that industries, shops, and other privately owned structures used by the public will be built for accessibility in the future and so that, when existing buildings are renovated, feasible improvements in accessibility will be made.

5. Assignment of responsibility and resources to specific units of Federal, State, and local governments to administer the accessibility legislation, to conduct and/or support research and demonstrations, and to work with voluntary, professional, business and industrial organizations to the end that all buildings and facilities used by the people of every community will be readily accessible to elderly and handicapped people.

6. Expansion of public and privately supported education and information programs so that no longer, merely through thoughtlessness, will millions of citizens be unable to use buildings, parks, and other facilities.

Even before the report was received, Congress had made substantial progress in accomplishing the purpose of the first of these recommendations. Early in 1967, companion bills to that effect had been introduced by Senator E. L. Bartlett (Alaska) and Congressman Charles E. Bennett (Fla.), among others. The Bartlett bill, S. 222, was reported and passed the Senate during August 1967. After the report was received, the bill passed the House, amended, on June 17, 1968. When Senate and House differences were resolved by a conference committee, the bill was given final approval by both houses late in July 1968, and the President signed it on August 12, 1968, as Public Law 90–480.

This act applies to buildings which are to be—

(1) Constructed or altered by or on behalf of the United States;

(2) Leased in whole or in part by the United States after construction or alteration in accordance with plans and specifications of the United States; and

(3) Financed in whole or in part by a grant or a loan made by the United States, if the building or facility is subject to standards for design, construction, or alteration issued under authority of the law authorizing the grant or loan.

It authorizes the Administrator of General Services to prescribe standards for the design, construction, and alteration of these buildings to insure that the physically handicapped will have ready access to, and use of them, and requires that buildings designed, constructed, or altered after the effective date of a standard applicable to such building be designed, constructed, or altered in accordance with the standard.

The act also provides that the Secretary of HUD, in consultation with the Secretary of HEW, is authorized to prescribe such standards for the design, construction, and alteration of buildings which are residential structures subject to the act, as may be necessary to insure that physically handicapped persons will have ready access to, and use of, such buildings.

Regulations implementing the Act are being developed at the present time.

CHAPTER V

THE INSTITUTIONALIZED ELDERLY: LONG-TERM CARE AND OTHER NEEDS

"Most of all, I want to keep my independence."

Anyone who speaks to older persons at some length may be impressed and perhaps moved by the frequency with which the above statement is made.

But in a nation where the aged elderly are increasing, and in which the number of single elderly persons—especially widows—is markedly on the increase, "independence" is often not easily maintainable.

A mark of the success or failure of our society, therefore, will be the ingenuity displayed in providing new environments in which dependency is served while independence of spirit and—as far as possible—physical mobility and comfort are maintained.

For elderly Americans, the transition from independence to institutionalization can be more than bearable; it may even be a meaningful fruition to life if the cost of care is within financial reach, surroundings are interesting, discomfort from illness either nonexistent or under control, and the management enlightened and efficient.

For many other Americans, however, "institutionalization" can mean that one way of life is wrenched from them while another, far less satisfactory mode of life, is substituted. Whether the institution be a nursing home, a custodial care home, or a hospital for the mentally ill, independence has been lost and an imperfect substitute has been provided.[1]

I. THE NURSING HOME [2]

Efforts were underway in 1968 to raise standards in nursing homes receiving payments through the medicaid program.

One provision of the Social Security Amendments of 1967 called for higher standards applicable to title XIX patients in skilled nursing homes. At the end of 1968, however, Federal regulations had not yet been formally announced.[3]

Developments in licensing: The 1967 amendments also established a National Advisory Council on Nursing Home Administration and charged that Council with the responsibility of developing guidelines for State licensing of nursing home administrators.

The Council conducted four public hearings during 1968 and heard from nursing home patients, newspaper editors, sons and daughters

[1] Surveys generally agree that about 5 percent of the 65+ population of this Nation are institutionalized. A recent survey indicated, however, that as many as 15 percent of the elderly may be in need of special services for the homebound. "Old People in Three Industrial Societies," by Ethel Shanas, Peter Townsend, Dorothy Wedderburn, Henning Friis, Poul Milhoj, and Jan Stehouwer.

[2] Acknowledging that solid statistics on nursing homes care are sparse, a Public Health Service brochure ("Nursing Home Utilization and Costs in Selected States," PHS Publication 946-8 No. 8, March 1968) provided the following data: "the number of nursing homes rose from 6,539 in 1954, to 11,981 in 1965; expenditures for nursing home care rose from $142 million in 1950 to $1.3 billion in 1965"; and, in the same period, "public expenditures increased seventeenfold from $30 million to $510 million."

[3] The new standards were included in legislation advanced by Senator Frank E. Moss of Utah as a result of hearings conducted by the Subcommittee on Long-Term Care, U.S. Senate Special Committee on Aging. See "Developments in Aging, 1967," pp. 84-89.

of nursing home patients, nursing home administrators, educators and others. The American Nursing Home Association stressed its support "of action and action programs designed to improve the nursing home field, to professionalize its leadership, and to increase the quality of care offered to the older American."

A representative of the American Association of Homes for the Aged described licensure as "a step in the development of a profession," and added:

> Licensing will not be an end in itself, nor a cure-all for our problems. We will need a commitment for professional education, a commitment backed with support for training. We will need to find ways to bring the nursing home, as a system for the delivery of services, into the broader health care spectrum. Rather than something to be feared, we should look upon licensing as an opportunity to coalesce independent and sometimes divergent trends in our field.

Advisory Council Chairman Harold Baumgarten, who is an associate professor of administrative medicine at Columbia University, has made a report to this committee summing up the significance of the hearing. His statement says in part:

> The first and most obvious thread woven into the fabric of the testimony was a plea, a strong plea, to do all in our power to make sure that nursing home administration is warm, human, responsive, and protective and not an efficient sharply defined science. My comment to you is that we must be ever aware of this essential humanistic approach to the care of the ill and elderly. We must not be so demanding of the system as to eliminate flexibility nor so precise in our measurements as to inhibit our ability to adjust the level and intensity of care. We should explore ways of permitting the institution and the program of care to adjust to the needs of the patients as opposed to forcing the patients to make difficult and often painful adjustments.
>
> A second major emphasis, which appeared throughout the testimony, was an enthusiastic acceptance of administrator licensure. This acceptance was coupled with a strong appeal to equated, demonstrated, and tested ability with the placing of equivalent responsibility. We were made to believe that there is a desire to be measured, to be educated, and to be qualified as professional individuals, following which the administrators would like to have the opportunity to exercise judgment and assume authority over their facilities. The limiting and discouraging factors identified to us were; first, the inept use of power by ill-informed institutional licensing agencies and their frequently inadequate inspectors, and, second, the power of owner-investors to exert influence over the home's operation. I suggest that we may need major changes in legislation at the State level and guidelines at the Federal level to clearly spell out the authority and responsibilities of the licensed and qualified nursing home administrator.

Dr. Baumgarten also saw a major need for widespread education of personnel who work in long-term-care institutions:

> It is my opinion that the lack of educational opportunities is alarming and the fragmented, disoriented, uncoordinated federally sponsored efforts are of such limited value as to be virtually ineffective. It is obvious that research, demonstration, and experimentation in the care of the elderly patient is severely limited, which of course limits the available body of knowledge for use by those of us who seek to teach in this important area.

II. OTHER FORMS OF CARE

The imposition of an "intermediate care" category of nursing home care [4] has raised questions about alternatives to skilled nursing home care. Advocates of this new form of federally supported care for the elderly say that it will be less costly and more appropriate than skilled nursing home care. Opponents say that it will cause "fragmentation" of care, and needless shifting from one institution—or wing of an institution—to others.

Considerable attention must be paid in the near future to other issues relating to categories of long-term care, and new ways must be found to relate such care more directly to existing or new health resources.[5]

Some basis for the statement made above can be found in a statement made by Mark Berke and Harry Weinstein of the Mount Zion Hospital, San Francisco, at a recent hearing.[6] They argued that overall health costs could be reduced only if high-cost hospitalization is reduced. To achieve this, coordination of many different kinds of facilities, including nursing homes and other kinds of homes for the aged, would be essential:

> The practices which have the greatest potential for reducing the cost of medical care also have the greatest potential for improving the quality of care.
>
> The cost reduction can be achieved by utilizing the least costly facility or service appropriate to the patient's need (and by preventing illness or the advance of illness or by providing restorative services which enable the patient to be served by a less costly facility).
>
> The improvement in quality of care stems from developing the full constellation of facilities necessary to supply appropriate care at lower cost. The overutilization of high-cost facilities such as the acute hospital represents not only

[4] A report from the Social and Rehabilitation Service (see app. 1 for complete text) gives the following description of the intermediate care facility established under the Social Security Amendments of 1967: ". . . States may be reimbursed for care of needy people in those homes under the same formula as used for care given medicaid patients in skilled nursing homes. Intermediate care facilities are meant to serve patients who require institutional care but do not require hospital or skilled nursing care. Only public assistance recipients may qualify for this facility."

[5] Some idea of the complexity of a truly comprehensive extended care service can be obtained from a study of the system now operated by the Veterans' Administration for approximately 30,000 patients, of which 56 percent are age 65 and over. Categories include: intermediate care for patients who are chronically ill and require more or less daily medical services, domiciliary care for ambulatory veterans, and restoration center care for domiciliary care for veterans would be expected to return to the community after rehabilitation. For a full report on the VA program, see app. 1, pp. 174–179.

[6] "Costs and Delivery of Health Services to Elderly Americans," hearing, Los Angeles, Calif., Oct. 16, 1968, U.S. Senate Special Committee on Aging, Subcommittee on Health of the Elderly.

wasted dollars but poor care because of the inappropriateness of the facility for the patient's need.

Efforts to reduce the number of individuals in need of expensive services have been advocated by many and we do not wish to be trite by joining sanctimoniously in such advocacy. Nevertheless, there is no broad-based, consistent, effective program of prevention and early diagnosis for the aged in this country and such programs must be established to serve the ends of lower cost and higher quality.

Facilities which must be available in addition to the acute hospital include:

Intensive rehabilitation unit.
Extended care facility.
Long-term care facility:
    Nursing homes.
    Homes for aged.
Coordinated home care.
Individual home services: that is, nurse, physical therapist, medical doctor, etc.
Day centers:
    Outpatient department.
    Private office.
Substitute homes.

Multidisciplined patient care planning teams must be involved early after hospital admission in order to shorten hospital stays and choose the appropriate alternative to hospitalization. Such teams can also participate in planning which prevents hospitalization.

The greater the success we have in using appropriate alternatives to hospitalization, the more the cost of care per patient day in the acute hospital must go up, since only the sickest patients requiring the most service and use of the most elaborate "hardware" will be served in such institutions.

Ultimately, then, we must arrive at a true assessment of health costs in terms of total community expenditure per 1,000 persons over age 65. Of the two costs involved, the one expressed by the per diem rate in the hospital must go up. Our only hope there is to stabilize the rise; that is to diminish the speed of rise. The other cost expressed as communal cost can go down by coordinated community effort. The community can make certain that its dollars are effectively spent and that it gets more for its money through avoidance of unnecessary duplication and of overutilization of expensive services and facilities.

III. THE ELDERLY IN MENTAL HOSPITALS

The Committee on Aging is now preparing a survey report describing successful programs to help institutionalized "geriatric patients" return to the community. In addition, the committee document will describe programs intended to prevent the need for institutionalization. Some of the reasons for committee concern:

—Approximately 40 percent of first mental hospital admissions are accounted for by persons over 60 years of age.
—Geriatric patients in mental hospitals now occupy one out of every five hospital beds of all descriptions, for all medical and surgical illnesses, in the country.
—It has been estimated that a minimum of 8 percent of persons over 65 in this country are severely impaired mentally.

CHAPTER VI

THE MIDDLE-AGED AND OLDER WORKER

Unless they know otherwise from personal experience, most Americans may think of "aging" problems as something that happens to people after they reach age 65. In terms of employment problems, however, age often becomes a major factor to people in their fifties, forties, or even the late thirties.

Such difficulties were examined by hearings conducted by two subcommittees of the Special Committee on Aging during 1968. Additional insights were provided during the latter half of 1968 by the implementation of the Age Discrimination Act of 1967.

I. STUDY AND HEARINGS ON "ADEQUACY OF SERVICES FOR OLDER WORKERS"

Problems—but also opportunities—in employment of middle-aged and older workers were presented and discussed at hearings on adequacy of services for older workers, conducted during 1968 by the Subcommittee on Employment and Retirement Incomes (Senator Jennings Randolph, chairman) and the Subcommittee on Federal, State, and Community Services (Senator Edward M. Kennedy, chairman).

Additional hearings are contemplated for 1969, but even in the form of interim statements the subcommittees can point to the following major findings from their joint study:

1. *So-called older workers* [1] *face employment problems of a magnitude and severity worthy of more widespread understanding and action.*—Secretary Wirtz summed up the situation by saying that one out of two jobs which become vacant is closed to all persons over 45 and one out of eight unemployed men 45 to 64 is unemployed for 6 months or more.[2]

The overall statistical picture was given by Louis H. Ravin, Special Assistant for Older Workers at the Department of Labor:

> Mr. Chairman, in much of the discussion of age and employment the subjects of pensions and retirement for age 65 have been in the forefront. This committee's hearings should serve as a vigorous reminder that many men and women feel the impact of age on their employment opportunities long before they reach their 60's. Their difficulties may become acute at 40 or 50 years of age and even earlier, when retirement is not a feasible alternative.
>
> You have heard some statistics on middle-aged and older workers and you will be hearing more. Statistics are useful—

[1] Older workers, by Department of Labor standards, are persons past age 45. For the purposes of this chapter, however, middle-aged workers are those between 45 and 55, and older workers are those above age 55.

[2] P. 12, "Adequacy of Services for Older Workers," hearing transcript July 24, 25, and 29, 1968.

but statistics are not human beings. Moreover, on the subject we are dealing with today, statistics have so far been better at raising questions than answering them.

There are now more than 22.6 million persons between age 45 and 54 and 17½ million between 55 and 64—that is, more than 40 million middle-aged people.

Older workers (45+) account for 30 million or almost two-fifths of the labor force. If we wanted to avoid facing problems—to be able to say "all's well with the world"—we could be content with one or two superficial statistics: Unemployment rates were low in 1967—3.1 for all males, and only 1.9 for men aged 45 to 54. That conceals as much as it reveals. In fact beginning about age 45:

—labor force participation falls off;
—unemployment begins to rise;
—duration of unemployment increases; and
—poverty increases.

These trends reflect the misfortunes of only a minority, but it is not such a small number at that. In 1967, a monthly average of 725,000 persons 45 years and over were unemployed, and their unemployment on the average was twice as long as for those under 45.

The proportions of the very-long-term unemployed made up of men 45 and older has jumped despite an improved employment situation—from 31.5 percent in 1961 to 49.2 percent in 1967. The long-term unemployed are small in number but it is no consolation to the victims to know that most people are better off than they.

In 1947, 48 percent of men 65 and over were in the labor force; in 1967, only 26 percent. There has also been a significant decline in participation of men 55 to 64. There are now more than 1¼ million men between 55 to 64 who are not in the labor force.

The dropout from the labor force may be accounted for in part by early retirements. To the extent that this reflects the retirement of men 62 to 64 under the optional provisions of the Social Security Act, they are for the most part persons of low income compelled to accept reduced benefits which will continue throughout their lifetime. Such a decision is not voluntary retirement to enjoy leisure as the fruit of long years of work, but simply acceptance of the inevitability of a life of poverty.

But a job means not only income for the older person; it is more than that—it is something to do, someplace to go, someone to talk to.

2. Capabilities of older workers are high, and loss of their talents and skills is a loss to the Nation.—Prof. Oscar J. Kaplan of San Diego State College testified: [3]

> Many studies have shown that the middle-aged worker has character and personality traits which make him a highly desirable employee. He tends to be more reliable, more

[3] Ibid. pp. 54, 57, and 58.

highly motivated, less mobile, less accident-prone, and less likely to be absent for trivial reasons.

* * * * *

. . . mature workers, persons in the age range of 40 to 65, generally speaking, are able physically and mentally, to competently discharge most of the tasks that we encounter in the work force. I draw attention to a number of very favorable factors that have not existed in the past.

For example, technological innovations now make it possible to relieve workers of heavy demands upon physical strength and this makes it possible for many persons who in the past might have been ruled out of the labor force to fill jobs which are quite stressful.

* * * * *

Middle-aged people today are healthier than their counterparts in other generations, and I think we can look forward to even greater gains along that line.

Additional testimony concerning work capabilities of older workers was given by Sol Swerdloff of the Bureau of Labor Statistics:[4]

Some years ago, the Bureau conducted a series of studies to explore some questions regarding the relative job performance of older workers versus workers in younger age groups. The findings of these studies were very helpful in destroying the myth about the widespread deterioration of workers' job performance with advancing age. The most important findings which emerged from these studies, which covered both production workers and office workers, were: First, the differences in output per man-hour among age groups were relatively small, and for office workers, particularly were insignificant; second, there was considerable variation among workers within age groups so that large proportions of the workers in older age groups exceeded the average performance of younger groups; and, third, workers in the older age groups had a steadier rate of output, with considerably less variation from week to week, than workers in younger age groups. Thus, arbitrary barriers to the employment of older workers which are related to the job performance were demonstrated to be unwarranted.

Still another estimate of the value of older workers was expressed by Miss Eleanor Fait, of the California State Employment Service:[5]

The amount of work and the number of jobs are not a fixed quantity. Consider the needs of the American people, their sophisticated demands, the services they will use and don't get, their comfort and recreational standards, and the amount of machinery needed to maintain these standards. There is literally no end in sight to the services that the American people want and will pay for.

Hugh McLeod, of the Minnesota Mining & Manufacturing Co., has said it this way:

[4] I bid P. 105.
[5] I bid P. 147.

> The need for people with specialized knowledge is so great that whole services businesses are growing out of it. Our modern economy is so involved with mass sales, mass service, mass production, mass research . . . that the exceptions provide vast opportunities for self-employment, a changing concept which should be more attractive to older workers.

3. Additional research is needed in many areas.—More than one witness saw a clearcut need for new designations of age groups for research. Louis Levine of the Institute for Research on Human Resources at the University of Pennsylvania, said for example: [6]

> Statisticians—and I spent a lifetime as a statistician on labor force and labor market data—realize full well that people should not be pigeonholed, but still for handling of statistical data in some manageable fashion one does set up classifications. This assumes homogeneity but there is no homogeneity between the worker 45 years of age and the worker 65 years of age. Indeed, one could almost take individual years and set them up as categories.
>
> At least more meaningful, it would seem to me, would be to talk about the worker 45 to 54 who, for all practical purposes, is identical with workers under 45 except for the prejudices that exist in the hiring process. Then the workers 55 through 59, who are in a gradation stage, so to speak, approaching the ages which now are being recognized as retirement ages with retirement income.
>
> Then certainly a category of 60 through 64, and then at 65 and above which should be broken out separately.

Secretary Wirtz gave this list of other research needs under study at the Department of Labor: [7]

> We propose in our research to do this—to find each subgroup within the older worker group which needs a special and different kind of remedial action. We will try to isolate, for example:
>
> (1) Those for whom the problem of age is compounded by sickness and physical handicap.
>
> (2) Those for whom the problem of "unemployment" manifests itself in an island of unemployment where a disproportionately large portion of the population is unemployed and poor:
>
> This is true in certain rural areas where employment has dried up.
>
> This is also true in the ghettos.
>
> (3) Those whose problems can be mitigated by formulating model pension plans which will avoid, for management, the current problems they see in covering older workers.
>
> (4) Those who are affected by the operation of seniority systems and the widespread practice of permitting entry only at the bottom rung of the ladder.
>
> (5) Those for whom opportunities beyond the conventional category of "gainfully employed" are needed.

[6] I bid P. 43.
[7] P. 13 of hearings cited in footnote 2.

4. A wide variety of existing programs or new innovations could be used to help the older worker: Among suggestions made were the following:

- Preventive services, such as training and counseling, beginning with the older worker while he is still employed to prevent problems after he loses his job.[8]
- Increased opportunities for self-improvement and vocational advancement in middle years, such as opportunities to upgrade and update training and education.[9]
- Department of Labor contracts with private nonprofit agencies in communities suffering from mass layoffs, to bring to bear all resources in the community on problems of unemployed older workers.[10]
- Job redesign to eliminate unnecessary difficulties for older workers in performing some types of work.[11]
- Private, non-profit employment organizations to cooperate with and supplement Department of Labor activities in solving employment problems of older workers.[12]

LEGISLATION INTRODUCED

As a result of these hearings and the studies of these two subcommittees, S. 4180, a proposed "Middle-Aged and Older Workers Full Employment Act of 1968," was introduced on October 10, 1968, with the cosponsorship of Senators Randolph, Kennedy, Williams, and seven other Senators. An identical bill, H.R. 20429, was introduced in the House by Congressman James H. Scheuer of New York. A section-by-section analysis of these companion bills appears on p. — of the Appendix. While the bill expired at the end of the 90th Congress, it will be revised and reintroduced in the 91st Congress.

II. AGE DISCRIMINATION IN EMPLOYMENT ACT[13]

The Age Discrimination in Employment Act of 1967 was in effect during approximately the last half of 1968. At subcommittee hearings conducted soon after the act went into effect, Secretary Wirtz discussed enforcement problems experienced in launching its enforcement:[14]

> Congress should be advised that there is at the present point a very real question as to whether it will be possible for us in the Department to administer this program, with any real effectiveness at all.
>
> We have no employees for the administration of this program, and by virtue of the enactment of the Revenue and Expenditures Control Act of 1968 I am faced with a very serious problem of whether I can find positions for the administration of this program. I must find those positions only by taking them away from other programs which are already

[8] Professor Kaplan, p. 58 of hearings cited in footnote 2.
[9] Professor Kaplan, p. 61 of hearings cited in footnote 2.
[10] Lester Fox of United Community Services, St. Joseph County, Ind., p. 246 of hearings cited in footnote 2.
[11] Mr. Swerdloff, p. 105 of hearings cited in footnote 2.
[12] Mrs. James H. Baxter, trustee, and Mrs. Gladys Sprinkle, director, Over-60 Counseling and Employment Service, Montgomery County, Md., pp. 155–162 of hearings cited in footnote 2.
[13] A brief explanatory leaflet prepared by the Department of Labor is reproduced in appendix 7, p. 257.
[14] Pp. 16 and 17 hearings cited in footnote 2.

established because by virtue of the law I can fill only three out of every four vacancies which come up.

This program is being administered in the same offices as is the minimum wage law.

I might just as well face the fact that as things now stand as a practical matter in order to put one person to the enforcement of this new law I must take one person away from the enforcement of the minimum wage law. That is the situation which we face today.

Later, however, Secretary Wirtz gave the following assurance:

I believe in this program so completely that I am going to do whatever is necessary to find some place that I can pull from some other division and some other unit in the Department some personnel to do this.

Report on Implementation: The Secretary's first report [15] on progress made by the antidiscrimination law offered the following major points:

—About 46 percent of the 79 million persons 16 years of age and over in the civilian labor force in September 1968 were in the 40–65 age bracket covered under the law (see table I). The number of 40–65 participants will go up in number by 1975 but remain at about the same proportion. In 1985, the proportion may be down to 41 percent.

—approximately 675,000 establishments fall within the scope of the law, and in these establishments there are an estimated 42 million jobs. It is not known how many are held by people who are 40–65.

—10,213 establishments were checked, usually in concurrent investigations of compliance by the establishments with the Fair Labor Standards Act and other labor statutes administered by the Wage and Hour and Public Contracts Divisions. The report added: "—it is much too early to draw any conclusions, but there are preliminary indications that the kinds of establishments involved in age discrimination are much larger than those typically involved in violation of the Fair Labor Standards Act or other labor standards legislation and that concurrent investigations may not be a satisfactory approach to scheduling Age Discrimination in Employment Act investigations."

—120 establishments employing approximately 31,000 workers were found to be in violation of one or more of the law's provisions.

—The most common discriminatory practices on the part of employers were refusal to hire older workers and illegal employment advertising.

—Illegal advertising was the most common type of discrimination practiced by employment agencies. (Field reports indicate that in the 72 newspapers examined in 63 cities in November and December of 1967, there were 3,633 help wanted advertisements using language which would indicate possible age discrimination. By late 1968, however, the number of such advertisements was reduced to 1,377.)

—26 States and Puerto Rico have ADEA-type laws in effect.

[15] "Age Discrimination in Employment Act of 1967, A Report Covering Activities in Connection With the Statute During 1968," received by Congress, Jan. 16, 1969.

—"Plans are now under consideration to make specific studies of three industries—air transportation, banking, and electrical machinery and equipment manufacturing—where there is a markedly lower percentage of employees 45 years and older than is true of employment in general."
—No action is recommended for changes in the present 40 to 65 age limits,[16] but the issue will be the subject of a separate report to be issued in 1969.
—Education and information activities included the mailing of material to 350,000 employers, 9,000 employment agencies, and 55,000 unions in May 1968.
—"While the policy is now clear with respect to age discrimination in employment, a very large job of education and enforcement remains to be done."

TABLE 1.—*Number and percent of persons in civilian labor force age 16 years and over, by specified age groups, September 1968*

Age groups	Civilian labor force	
	Number (thousands)	Percent
Total	78, 546	100. 0
Under 40 years	39, 028	49. 7
40 to 65 years	36, 331	46. 2
65 years and over	3, 187	4. 1

Source: Employment and Earnings, Bureau of Labor Statistics, October 1968.

III. OTHER EMPLOYMENT DEVELOPMENTS

A. VOCATIONAL REHABILITATION AMENDMENTS OF 1968

As signed into law on July 7, 1968 (Public Law 90–391), these amendments could be particularly helpful to workers age 45 and over in gaining employment.

Senator Harrison A. Williams, commenting on the amendments in a floor statement on June 28, said:

> . . . Perhaps the most significant amendment in the bill from the standpoint of the elderly is its definition of disadvantaged individuals to include individuals disadvantaged by reason of advanced age, for the purposes of determining eligibility for services under the vocational evaluation and work-adjustment program proposed by the bill. Thus, for the first time in the history of Federal vocational rehabilitation legislation, older persons will be eligible for vocational rehabilitation assistance solely on the basis of age, without reference to whether they are suffering a physical or mental disability.
>
> Even without this special provision for the elderly, the vocational rehabilitation program could have been expected

[16] Text of Secretary Wirtz's letter of November 28 stating reasons for recommending no change at this time may be found in appendix 7, p. 265.

to help many in this age group who are disabled. Since 1945, when 7,244 disabled persons 45 years of age and older were rehabilitated, there has been a steady increase in the number of aging handicapped individuals rehabilitated into employment. For example, in fiscal year 1966, 41,300 persons over 45 were rehabilitated, over 5 times the 1945 figure. A total of 47,000 persons age 45 and beyond were rehabilitated during fiscal 1967, and it is estimated that 53,000 of them will be rehabilitated during fiscal 1968, the current year which will end Sunday, and that 60,300 will be rehabilitated during fiscal year 1969, which begins next Monday. These figures include only disabled individuals, not older individuals who are disadvantaged solely on account of their advanced ages, who will become eligible for a type of vocational rehabilitation under the amendments in the bill we passed yesterday. Rehabilitation for members of that group will increase the number of workers age 45 and over assisted by this legislation beyond the estimated 60,300 older individuals who will be aided during fiscal 1969 even if these amendments do not become law.

B. MDTA Extension

Programs authorized by the Manpower Development and Training Act of 1962 increase employment opportunities for older workers as well as for workers of other ages. During 1968, Congress enacted Senate bill 2938, which extends and amended that act. The bill was signed into law on October 24, 1968 (Public Law 90–636).

The new law extends until June 30, 1970, the authorizations for labor mobility demonstration projects, trainee placement assistance demonstration projects, and training in correctional institutions, and extends until June 30, 1972, operating authority to conduct the basic manpower training programs (institutional and on the job) under title II of the MDTA. New authorizations include those for labor market information and training and technical assistance.

C. Establishment of National Institute of Industrial Gerontology [17]

The National Institute of Industrial Gerontology was established in January, 1968 by the National Council on the Aging under a contract with the U.S. Employment Service. The Institute will carry out research on the employment and retirement problems of middle-aged and older workers.

The Institute has also begun regular publication of "Industrial Gerontology, a Compendium of current papers on Middle-Aged and Older Workers." In the first issue, Editor-in-Chief William D. Torrence, Professor of Management at the University of Nebraska, wrote:

> It is hoped that Industrial Gerontology will prove to be as originally envisioned a useful tool in the hands of research specialists, policymakers and practitioners.

[17] A report on the Institute and its work appears in appendix 7, p. 263.

CHAPTER VII

SERVICE OPPORTUNITIES FOR OLDER AMERICANS

Ten years ago, the bill that led to the White House Conference on Aging in 1961 made this declaration:

> The Congress hereby finds and declares that the public interest requires the enactment of legislation to formulate recommendations for *immediate action in improving the developing programs to permit the country to take advantage of the experience and skills of the older persons in our population.* [emphasis added.]

The fundamental concept suggested in that excerpt has reappeared in several public policy statements made since 1959. The Senate Committee on Aging in August 1964 approved a report calling "for establishment of a National Senior Service Corps that would serve the needs of both older adults who would welcome opportunity for useful activity and their communities which need their services." The Older Americans Act of 1965 declared "pursuit of meaningful activity within the widest range of civic, cultural, and recreational opportunities" to be a major national objective. Legislation introduced in 1966 and 1967 to establish an Older Americans Community Service program resulted in hearings at which the senior service principle was widely lauded.[1]

And finally, in June 1968, the U.S. Administration on Aging sent to the Congress legislation intended to establish a service roles [2] in retirement program which would "provide opportunities for persons aged 60 or over to render supportive service to children and older persons having exceptional needs."

Congressional sanction of either the community service bill or the AoA proposal was not, however, granted during the 90th Congress. The major advances in service opportunities for the elderly occurred in far-reaching programs supported by the Office of Economic Opportunity and the Department of Labor. In addition, there arose the possibility that an attempt made to earmark OEO funds for the broadening of a new service program would be at least partially successful, and a broader Department of Labor program was proposed.

I. THE AoA PROPOSAL

Major new proposals for broadening the Older Americans Act of 1965 were advanced in legislation introduced at the request of the Department of Health, Education, and Welfare last June. The key provisions and purposes of a new "Service Roles in Retirement

[1] For a discussion of the legislation, see pp. 29–37, "Developments in Aging—1967."
[2] For campaign views on service opportunities for older Americans of Presidential candidates Nixon and Humphrey see app. 10, p. 273.

Program"—a proposed new title VI of the Older Americans Act [3]—were described at the Senate hearing by AoA Commissioner William Bechill: [4]

> The Secretary of Health, Education, and Welfare would be authorized to make grants to or contracts with public or nonprofit private agencies and organizations to pay not more than 90 percent of the cost of the development and operation of projects designed to provide opportunities for persons aged 60 or over who are no longer in the regular work force, to render supportive services to children and older persons having exceptional needs. Preference would be given to projects in which priority is given in the enrollment of participants to low-income older persons. Three types of programs would be authorized under this new title:
>
> 1. Services by older persons to children receiving institutional care in hospitals, homes for dependent and neglected children, or other establishments providing care for children on a temporary or permanent residential basis. At least 90 percent of the older persons serving in these projects would be low-income.
>
> 2. Services by older persons to children in such capacities as aids or tutors in settings such as day care centers or nursery schools for children who are from low-income families (or from urban or rural areas with high concentrations or proportions of low-income persons).
>
> 3. Services by older persons to older persons in need of special, personalized assistance because of physical infirmities or other special circumstances.

The Commissioner also quoted HEW Secretary Wilbur J. Cohen as having the following to say in support of title VI:

> The new "Service Roles in Retirement" unites two key concepts: new opportunities for older citizens of this Nation to give of their skills and talents to their communities; and the enrichment of the lives of neglected children and less fortunate older people through their efforts.

Speaking later in the year [5] Commissioner Bechill discussed title VI further:

> The proposal was designed to build upon the significant breakthrough achieved by the foster grandparent program.[6] It proposed the creation of a program in which those served received human benefits which society had previously not been able to provide; and in which those providing these services received a variety of supportive services—training in human relationships, counseling on personal problems, the satisfaction of involvement in a service program, and a sense of involvement with, and contribution to, the community.

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[3] For legislative history, see app. 11, p. 275.
[4] P. 9, hearing before the Special Subcommittee on Aging, U.S. Senate Committee on Labor and Public Welfare, on S. 3677, July 1, 1968.
[5] At a speech, "The Older Americans Act—Where do We Go from Here," delivered at the National Conference of State Executives on Aging, October 25, Washington, D.C.
[6] See pp. 69–70 of this chapter for details on that program.

> These are the elements which distinguish service roles in retirement from a standard employment project. And the settings for this type of service are, for the most part, in HEW-supported programs.

Opposition to title VI: William R. Hutton, executive director of the National Council of Senior Citizens, appeared at the July hearing and said the Council "considers this particular proposal unfortunate and unwise." He pointed out that the Department of Labor, as a result of a commitment made by Secretary Willard Wirtz in 1967, had established pilot "Senior Aide" programs early in 1968, and he added:

> . . . The Department of Labor is best equipped to administer programs to employ the elderly but we are concerned because HEW's Social and Rehabilitation Service (the parent agency for the AoA) is so eager to expand its present activity. We feel HEW has enough to do without reaching after new programs that should properly fall within the jurisdiction of the Labor Department . . . .

A similar view was expressed by Dr. Blue Carstenson, Director, Senior Member Council, National Farmers Union:

> We believe that the Senior Citizen Service Corps programs operated by the Department of Labor will prove to be more effective and efficiently run than the foster grandparent program. We believe that by keeping these employment programs closely related to the employment service and the manpower programs and the on-the-job programs that progress can be made in opening new fields of employment for older workers. We think it would be a serious error to establish two Senior Citizen Service Corps programs which would be the result of this legislation, both competing with each other.

The conflict between the "service" concept advanced by the AoA and the "employment" concept advanced by opponents of title VI contributed to the controversy which was continued on July 15 and 18 at hearings by the Select Subcommittee on Education of the House Committee on Education and Labor. Support for title VI was expressed by the American Association of Retired Persons-National Retired Teachers Association and later by representatives of the National Association of State Officials on Aging. The House of Representatives passed a compromise bill on October 3, but the Senate did not act and the AoA amendments, including title VI, died.

II. ONGOING SENIOR SERVICE PILOT PROGRAMS

Although the dispute over title VI raised major questions about the outlook for a comprehensive, national older American community service program, existing pilot programs—and an entirely new one—were operational in 1968.

A. Foster Grandparents

This 3-year-old program administered by the Administration on Aging under contract with the Office of Economic Opportunity, re-

cruits, trains, and pays participants 60 years or over to provide personal attention to deprived, dependent, neglected, or mentally retarded children. Each foster grandparent spends 2 hours daily with each of two children, 5 days a week, giving individual attention and care.

At year's end, 4,055 participants were at work within 184 institutions in 40 States and Puerto Rico. Thirty-seven percent were between ages 65 and 69 and 40 percent were 70 or over. Eighty-one percent were women.

Categories of participating institutions:	Number
Mentally retarded	80
Day care	14
Dependent and neglected	21
Emotionally disturbed	11
Correctional	3
Physically handicapped	7
Hospitals: General, children's, and tuberculosis	26
Other: Mental institutions, special classes, public schools, Headstart homes, and programs	22
Total	184

The AoA, in a report [7] to this committee, said that the 1-to-1 relationship is especially beneficial to the children, and that "the program enables the 'grandparent' to remain active in the community, to gain a sense of dignity in this service role, and add supplementary income."

B. Operation Mainstream's "Green Thumb Project"

Operation Mainstream, administered by the Department of Labor's Manpower Administration, provides job opportunities for unemployed adult poor persons in activities intended to improve the social and physical environment of their communities.[8]

The largest single contractor for the 1969 calendar year was Green Thumb, Inc., which provides job opportunities for 2,044 older and retired, low-income farmers in 14 States. Green Thumb, sponsored nationally by the National Farmers Union, has provided workers for a broad variety of service projects in cooperation with local groups and government agencies. Most projects involve beautification and improvement of publicly owned areas such as parks and roadsides, restoration of historical sites, and establishment of recreation areas.[9]

The Department of Labor estimates that approximately 80 percent of Federal funds will be used for worker's salaries, social security, and fringe benefits, such as transportation and medical services. The average income of the participants was $900 annually, but Green Thumb enables them to earn extra income up to $1,500, yearly.

[7] See app. 1, pp. 129–130, for text of report.
[8] For a Department of Labor report on Operation Mainstream, see app. 1, pp. 138.
[9] An article in the New York Times of Nov. 24, 1968, described a large number of projects underway in New Jersey. There, 142 retired farmers are working on 20 projects in parks and gamelands. "One of the projects," said the report, "is giving rural Burlington County its first park in Mount Holly, the county seat. This unincorporated village of 8,000 persons was settled by the Quakers around 1680 and is noted for its 18th century buildings . . . ." The Green Thumb project is restoring several old buildings there, and is working in gardens at Ringwood State Park.

The State-by-State story on Green Thumb early in 1969 was:

State	Enrollment	Total cost	Federal share
Arkansas	282	$720, 200	$576, 290
Indiana	282	710, 755	569, 005
Kentucky	70	199, 090	159, 060
Minnesota	282	730, 955	584, 885
Nebraska	70	195, 700	156, 750
New Jersey	142	375, 755	301, 095
New York	70	200, 480	160, 450
Oklahoma	70	203, 890	162, 770
Oregon	142	388, 595	310, 695
Pennsylvania	70	198, 460	158, 430
South Dakota	70	198, 030	158, 000
Utah	70	202, 070	162, 040
Virginia	142	368, 060	294, 480
Wisconsin	282	718, 280	574, 370

A new contract, running for the remainder of the 1969 calendar year, provides $5,600,590 in Federal funds for the project.

C. "Senior Aides" Program Begins

Secretary of Labor Wirtz, acting on a pledge made at a hearing in 1967, acted early in 1968 to establish two new pilot projects collectively known as the Department of Labor Community Senior Service Corps program. Over $1 million each was funded for programs to be administered by the National Council on the Aging and the National Council of Senior Citizens. The goal was to enroll 800 persons age 55 and over in 20 localities across the Nation. Participants will work 20 hours a week to provide social, health, and educational services.

The first concrete results of the Department of Labor action occurred on June 26, when the National Council of Senior Citizens announced that it had designated 10 areas for projects:

Allegheny County, Pa.: Forty workers will help the aged poor not adequately served by existing agencies.

Buffalo, N.Y.: This project will require 40 workers to provide health and nutrition services for needy elderly, personal services for the ill and disabled, homemaker services for shut-ins, and other services for the elderly poor.

Chicago, Ill.: The Chicago Committee on Urban Opportunity will require 17 workers to serve as clerical and program aides. The Chicago Jewish Vocational Service will take on 15 workers to fill gaps in the operation of its rehabilitation workshop programs, work therapy centers, and at three old people's homes. The Hull House Association will employ seven senior aides as teacher aides and in other services it provides for the community.

Dade County, Fla.: The subcontract calls for six food satellite managers, six home visitors, six neighborhood workers, eight recreation aides, and eight workers to provide services in the six senior centers of Dade County, Inc.

Detroit, Mich.: 28 community resources aides, eight home service aides, and four workers who will instruct young mothers in household management, will help make a better life for poor families in the central city.

MILWAUKEE, WIS.: 35 information specialists will locate and notify the elderly poor of services and facilities available to them. Another five will serve as program coordinators.

MINNEAPOLIS, MINN.: The subcontract calls for six workers at the public library, five at the institute of arts, 12 at the senior-citizens' centers, and others in a project to provide musical entertainment at public housing projects, nursing homes, and community centers.

NEW BEDFORD, MASS.: Workers here will perform socially useful services for a dozen community agencies. Five aides for example, will work with retarded children.

PROVIDENCE, R.I.: The Providence public school system will employ 40 senior aides on a program aimed at persuading illiterate and semiliterate elderly to enter classes intended to improve their general knowledge and make them more employable.

WASHINGTON, D.C.: 40 senior aides will assist in the operation of day-care centers, neighborhood recreation centers, assisting community organizers in providing social services to the elderly, and assisting neighborhood employment offices as employment service aides.

The National Council on the Aging, reporting on progress made under its contracts with the Department of Labor, has provided this description of activities:

- In the hunger counties of rural Maine, food-assistance workers, after proper certification by the Department of Agriculture, have been engaged in registering surplus commodities recipients, ordering and maintaining an inventory of food items, arranging for packaging, storage, and distribution of these surplus goods, and demonstrating the use of the commodities.
- In rural Vermont, consumer education aides, working under the auspices of the University of Vermont extension service are, with mapped areas to cover, interviewing a selected sample of elderly persons, living within certain specified areas, in relation to consumer problems.
- In West Virginia, senior community service program enrollees are extending the operation of a vegetable cooperative into a deprived area, where the introduction of scientific vegetable cultivation could help to raise numerous other families above the poverty level.
- In Kentucky, enrollees in a home-repair program not only repair substandard homes for elderly indigent persons but at the same time instruct and supervise mainstream and out-of-school neighborhood youth.
- In New Jersey, social security aides study records to make sure that persons entitled to disability and death benefits are receiving them.
- In California, hospital aides provide personalized, nonmedical, supportive services to patients and their families in a hospital emergency ward.
- In Texas, counseling aides work in suicide-prevention and juvenile-detention centers. In the former, they accept calls from potential suicide cases, assess the problem, and make proper referrals. They also maintain a telephone reassurance system for the elderly in their area. In the latter, they provide

personalized counseling on a 1-to-1 basis with first-time youthful offenders, many of whom are accused of serious crimes, including murder.

Detailed records on relevant characteristics of enrollees, work records, and types of jobs are being kept, in the hope of providing a basis for a sound nationwide Federal program for employment of older people in public service.

D. Individual AoA Projects

The Administration on Aging supports several individual projects involving participation of volunteers for the provision of services to others. One of the most notable efforts is Project SERVE, a demonstration effort financed in part by the AoA, with matching funds provided by the Community Service Society of New York. A progress report issued on August 31 said that in 20 months of existence, the project had enlisted 326 volunteers, and 256 were registered at the time of the report. Working without wages or stipends, the volunteers had served in a State institution for the mentally retarded, a U.S. Public Health Service hospital, a geriatric hospital and home and in a service program for institutionalized girls. They had also conducted a consumer survey, a bloodmobile program, and a telephone reassurance program. An unusual feature of the project is the provision of group transportation by bus. Sponsors of the project were acting in 1968 to investigate the possibilities of extending the SERVE program, or parts of it, to other boroughs of New York City and also to explore all avenues of interpretation and communication outside of New York City for dissemination of SERVE findings, so as to spur interest in developing similar programs in other parts of the Nation.[10]

E. Project FIND

Supported by OEO funds, Project FIND employs 300 older poor persons in projects operating from 12 cities: New York City; Philipsburg, N.J.; Warren, Pa.; Washington, D.C.; Huntington, W. Va.; St. Petersburg, Fla.; Pontiac, Mich.; Hammond, Ind.; Milan, Mo.; Alexandria, La.; Muskogee, Okla.; and Watsonville, Calif. The purpose of this demonstration program is to document service needs of elderly poor persons and to provide emergency services where needed. A FIND report for January 1–June 30, 1968—issued by the contractor for the project, the National Council on the Aging—listed the following activities for participants:

—Contacted 43,556 households, bringing the total to 89,789 households contacted since the beginning of the project;
—Interviewed 18,067 older persons, bringing the total to 41,017;
—Made 13,021 referrals for help to 10,426 of those found, bringing the total to 24,481 referrals for 18,348 persons;
—Solicited 16,340 volunteer hours for FIND, bringing the total to 48,369 hours, of which 19,568 hours were volunteered by FIND staff;
—Continued the operation and development of information centers, senior center groups and clubs;

[10] Second progress report, Aug. 31, 1968, SERVE, Community Service Society of New York, 105 E. 22d Street, New York 10010.

—Generated new programs and used techniques of social action to benefit the older poor in their communities. In addition:
—Other demonstration programs to increase service and to employ the older poor were completed or neared completion in 14 different settings at regional, State, and local levels;
—Training was provided to 4,444 persons at 49 different meetings and conferences, bringing the total since the beginning of the contract to 10,258 people at 125 different meetings at national, regional, State, and local levels;
—Technical assistance was provided for the first time to 293 local, State, and regional agencies and to several national agencies both public and private, bringing the total during the past 15 months to well over 900 agencies served through the project's consultation and technical assistance services.

III. EARMARKING OF FUNDS FOR SENIOR SERVICE PROGRAMS

The President's budget for fiscal 1969, issued early in 1968, did not expressly designate any funds for senior service programs, such as the OEO Senior Opportunities and Services (authorized in 1967) or the Department of Labor's senior aides program.

No earmarking action was taken in the House in passing H.R. 18037, the appropriation bill for those departments and agencies. However, the Senate Appropriations Committee inserted the following language (submitted by one of its members, Senator Byrd of West Virginia) in its report on that bill:

> The Department of Labor in administering title I–B of the Economic Opportunity Act shall assure that not less than $10 million, over and above funds obligated in fiscal year 1968 for community senior service programs, will be available to continue, to expand, and to extend these projects to other rural and urban areas.
>
> In its review of the operations of the Office of Economic Opportunity over the past year, the committee has found a disturbing lack of expenditure of program funds for the elderly poor. The committee notes that the Economic Opportunity Act was significantly amended in the last session in five titles to emphasize the need for a major expansion of activities on behalf of the elderly poor. Despite these authorizations, OEO has continued to relegate older persons programs and services to second, or less, priority with the result that less than 5 percent of OEO funds were specifically directed to serve the 55 and above group which represents from 25 to 30 percent of the Nation's poor. Even though the Congress authorized a major new special emphasis program, senior opportunities and services, section 222(a)(8) in the 1967 session through which OEO could have channeled major program funds to meet the legislative intent, the committee notes that only a few token, last minute programs were funded under this section.
>
> Unfortunately, this is not a new situation within OEO priorities. For the past 4 years the Congress and outside private

> agencies have been urging OEO to give greater equity to the needs of the elderly. OEO has chosen to give only token acknowledgement to these reasonable requests. The committee, therefore, feels that it has no choice but to specifically require OEO to meet its statutory and programmatic mandate and earmarks $50 million in title II funds to be channeled through section 222(a)(8). We believe that such an earmark will allow OEO to develop a significant national older persons program without constraint on its other program plans. The committee also instructs OEO to maintain its current level of expenditure on behalf of the elderly in all OEO titles.

The bill, H.R. 18037, then passed the Senate without repudiation of this direction. It went to a Senate-House conference committee to iron out differences between the versions of the bill which had passed the two Houses, where this language was not altered. When the compromise approved by the conference committee was being debated on the House Floor, Chairman Mahon of the House conferees commented:[11]

> There is no need to discuss the amount provided for OEO. It should be made clear, however, that the conferees did not agree to assign any specific funds for the various programs which are undertaken . . . In short, the conferees have not undertaken to specifically earmark funds which are available to the Office of Economic Opportunity in the measure before us.

On October 9, 1968, when the conference report was presented to the Senate, a contrary view was taken, as shown by the following colloquy between Senator Byrd of West Virginia and Senator Hill (chairman of the Senate conferees):[12]

> Mr. BYRD of West Virginia. Mr. President, I note that in the conference report the statement of the managers on the part of the House deleted certain earmarking contained in the Senate report, however, no mention was made of the Senate directions to the Office of Economic Opportunity for specific program expenditures. I am particularly interested that not less than $10 million, over and above funds obligated in fiscal year 1968 for community senior service programs under title I–B of the act, will be available to continue and expand these projects to other rural and urban areas. The other direction of great importance is that not less than $50 million in community action funds under title II of the act, be earmarked for senior opportunities and services.
>
> While participating in the meeting of the conferees I heard no discussion with regard to deleting any of the Senate earmarking within the appropriation for the economic opportunity program; thus, is it not your opinion that the directions to the Office of Economic Opportunity, as contained within the Senate report, remain in effect?

[11] P. H9432, Congressional Record, vol. 114, 90th Cong., second sess., Oct. 3, 1968.
[12] Pp. S12355–S12356, Congressional Record, vol. 114, 90th Cong., second sess., Oct. 9, 1968.

> Mr. HILL. Mr. President, the Senator is exactly correct. Just a few minutes ago, in explaining the bill, I stated on behalf of the Senate conferees that the Department of Labor shall assure that not less than $10 million over and above funds obligated in fiscal year 1968 for community senior service programs . . . will be available to continue, to expand, and to extend these projects to other rural and urban areas.
>
> I also stated that there is $50 million of community action program funds, title II of the act, for senior opportunities and services to assist the elderly poor.

(On March 1, 1969, both the Department of Labor and the Office of Economic Opportunity had allocated funds in partial compliance with this direction, with a possibility of additional allocations during the remainder of the fiscal year. The Department of Labor had allocated $1,100,000 to increase funding for the Green Thumb project over the level of the preceding fiscal year, to enable it to employ more participants. It had allocated $1,800,000 to increase the funding level of the senior aides program administered under a contract with the National Council of Senior Citizens. This increase will make possible an increase in the average number of participants in local projects from 40 to 60, and will enable four more localities to have senior aides programs.)

The Office of Economic Opportunity has allocated $4,800,000 for its senior opportunities and services program, with a possibility of additional increases during the remainder of the fiscal year.

IV. LEGISLATION FOR A BROADENED DEPARTMENT OF LABOR PROGRAM

Senate bill 4180—introduced in both the Senate and the House on October 10, 1968—was intended to express legislatively several proposals made at hearings earlier in the year, adequacy of services for older workers.[13] One of the provisions would authorize the Secretary of Labor to establish and administer a community senior service program for individuals aged 55 and over who would render services that would not otherwise be provided. Sponsors of the bill indicated that the introduction of the legislation so late in the year was intended to provide an opportunity for discussion and suggestions for improvement.

> **The soundness of the concept of community service by older Americans—either as paid participants or as volunteers—has been amply demonstrated in many promising pilot programs. The committee renews its recommendation that advantage be taken of the lessons learned within recent years, and that a comprehensive national program—using all available resources at Federal, State, and local levels—be considered by the Congress and enacted into law at the earliest possible date.**

[13] See chap. VI for additional discussion of S. 4180 and the hearing.

CHAPTER VIII

HOW SHALL BASIC SERVICES BE PROVIDED?

One of the major purposes of the proposed 1968 amendments to the Older Americans Act [1] was to strengthen Federal-State machinery intended to provide or coordinate basic services to the elderly. Such services may be related to health problems, but they usually deal with other needs related to aging. Many elderly persons, for example, need homemaker care to help them live independently. Others may require information about services available to them, including recreation opportunities. Several Federal agencies now provide such services in one form or another, but there appears to be a growing concern about fundamental problems of organization.

I. THE "FRAGMENTATION" OR NONEXISTENCE OF SERVICES

Three authorities on aging, speaking on widely varying topics at different times, reached almost identical conclusions in 1968 about services for older people:

From Dr. Wilma Donahue, codirector of the Institute of Gerontology at the University of Michigan-Wayne University: [2]

> There is no need for me to enumerate the almost endless list of needed services because you are as familiar with it as I. The point of concern is that while we know what services are needed, and that everyone of them exists some place or other in the Nation, there is no single community that even approximates the gamut, nor is any community a model for comprehensive and coordinated planning. This lack of systematic planning and coordination results in inefficiency, excesses and gaps, competitiveness, and waste of efforts and funds.

From Mrs. Geneva Mathiasen, then Executive Director of the National Council on the Aging: [3]

> It is reasonable to expect that the special requirements and particularly the special services needed for the elderly cannot be soundly estimated for we have had little concept and no experience anywhere in providing the full range of services for the elderly . . .

From William D. Bechill, Commissioner, U.S. Administration on Aging:

> The pattern that has evolved—numerous small grants [4]—multiplies the management problems of program operation.

[1] For a legislative history of the amendments, which did not become law, see app. 11, p. 275.
[2] From speech delivered at the Institute for State Executives on Aging, Aug. 18, 1968.
[3] P. 60 Hearing on Usefulness of Model Cities Program to the Elderly.
[4] In a speech delivered at the National Conference of State Executives on Aging, October 25, 1968, Washington, D.C.

> There are more project managers to oversee and deal with. The projects themselves provide varying levels of service to limited service areas and to limited numbers. Some of the projects have an uncertain future when Federal support is terminated. Who in this room is confident that the 700 projects which are moving toward their last year of Federally supported operation will all be with us at the same level of operation 2 years from now? The pattern also, in my opinion, leads to a slower growth rate for services for older persons than might be achieved.

Commissioner Bechill was referring to projects approved under title III of the Older Americans Act. Title III described by the Commissioner as the "mainstream program" of the Older Americans Act, served 580,780 persons during the most recent fiscal year to provide a variety of services including: homemaker-home health aid assistance, friendly visiting, regular telephone reassurance calls; referral to foster home care; protective services for individuals in need of help in managing their financial affairs; delivery of some health-related subjects, recreation and referral services available at senior centers and elsewhere; and support for projects that enlist volunteers to give service to others.[5]

In addition, the Administration on Aging—under the reorganization plan that created the Social and Rehabilitation Service in 1967—is responsible for developing the social services to be made available to older persons under titles I, XVI, and XIX of the Social Security Act.[6]

The scope of service programs for Old Age Assistance recipients under section 1115 of the Social Security Act is large, as indicated by a partial listing of the 14 different projects during 1968 which were totally or partially concerned with providing a variety of services to elderly recipients of public welfare under the auspices of State public welfare agencies:[7]

—Two States participated in model projects under a National Plan for Protective Services [8] to the Aged. One was in a metropolitan area and another was in a rural setting.

—The Texas State Department of Public Welfare continued to carry out a demonstration in provision of comprehensive services to the aged, ill, and handicapped tenants in Dallas and Houston public housing.

—A number of States have been demonstrating the value of providing homemaker services.

—Two States are demonstrating the use of foster homes for older adults.

SERVICES FROM THE OEO

According to the Office of Economic Opportunity 1968 Yearend Report, "101 communities in 42 States met the needs of the elderly poor through senior opportunities and service programs initiated by local Community Action Agencies. Health care, transportation, consumer education, day care, and senior citizens centers were provided."

[5] For an AoA report on all its activities, see app. 1, p. 123.
[6] Ibid, p. 125
[7] For a more detailed report from the Social and Rehabilitation Service, see app. 1, pp. 161–166.
[8] Additional discussion of protective services on p. 83 of this chapter.

A more detailed OEO statement [9] described other service activities including the development of an "Operation Late Start." Miss Genevieve Blatt, until late in 1968 the assistant director responsible for older person activities in OEO, advanced the "Late Start" concept as roughly comparable to the "Head-Start" OEO program for disadvantaged youngsters. The program would organize recently retired persons into small neighborhood groups, arrange daily meetings at mutually convenient sites, arrange for continuing health care and referral for other needed services, provide one nutritious meal daily; and schedule daily information sessions. A national demonstration contract to implement the program in four cities under the direction of the American Association of Retired Persons was under negotiation at the end of 1968.

Questions About the Future: Any review of the sources of services for the elderly raises perplexing issues that will require resolution before comprehensive, complete systems for providing such services can be established.

Commissioner Bechill, in what he described as his own appraisal and assessment of our present situation in a speech [10] late in the year to executives of State agencies on aging, listed several unresolved questions that have a bearing on future delivery of services for the elderly:

1. How to strengthen the State agency on aging in its planning-stimulation-coordination and evaluation roles relative to State, local government, and private agencies providing services?
2. How do we get more State involvement in the title III program—through mandatory matching by the States?
3. What services should be provided through title III if any? How do they relate to the services provided, or potentially provided by other agency systems? When we speak of filling gaps do we mean permanently, or until picked up by a functional agency system? For example, the debate over title VI.
4. What is the desirable delivery network for services to older persons *locally*? Government? Private? Mixed? *What mix?*
5. Can we justify proceeding on a random basis? Should title III grants be primarily given for (1) local planning and (2) local information and referral service? How do these functions relate to our concept of the multipurpose senior center?
6. Should information and referral be taken over as a State agency function provided through local offices? Could this be practically combined with casefinding, public information, special transportation, and evaluation? Would this type of operation lead to a better planning capability?
7. Should State agencies on aging assume an ombudsman role toward older persons being served by other agencies?
8. If we withdrew from the direct support of services in title III, how do we assure that the health, education,

[9] For full text, see app. 1, p. 201.
[10] Speech cited in footnote 4.

rehabilitation, recreation, and welfare agencies actually provide the needed services?

9. What kind of staffing—in numbers and in qualifications—do State agencies on aging need to move effectively in the directions we are discussing? Are you taking advantage of the graduates now coming out of title V training?

10. How do we get feedback from older persons themselves as to (1) what they need and (2) how they think the needs are being met?

11. Finally, are we moving toward an ordered system of services which meet priority needs? Or are we adding to a conglomerate of services—that serve some people very well, many people partially, and most people not at all?

II. STEPS TOWARD SOLUTIONS

Several of the questions raised by the Commissioner may receive attention in a series of AoA demonstration "partnerships in planning and action" by Federal, State, county, and city governments designed to deliver basic services to older people when and where they are most needed.

Commissioner Bechill, in announcing the awards on October 18, said, "they will provide models for big cities, small towns, and rural areas all over the country. Services to help older people meet problems of health, income, and housing are now sometimes fragmented by jurisdiction boundaries. These new projects are designed to bring together all public and private resources to develop more comprehensive community service programs for older people."

A grant for $192,576 to the city of New York is worthy of special note because it will strengthen a newly established city office of aging, one of several established in large municipalities within recent years. This trend toward community offices of aging could contribute to the development of a more rational service delivery system. On the other hand, such municipal offices could contribute to fragmentation if their activities are not coordinated with State and private programs.

In New York City, under the AoA "partnership planning" grant, the new *city* office will provide leadership in developing, planning, and expanding housing, income maintenance services, health programs, and recreational activities. The new *city* office will provide leadership in developing, planning, and expanding housing, income maintenance services, health programs, and recreational activities for more than a million New Yorkers 65 and older. It will also coordinate the work of voluntary and public agencies and devise new programs to meet educational, employment, social, and psychological needs of older people.

The *neighborhood* offices will be particularly concerned with collecting information from older people and public and private agencies on needs and services, helping coordinate and intensify outreach efforts, recommending new programs, and elimination of duplications. Each office will include five part-time paid older people on its staff.

An Administration on Aging report provides the planning information on the other "partnership and planning" projects:

Kansas City, Mo., city-county office: Services for the aging in this metropolitan area have been largely initiated on an individual project

basis and confined by political boundaries. For the new demonstration project, the city-county units will now join forces to increase and reallocate resources for both areas. The coordinating agency will be a new city-county office of aging to be established with State funds (title III) of the Older Americans Act.

The Kansas City title IV demonstration grant, $76,567 for first year of 3, will make possible participation by individual agencies in identifying objectives, resources, and needs for a program of comprehensive services. A program planning and budgeting system (PPBS) will be developed for use in setting priorities and decisionmaking—a system adaptable to needs of many communities. Greater involvement of older people in the service-giving aspects of the program will be sought as a fundamental local resource.

Luzerne County, Pa., county commission-senior center outreach unit.—The county commissioners will set up a central unit in their office to provide coordinated health and welfare services through senior centers throughout the county. The centers will serve as part-time clinics for periodic medical examinations through an arrangement with local physicians. Ten older people will be trained to serve as community aides in locating isolated older persons in need, and following through with delivery of services to them. The Federal grant is $69,400 for the first of 3 years.

Las Cruces, N.M., State-local partnership.—The State health and social services department will use Las Cruces as a model area to demonstrate how a State-local partnership with emphasis on local initiative can provide comprehensive coordinated services. A senior citizens advisory board, established at the local level and made up of representatives of public and private agencies and unaffiliated older people, will determine needs, set program priorities, and make recommendations for necessary changes to the State agencies. The local senior center will implement activities recommended by the board. Federal funds total $26,809 for the first year of 3.

Prince Georges County, Md., phased development.—Legal barriers, as well as lack of existing services, appear to stand in the way of adequate attention to total needs of older people in the county. The AoA grant for a phased demonstration will permit the Prince Georges County Division of Services and Programs for the Aging to: (1) study the legal roadblocks, propose new legislation, and improve administrative organization; (2) encourage expansion of services made possible by these changes, to include home finding, relocation help, foster care, transportation, protective services, and counseling and referral, and finally (3) seek private capital investment to provide facilities for senior centers, housing, intermediate care institutions, nursing homes, and hospitals. The Federal grant for the first year is $36,984.

Roxbury, Mass., community-based social service organization.—A first year grant of $53,473 is made to the Ecumenical Center in Roxbury to demonstrate the use of nutritional services for older people as a focus around which to develop other social services. The center will provide group meals at low-cost, home-delivered meals with "Meal companions," mobile neighborhood markets on wheels to the homebound, and nutrition and health education programs. It will operate in cooperation with other neighborhood service projects and model cities programs.

There is growing recognition of the need for more precise definition of objectives and closer coordination of efforts in providing basic services needed by the elderly. This committee, however, finds that its conclusion in 1968 about services remains valid: "There is an obvious, pressing need for organized, comprehensive discussions of goals and methods for delivering services to older Americans. A White House Conference on Aging [11]—and the State Conference that would be held in preparation—offer ideal opportunities for such discussion."

III. AREAS OF SPECIAL NEED

A. Transportation Problems

At hearings on practically every subject it examines, the committee on aging receives complaints about problems that are intensified by unavailability or fare costs of public transportation facilities. One hopeful sign of progress was the announcement by the Department of Transportation of a 1-year research study of the transportation needs of the "physically handicapped." Secretary of Transportation Alan S. Boyd pointed out that 30 million Americans are hindered in travel because of physical handicaps or advancing age, and that some 14 million persons over 65 are impeded by one or more chronic ailments.

In a later statement [12] a representative of the Department said:

> Let me assure you that we very definitely do intend that the aged population be covered in this study. Attention to the transportation of older persons is indicated from the following paragraph * * * which has been incorporated into the contract:
>
> As the size of the aged population increases both absolutely and relative to the total, the urgency of accommodating them becomes more clear. With improvement in health standards—especially in the area of geriatrics—this group is expected to increase substantially. *To not take this fact into account now is to risk the creation of a large immobile segment of the population.* . . . [Emphasis added.]

Using AoA funds, several cities are experimenting with transportation projects of one kind or another. In Chicago, for example, "minibuses" have been put into service in conjunction with other projects of daily importance to the elderly.

B. Legal Services

Many legal questions can arise when retirement begins, among them: entitlement to social security or private pension benefits; eligibility for Medicare or other forms of public-supported medical assistance; denial of application for publicly supported middle-cost or low-cost public housing and arrangements for nursing home or "life-care" shelter. For the low-income elderly, such problems can be especially severe.

[11] See app. III for the text of the law calling for a White House Conference on Aging in 1971.

[12] Letter to Senator Harrison A. Williams, chairman of the Senate Special Committee on Aging, from James R. Nelson, Director of the Office of Economics at DOT, May 28, 1968.

Here again, several communities are using AoA funds to provide assistance of one kind or another.

In addition, the Office of Economic Opportunity has contracted with the National Council of Senior Citizens for a program of legal research and services for the elderly poor. Eleven pilot project sites have been selected from more than three dozen proposals received. By mid-1969 several projects should be operational.

C. Protective Services

Closely related to legal services, protective services provide help for the impaired older persons who need specialized help in managing their financial resources and maintaining their independence within the community.[13]

The complexity of the problem, and the urgency of the need, may be seen from a reading of the recommendations made at a conference conducted by the National Institute on Protective Service for Older People held in Houston in January 1968. Conferees, after long discussion, agreed that "traditional methods of practice in medicine, law, and social work were inadequate." They also asked for public and private agencies to work together for new definitions of goals and innovations. At least 14 pilot projects on protective services are now at work. The Senate Committee on Aging is evaluating their work and other aspects of the problem.

[13] For information on a Veterans' Administration guardianship program, see app. 1, p. 178.

CHAPTER IX

"TRIPLE JEOPARDY" AMONG MINORITY GROUPS

Aged and aging members of minority groups in the United States were described [1] during 1968 as living in "triple jeopardy." [2] They are old. They comprise a minority within a minority. And the overwhelming majority live in poverty.

To explore the nature and dimensions of "triple jeopardy," the Senate Special Committee on Aging continued studies begun in 1967 on the Negro and American Indian. During 1968 and early 1969 the committee conducted hearings in California, Texas, and Washington, D.C., on "Usefulness and Availability of Federal Programs and Services to Elderly Mexican-Americans." [3]

I. AREAS OF SPECIAL NEED AMONG NEGROES

Introductory testimony taken by the committee in 1967 [4] included a declaration from Mr. Hobart Jackson [5] that "the plight of the Negro generally has worsened, I think, in the country with reference to the closing of the gap between whites and Negroes in economic terms . . . Very little has been done in terms of improving the income maintenance situation . . . Very little has been done to improve their housing, their health, and other services, their educations, and opportunities for fulfillment during leisure hours."

Hearings in 1968: Testimony taken during hearings on health and the model cities program provide additional insights into the problems described by Mr. Jackson. In Los Angeles,[6] for example, one of our witnesses said that shortages of medical manpower, limited access to medical facilities, and delays in processing of Medicare and Medicaid claims were causing special hardships among the elderly Negro population there. Dr. Clarence Littlejohn, chairman of the health committee of the Urban League of Greater Los Angeles, said that health care problems are intensified because more and more providers of such care are leaving "ghetto" areas:

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[1] From statement by the Rev. Andrew Young, executive vice-president, Southern Christian Leadership Council, at an Atlanta, Ga., regional conference of the National Council on the Aging on November 14. See also testimony by Bexar County Commissioner Edward Pena, Dec. 19, 1969, at hearing on "Usefulness and Availability of Federal Programs and Services to Elderly Mexican-Americans" before the Senate Special Committee on Aging, San Antonio, Tex.

[2] This descriptive phrase is related to a study called "Double Jeopardy" prepared by the National Urban League almost 5 years ago. That report made a strong case for the premise that inadequacies in present Federal programs and services for older Americans cause their most intensive personal and social damage among elderly members of minority groups. For additional discussion of that report and related matters, see testimony by Hobart Jackson, Jeweldean Jones, and Dr. Lionel M. Swan, pp. 125–155, hearing on "Long Range Program and Research Needs in Aging and Related Fields," by the U.S. Senate Committee on Aging, Washington, D.C., Dec. 6, 1967.

[3] Usefulness and availability of Federal programs and services to elderly Mexican-Americans: Pt. 1. Los Angeles, Calif., Dec. 17; pt. 2. El Paso, Tex., Dec. 18, 1968; pt. 3. San Antonio, Tex., Dec. 19, 1968; pt. 4. Washington, D.C., Jan. 14, 15, 1969.

[4] P. 135, 136 of hearings cited in footnote 2.

[5] Administrator, Stephen Smith Home, Philadelphia, Pa.; and member of the Board of Directors, National Council on the Aging.

[6] See testimony by Mrs. Juanita Dudley, Dr. Clarence Littlejohn, and Dr. Philip R. Drew, hearings on "Costs and Delivery of Health Services to Older Americans," Los Angeles, Calif., Oct. 16, 1968.

Many are locating on the periphery of the ghetto and are reducing their Medi-Cal participation as rapidly as their private practice increases. Others are moving to the periphery in order to increase the amount of Medi-Cal payments and decrease delays in the receipt of such payments.

Some are seeing recipients only on certain days or at certain times during the day. Some are outright refusing to see recipients. Continuity of medical care is becoming nonexistent. Community hospitals are having increased difficulty obtaining consultants in upgrading medical care at the community level and with Los Angeles so spread out, this is profoundly tragic.

Moonlighting in Watts and East Los Angeles is becoming more prevalent and it is as evil as the absentee landlord system. All too frequently, the moonlighting physician is not available more than one-half to 1 day per week for followup, and emergency rooms, or the few doctors left in the ghetto are asked to perform this service.

The moonlighting vendor is frequently from an area with a higher unit—fee for service—rating by the Medi-Cal program and, of course, bills from his office—so located.

Denial of equal job opportunity is inherent in these inequitable and probably illegal disparities.

Discriminatory and severe reviews of claims of major providers of services to the poor frequently cause interminable delays in payments and denial of payments for substantiated services. Many cuts and deletions appear capricious, arbi trary, and certainly discriminatory.

For example: two comparably trained physicians billing for comparable services on patients in the same hospital side by side in the same room may receive different fees dependent upon the location of their billing office in Los Angeles County.

Frequently, in the same batch of claims returned to vendors, there may be three or more different fees for the same item or service number. These claims are supposedly reviewed by peers. The whimsical nature and arbitrariness of cuts, particularly of claims from ghetto physicians, suggest lack of guidelines and/or the political philosophies and prejudices creeping into the judgments of some reviewers. It also suggests that many reviewers are ill-informed and/or insensitive to the health care among people of poverty. This system must be improved.

Complaints about poor health care in predominately Negro neighborhoods were also heard at several of the model cities hearings conducted in 1968.[7] Health problems, it was said, were directly tied to other longstanding difficulties, including: inadequate income, poor housing, and a general shortage of nursing homes in central urban areas. In Seattle, initial planning was underway for an income maintenance plan and for new departures in the financing of housing.

[7] Usefulness of the model cities program to the elderly: Pt. 1. Washington, D.C., July 23, 1968; pt. 2. Seattle, Wash., Oct. 14, 1968; pt. 3. Ogden, Utah, Oct. 24, 1968; pt. 4. Syracuse, N.Y., Dec. 9, 1968; pt. 5. Atlanta, Ga., Dec. 11, 1968.

In Atlanta, model cities planners will experiment with employment programs that will provide much-needed services in low-income neighborhoods.

In one St. Louis target area, where 50 percent of the residents are Negroes, the primary source of income is old-age assistance. The model city director for that city gave this description: [8]

> . . . the needs of 6,592 older persons in the St. Louis model city area are not adequately met. Older persons often find themselves increasingly isolated because of lack of funds, lack of inner resources, fear of attack, lack of family and community roots.
>
> The experience of being without cash, food, and comfort is distressing at any age. In later years, when one has less physical vigor and fewer resources, the experience is devastating. Such confirmation of hopelessness and helplessness strips the elderly of dignity and replaces that dignity with despair.

Summing up the effects of problems such as those described above, a Duke University professor of medical sociology offered this comment and proposal during 1968: [9]

> . . . it is now the case that (1) most Negroes die earlier, (2) perceive of themselves as being old earlier, and (3) are, in fact, old earlier than are whites. Hence, this serious and highly pragmatic proposal: The minimum age eligibility for retirement benefits should be racially differentiated to reflect present racial differences in life expectancies. Remaining life expectancy at age 45 may be an appropriate base for computing such differentials.

District of Columbia Model Health Center.—A promising experiment in providing new types of nursing home and other care for the elderly poor in the inner city was begun in 1968. The National Medical Association has 97-percent representation of Negroes among its membership, is sponsoring demonstration programs with technical assistance and financial support from the Departments of Health, Education, and Welfare, and Housing and Urban Development.

Major objectives are to construct and provide:

1. Extended Care Facilities for patients needing health care, but of a type less intensive and less expensive than that provided by a hospital.
2. Skilled Nursing Homes for patients requiring more care than that provided by home health care, but less than that provided in an extended-care facility.
3. Social Care Institution for those patients requiring minimal medical care in a homelike environment.
4. Housing for the Elderly including social care and incidental infirmary facilities for low-income families who are elderly but not in need of special health services or facilities.
5. Medical Building equipped for the group practice of medicine to provide outpatient care for residents in low-income urban areas.

[8] See hearing cited in footnote 7, pt. 1.

[9] From "Aged Negroes: Their Cultural Departures from Statistical Stereotypes and Rural-Urban Differences," a paper presented by Jacquelyne Johnson Jackson, Ph. D. at the annual meeting of the Gerontological Society, Oct. 30, 1968, Denver, Colo.

6. MEDICAL OFFICE BUILDING equipped for the sole practice of medicine in poor urban neighborhoods.
7. NEIGHBORHOOD SERVICE CENTER to provide facilities for social services, job training and placement, counseling, recreation, and related services.

Announcing the project in January 1968, President Johnson said:

> I believe this project can offer badly needed health and housing care for the elderly and the poor in Washington. I hope it will serve as an example for other cities which lack adequate health care in poverty areas. It is an example of how concerned citizens in a voluntary association can work with government to solve urgent problems.

Dr. Lionel M. Swan, president of the foundation established to administer the project, said that the groundbreaking ceremonies on December 14 symbolized the first step "to end forever the current discrimination against the poor in the delivery of health care." The new system of health care in the Washington, D.C., pilot project, he added, is "destined to reduce the shameful mortality and morbidity rates among the poor, especially the black poor, from diseases which are preventable or treatable with our present medical knowledge and resources."

The Committee on Aging is continuing its study of problems and promising developments related to the elderly Negro.

II. THE MEXICAN-AMERICAN OF THE SOUTHWEST

Senator Ralph Yarborough, of Texas, began 4 days of Committee on Aging hearings on "Availability and Usefulness of Federal Programs and Services to the Elderly Mexican-Americans" with the following declarations: [10]

> In the Older Americans Act of 1965, and elsewhere, the Congress has declared that the United States is pledged to help aged and aging Americans lead secure and satisfying lives. That pledge applies to all older Americans, including members of minority groups.
>
> And yet, within the past year, the Senate Special Committee on Aging has received disquieting reports about unique problems faced by elderly citizens of Mexican heritage in this Nation. The Chairman of that committee—Senator Harrison A. Williams of New Jersey—and I have been in touch with the Administration on Aging and other Federal agencies to inquire about problems caused by communication failure, by inadequate local resources to provide much-needed programs for the elderly Mexican-American, and by sheer neglect.
>
> * * * * *
>
> Service in the Committee on Aging, together with my near-lifelong concern about Mexican-Americans, led me to ask, even before Senator Williams and I had our talk, whether Federal programs and services are really helping—or even

[10] Senator Yarborough conducted the hearings on behalf of the Senate Special Committee on Aging. See footnote 3 for dates and sites of hearings.

reaching—older Mexican-Americans in the Southwestern States.

One of my questions was directed to the U.S. Administration on Aging. The answer I received was disquieting. The AoA told me about the following problems:

—Difficulties encountered by some communities in meeting matching requirements for Federal programs under the Older Americans Act.

—Shortages of bilingual staff members needed to make programs effective.

—Grave research deficiencies that must be overcome if Federal and local agencies are to have a factual basis for appropriate programs or services.

Los Angeles witnesses gave details on difficulties encountered by low-income participants in the medicare program, plans for community action to provide services for the elderly, the need for bilingual staff in public programs. In El Paso, housing problems and low welfare standards received special attention. San Antonio testimony centered largely on the response of the elderly Mexican-American to public housing projects and a new model cities program in that city. In Washington, D.C., Federal officials and representatives of national organizations on Aging met with officials of Mexican-American organizations for a "round table" discussion.

A report giving conclusions and recommendations for action will be published in 1969 as a result of the hearings and related studies.

CHAPTER X

MODEL CITIES AND THE OLDER AMERICAN

President Lyndon B. Johnson, in his 1967 message on aid for the aged, requested the Department of Housing and Urban Development "to make certain that the model cities program give special attention to the needs of older people in poor housing and decaying neighborhoods."

Concern for the elderly in model neighborhoods is well founded. For one thing, their numbers are high: One study by the Model Cities Administration shows that the population of 60-plus people was more than 20 percent in six target cities and between 10 and 20 percent in 35 others. (See table 1.) The Administration on Aging estimated that two-thirds of the population past age 65 live in urban areas and about 50 percent live inside the central cities of metropolitan areas.

TABLE 1.—*Percentage of Aged Population in Model Cities Neighborhoods*

Six cities with 20.1 percent and over

Texarkana, Tex	26.0	Portland, Maine	23.6
Springfield, Mass	25.6	Duluth, Minn	21.6
Denver, Colo	24.4	Reading, Pa	21.2

Thirty-five cities with 10.1 to 20 percent

Manchester, N.H	20.0	Hartford, Conn	13.5
Seattle, Wash	19.0	New Bedford, Mass	13.2
Waco, Tex	18.5	Tampa, Fla	12.6
Butte, Mont	18.4	Boston, Mass	12.4
East St. Louis, Ill	17.0	Providence, R.I	12.1
Pittsburgh, Pa	16.8	Trinidad, Colo	12.0
Minneapolis, Minn	16.7	Highland Park, Mich	11.8
Trenton, N.J	15.9	Chicago, Ill	11.7
Lowell, Mass	15.5	Rochester, N.Y	11.4
Newark, N.J	15.4	Texarkana, Ark	11.4
Portland, Oreg	15.2	Columbus, Ohio	11.2
Worchester, Mass	14.8	New Haven, Conn	11.2
Des Moines, Iowa	14.2	Toledo, Ohio	11.2
Helena, Mont	14.1	Athens, Ga	11.1
Smithville, Tenn	14.0	Philadelphia, Pa	11.0
Cohoes, N.Y	13.8	Cambridge, Mass	10.5
Kansas City, Mo	13.6	McAlester, Okla	10.1
Detroit, Mich	13.5		

Twenty-eight cities with 1 to 10 percent

San Antonio, Tex	10.0	Baltimore, Md	6.8
Wichita, Kans	9.9	Nashville, Tenn	6.7
Wilkes-Barre, Pa	9.8	Flint, Mich	6.6
Richmond, Calif	9.2	Gainesville, Ga	6.6
Dayton, Ohio	8.6	Charlotte, N.C	6.5
St. Louis, Mo	8.5	Pikeville, Ky	6.3
Atlanta, Ga	8.4	Oakland, Calif	6.0
Buffalo, N.Y	8.3	Eagle Pass, Tex	5.9
Bridgeport, Conn	7.6	Gary, Ind	5.9
Huntsville, Ala	7.4	Tulsa, Okla	5.9
Winooski, Vt	7.4	Albuquerque, N. Mex	5.7
Winston-Salem, N.C	7.4	Dade County, Fla	5.4
New York City	7.0	Honolulu, Hawaii	4.4
Washington, D.C	7.0	San Juan, P.R	3.5

Five cities with no information re aged population

Bowling Green, Ky.
Fresno, Calif.
Norfolk, Va.
Poughkeepsie, N.Y.
Saginaw, Mich.

Source: Model Cities Administration, Department of Housing and Urban Development.

For one thing, many of the elderly in such urban centers are living in poverty, and many are isolated almost to the point of invisibility.

Recognizing that the model cities program offered an opportunity to explore and cope with the problems of the elderly in metropolitan areas on a scale never before possible, the Senate Special Committee on Aging has held hearings on "Usefulness of the Model Cities Program to the Elderly." [1]

Senator Frank E. Moss,[2] opening the hearings in July, made this observation:

> Broad objectives as spelled out in the (model cities) law itself, indicate that this program is clearly intended to do far more than change the appearance of neighborhoods or to erect new buildings in place of old ones. What is obviously sought here is an improvement in the way of life for people who live in parts of our cities that for too long have been neglected. Older Americans live in those target areas; they should be served along with all other age groups.

I. OPPORTUNITIES FOR JOINT ACTION

Practically every problem mentioned in the preceding chapters—low income, inadequacy of health resources, unavailability of low-cost nursing home care, limited opportunities for employment, nonexistence or inadequacy of basic services, and unique problems of minority groups—are under study by model cities' directors in the municipalities visited by the committee in 1968. The range of proposals now under consideration suggests that the model cities program—if funding levels are adequate—could lead to much-needed innovation to provide solutions to longstanding problems.

[1] Usefulness of the model cities program to the elderly: Pt. 1. Washington, D.C., July 23, 1968; pt. 2. Seattle, Wash., Oct. 14, 1968; pt. 3. Ogden, Utah, Oct. 24, 1968; pt. 4. Syracuse, N.Y., Dec. 9, 1968; pt. 5. Atlanta, Ga., Dec. 11, 1968.

[2] Senator Moss is Chairman of the Subcommittees on Housing of the Elderly, and Long-Term Care in the Senate Special Committee on Aging. He conducted model cities hearings, however, on behalf of the full committee at the invitation of committee Chairman Harrison A. Williams.

Project planners in Seattle,[3] for example, are attempting to provide better health services that will be of direct help to the large number of the elderly in target neighborhoods. They are also working on plans for an income maintenance plan. In Atlanta, Ga.,[4] model city Office of Economic Opportunity officials hope to establish several day care centers at which elderly women look after youngsters. One pilot project in that city has already won widespread attention. In Ogden, Utah, private and public agencies were cooperating on plans to provide employment counseling.

Some idea of the range of possible uses of the model cities program on behalf of the elderly can be obtained from the following excerpts from the Washington, D.C., hearing:

—David Joyce, Chief of the Division of Community Affairs, Providence, R.I.:

> Oftentimes, services available to citizens within a city are not utilized by residents of the model cities area. Consequently, I would recommend that serious study and thought be given during the planning stages of the program to the development and possible implementation of a multipurpose center located within the model cities area to service elderly persons. These centers could be established rendering many diversified services such as health advice, social service, casework and referral, educational counseling, employment counseling, and to some degree, limited recreational facilities.
>
> It is this kind of establishment that could act as a focal point of activity for this segment of the populace. The facility should be staffed with professional workers knowledgeable in the various fields enumerated above. Although varied kinds of assistance could not be directly serviceable from the center, supportative services could be administered outside of the center facility. In keeping with this kind of facility, social caseworkers could be assigned to caseloads within the model cities area carrying out normal casework practices of interviewing, diagnosing and referring the various social, economic and health ills of the clientele.
>
> The acute problem of social isolation existing in many of the central core cities should be minimized to a great degree by the establishment of such a diversified center. In fact, the problem of isolation could be faced more directly by the establishment of a friendly visiting service for elderly persons. This specialized service could act as a feed-back to the social service center in making available various kinds of service to the elderly as a group.

—Mrs. Marie C. McGuire, assistant for problems of the elderly and handicapped at the U.S. Department of Housing and Urban Development:

> In terms of physical development of housing and other facilities . . . we should consider the following:

[3] It was announced early in 1969 that Seattle received approval for its 5-year model cities plan, and that the city will receive $5.2 million in Model Cities supplemental funds.

[4] Atlanta will receive $7,100,000 in supplemental funds.

1. The construction of new rental housing specially designed for the elderly and responsive to various income groups.

2. The rehabilitation of existing rental housing, either by purchase or lease by public sponsors, or by private action.

3. The retention of homeownership, and, where necessary, assistance in the rehabilitation of these homes, not only because many older people prefer to remain in their own homes, but to minimize the need for new and costly housing. We also must face the necessity of services that older people may need in order to remain in their homes, such as home aides, visiting nurses, meals on wheels, and friendly visitors, and others.

It will be a comfort to know that, at least in the model city areas, the elderly will not be living in fourth-rate hotels, four-story walkups to dreary quarters, or rooms in slum basements or over dirt-floor garages and in firetraps.

4. Community centers for the full or part-time use by older persons with other age groups and with their own peers are essential to the well-being of senior citizens in any given neighborhood.

—William D. Bechill, Commissioner of the Administration on Aging:

Limited mobility is one of the common problems of older people, especially when major reliance must be placed on public transportation. In the inner city areas particularly, we know that there are large numbers of older people who are isolated and find it very difficult to shop, visit friends, or obtain needed services because of lack of mobility and access to transportation.

If transportation needs of older people are identified as a major problem in the model cities program, we hope that some special planning and special arrangements could be made to assist in this area. In one of our research and demonstration projects conducted by the YMCA of Chicago in an innercity area, substantial success has been achieved with a mobile unit. Senior citizens have used the van for shopping, trips, home-delivered meals, and other activities. By using the van for transportation, the YMCA has been able to organize small group meetings and bring older people to the center. Over 2,500 older people have been served as a result.

This is a very outstanding project that involves really the bringing of a center on wheels to many older people in the downtown area of Chicago.

In one instance, I think this center afforded some of those people the first opportunity they had had for any immediate social contact with other people for years. The benefits from this one program are outstanding.

—Mrs. Margaret Bush Wilson, acting director, St. Louis Model City Agency:

According to recent figures, approximately 10.41 percent of our model city population is age 65 or over—or approxi-

mately 6,592 persons. Fifty percent of this elderly population is black and 50 percent is white. Some 3,027 are male and 3,565 are female.

The primary source of income for this age group is old-age assistance. The most urgent needs of our aging population have been well documented. These needs include improved standards of income maintenance, better housing, and better health, medical, and social services.

A quick look at the resources available to meet these needs in St. Louis model city area reveals the following:

There are five major health facilities available to the elderly whose services are either free or based on ability to pay. Two are city hospitals—Homer G. Phillips Hospital on the north side, and St. Louis City Hospital on the south—neither of which are located in the model city area and, for the elderly, transportation to these services can be a problem.

Another is a veterans hospital located on the western boundary of the model city area—John Cochran Veterans' Hospital. And, two are health centers on the north side of the model city area—Jefferson-Cass Health Center and Montgomery Health Center—which is a center developed out of a neighborhood resident corporation.

In addition, the visiting nurse association provides home visits based on need. The value of this service is computed to be $6 for the first hour and $1 for each 15 minutes thereafter. It is available to the elderly based on ability to pay.

—Mr. Mark Yessian, consultant on urban development:

The relocation agency alone cannot be expected to offer the multitude of services needed by their elderly clients. The active involvement of the citywide social service network is clearly needed. But in many cases most of the other agencies have their own hands full and in addition often have little understanding or interest in the problems of elderly relocatees. The model cities program might be looked upon as an opportunity to correct such situations and to promote the coordination and involvement of social service agencies in relocation efforts. Interagency training programs geared to workers at the operational level rather than the policy-making level could be a useful means toward this end. By promoting interagency contacts between workers and by providing information concerning particular social service needs, such programs could certainly help in oiling the wheels of the social service network.

II. THE USE OF SUPPLEMENTAL FUNDS

One reason for hoping that the model cities program can cope with problems such as those suggested in the preceding paragraphs is that the program is designed to encourage innovation by offering "supplemental" funds. Mrs. McGuire gave the following comments on that feature of the program:

To me, one of the most exciting aspects of the model cities program is its own innovative provision for supplemental

grants, which can be used by the city demonstration agency in imaginative ways to assist it in carrying out its plans. The supplemental grants are not earmarked by law for any one specific project or activity. They may be used without further local matching, as Secretary Taylor already has said, for any project or activity included as part of the approved comprehensive program.

The maximum amount of the supplemental grant is 80 percent of the aggregate amount of non-Federal contributions required for all projects or activities assisted by Federal grant-in-aid programs carried out in connection with an approved model cities program.

Cities are expected to be innovative in their use of supplemental funds, to test new ideas, develop new techniques, and perfect new problem-solving tools. Thus, these supplemental grants provide possible sources of funds needed to put some of these ideas for the older residents into effect in a model neighborhood. A community could experiment with an adult recreation facility, or special services for the elderly in a neighborhood center, or special educational opportunities.

If only one such neighborhood reflected such a completely balanced program for the elderly, this alone could be a good example for many, many cities and States to follow.

Funds could be used to demonstrate the effectiveness of personal services to sustain independent living, or continued counseling and other services to discharged mental health patients. They could permit special treatment based on individual needs rather than the average, looking at them as an individual instead of as a group.

In effect, these are the funds which can enable a model neighborhood program to experiment, to innovate, to make dreams a reality.

III. IMPACT OF THE 1968 HOUSING AND URBAN DEVELOPMENT ACT

As discussed in chapter 4 of this report, the 1968 Housing Act would provide new programs and funds of direct help to the elderly. A HUD analysis provided to this committee indicates that the following provisions may be of special significance in the model cities programs:[5]

Aids for homeownership and rental housing.
Loans to nonprofit sponsors.
Limited dividend sponsorship in direct loan program.
Low rent public housing authorization increases.
Home rehabilitation loans and grants.
Broadened relocation assistance.
Mortgage insurance for nursing home equipment.
Mortgage insurance for nonprofit hospitals.

In addition, HUD reports, the 1968 legislation provided:

. . . for increased authorizations for the model cities program itself, and for rent supplements, among others. The

[5] For the full text of the HUD statement, see pp. 28-29 of hearings cited in footnote 1.

1968 act authorizes HUD to guarantee borrowings of private developers of new communities and to make supplementary grants to States and localities in connection with federally aided water, sewer, and open space land projects that assist the new community development. The act authorizes an alternative form of urban renewal to facilitate more rapid renewal and development of urban areas through a new neighborhood development program. Another provision authorizes the FHA to insure mortgages on properties in older, declining urban areas and a Special Risk Insurance Fund was established to cover losses arising out of such activities. Other provisions of the 1968 housing legislation also will assist the elderly and families of all ages toward attaining the national goal of "A decent home and a suitable living environment for every American family."

This Committee will conclude its study of the Model Cities Program in 1969, but the following interim observation is offered at this time:

Goals for the Model Cities Program—as established by Federal officials and by those private and public citizens now seeking to establish projects at the local level—are ambitious, and it is well that they are so, because the need is great. The elderly population in target areas stand to benefit, in particular, if such ambitions are fulfilled. Every effort should be made during 1969—a critical period in the evolution of a complex program—to assure that the model cities effort succeeds in developing and implementing much-needed innovations and combinations of programs in neighborhoods of great need.

CHAPTER XI

RESEARCH NEEDS IN AGING

Scholarly research projects related to aging can be found in great abundance on library shelves and in gerotological study centers. Even among those who contribute to such studies, however, there is a pervasive feeling that studies on aging are funded at the Federal level at inadequate levels on a multitude of unrelated subjects.[1] In 1968, however, two steps of potential significance were taken: (1) A bill proposing an intensive review of research on the biological process of aging as a possible prelude to a 5-year research effort on a scale never attempted before, and (2) the award of a grant intended to help leading scholars and scientists study research priorities in many fields related to aging.

In addition, several Federal agencies continued or broadened research efforts; and a possible threat to international cooperation on research was averted.

I. THE RESEARCH IN AGING BILL

Acting upon the suggestion of a large number of biochemists and other scientists, Senator Harrison A. Williams proposed on July 15 that the Congress establish an Aging Research Commission which would plan a 5-year program of intensive coordinated research into the origin of the aging process. Along with the bill, he also introduced into the Congressional Record several expressions of support from authorities in the field.[2]

II. SURVEY UNDERWAY BY GERONTOLOGICAL SOCIETY

Announcement was made on December 13 of a $49,987 Administration on Aging grant to the Gerontological Society. The funds will be used to support establishment of a committee in psychology, psychiatry, social welfare, economics, sociology, and anthropology to review existing knowledge and gaps in research in social gerontology, identify top priority problem areas, and suggest research and development goals for the next decade.[3]

III. RESEARCH ACTIVITIES IN FEDERAL AGENCIES

Projects now underway in the Adult Development and Aging Branch, National Institute of Child Health and Human Development; the National Institute of Mental Health; the Veterans' Administra-

[1] See Testimony by Carl Eisdorfer, Associate Professor of Medical Psychology and Psychiatry, Duke University; and Bernard L. Strehler, Professor of Biology, University of Southern California pp. 190-214, "Long Range Program and Research Needs in Aging and Related Fields," a hearing before the U.S. Senate Special Committee on Aging, Washington, D.C. Dec. 5-6, 1967.

[2] The Senator's floor statement is reprinted in app. 8, p. 267 along with an analysis of major provisions. The Senator introduced a similar bill on Feb. 4, 1969.

[3] A news release and fact sheet giving additional details appear in app. 8, p. 269.

tion; and the U.S. Atomic Energy Commission are described in reports by each of those governmental units in appendix 1.

IV. USE OF SPECIAL FOREIGN CURRENCY PROGRAM FOR AGING RESEARCH AND TRAINING

The fiscal 1969 appropriation bill for the Departments of Labor and Health, Education, and Welfare and related agencies (H.R. 18037), as passed by the House on June 26, 1968, proposed the appropriation of $5 million of counterpart funds for research and training in vocational rehabilitation. When that bill reached the Senate floor, Chairman Williams of the Special Committee on Aging offered an amendment to permit those funds to be used not only for vocational rehabilitation research and training but also for "aging and other research and training by the Social and Rehabilitation Service." The Senate agreed to the amendment, and it was approved by the Senate-House conference committee which subsequently met to iron out differences between the Senate and House versions of the bill. Therefore, the bill as enacted [4] permits the use of special foreign currency for aging research and training.

[4] Title II, Public Law 90-557 (Oct. 11, 1968).

CHAPTER XII

THE GROWING NEED FOR TRAINED PERSONNEL IN AGING AND RELATED FIELDS

As the number of older Americans increases, so does the demand for specialized services and trained administrators for many kinds of facilities, including housing, intended to serve the elderly. Aging has thus produced many growth industries, but government and private resources have not yet been successful in providing the specialists needed now and even more so in the future.

Fortunately, the most comprehensive evaluations made yet about the size and nature of the problem were produced in 1968. In addition, significant steps have been taken to provide innovative training, and educators and others have participated in courses meant to help them develop training programs in aging at universities and other educational institutions.

I. THE 1968 SURVEYS OF THE PROBLEM

Congressional concern [1] about training needs resulted in a request that the Administration on Aging undertake a study and evaluation of the immediate and foreseeable need for trained personnel to carry out programs related to the objectives of the Older Americans Act. In 1968, the following major findings were reported:

OVERALL NEEDS: Under an AoA contract, the Surveys and Research Corporation issued a report [2] which made the following major points:

—. . . Most if not all service programs are faced with critical shortages of trained personnel. The outlook is for little improvement in this regard unless drastic changes are made in the scope and character of the training effort.

—At least a third of a million professional and technical workers are employed in programs serving older people exclusively or primarily. In all likelihood, fewer than 10 to 20 percent of these have had formal preparation for work with older people. A projection of future demand, if necessarily a gross one, would place requirements for trained workers in 1980 at a level 2 and 3 times above that of 1968.

—Home medical care programs and the provision of social services to older people through social agencies appear destined for major expansion. As these programs grow in number and size, they will make demands for personnel. The need for social workers, social work aides, and community aides trained to serve older

[1] See pp. 142–143, "Developments in Aging, 1967", for discussion.

[2] The Demand for Personnel and Training in the Field of Aging, Oct. 1, 1968. (Later submitted to the Congress by HEW Secretary Cohen.)

people in public-welfare agencies, long-term care facilities, information-referral services, retirement-housing projects, and in other facilities, largely unfulfilled, runs into many thousands.

—One of the most serious deficiencies turned up by the present study is the paucity of basic information on the demand for and supply of personnel in the field. The first recommendation in the report is addressed to this subject, in recognition of the fact that such information is fundamental to efforts to recruit personnel and to provide training opportunities.

PROBLEMS IN HOUSING: Another AoA contract went to the National Association of Housing and Redevelopment Officials. As a result of NAHRO's survey, the following statements were provided in the final report:

—Management personnel in governmentally assisted housing projects designed for occupancy by the elderly currently number about 4,900. Few have had specialized preparation for working with older people. Estimated requirements for such personnel in 1970 range from 8,000 to 13,000. Corresponding figures for 1980 are from 32,000 to 43,000.

—An even more compelling need for trained personnel exists in the field of nursing and personal care homes if these facilities are to provide adequate medical care, restorative services, and stimulating activity programs. Some 24,000 persons are employed in administrative capacities in such homes at the present time, most of whom will require special training if they are to meet licensing requirements now being developed in response to the Social Security Act Amendments of 1967. A special analysis made for the present report points to the strong likelihood of a doubling and a tripling in the number of beds in use by 1980, with a need for corresponding increases in the number of trained personnel.[3]

RECREATION PERSONNEL: A third contract—granted to the National Recreation and Park Association—was used for a study of personnel needs in the field of recreation. The report declared:

—. . . at present there is a full-time equivalent of approximately 15,000 recreation personnel working with older adults. Projected needs are for 23,000—31,000 such workers in 1970 and 26,000—76,000 in 1980.

The C & S report, seeing a clear need for widespread training efforts at universities and elsewhere, made 23 recommendations.[4]

Survey data clearly indicates a widespread need for more trained personnel in many fields related to aging. Unless great efforts are made to provide such personnel, Federal funds will not be put to best possible use in programs and for purposes of direct importance to elderly Americans. Early congressional consideration should be given to recommendations made in 1968 and to other proposals that may arise.

[3] For additional discussion of the NAHRO study findings, see "Study of Housing Management for Elderly Points up need for More, Better Trained Management Personnel for All Low-Income Housing," an article in the Journal of Housing, No. 10, 1968.

[4] See app. 9, p. 271 for summary.

II. TRAINING PROGRAMS NOW AT WORK

A large number of training programs are described in appendix 1 [5] reports from the Administration on Aging, the Social and Rehabilitation Service, the Public Health Service, the Office of Economic Opportunity, the National Institute of Mental Health, and the U.S. Office of Education. The purpose in most cases is to provide support, as far as is possible at present levels of funding, for training of specialists.

Other possibilities for more widespread dissemination of information about aging are suggested by the use to which Administration on Aging funds have been employed in programs that bring representatives of many disciplines of higher education together for intensive lecture and discussion programs.

In New Jersey, the State division on aging conducted two seminars on gerontology and higher education during 1968. Universities, schools of nursing, and community colleges were represented on each occasion. Conferees met from February 1–4 and February 23–25 for the first seminar and for a similar number of days for the second.[6]

Another AoA grant was used in 1968 to fund seminars in social gerontology for faculty of Michigan educational institutions. The University of Michigan—Wayne State University invited faculty of universities and colleges (including junior and community colleges) to conferences intended to help them develop their own training programs in aging at their educational institutions. The seminar consists of eight weekend sessions (Friday evening, Saturday, and Sunday morning) a month apart.

[5] Pp. 128–129, 144, 153, 160, 203.
[6] For additional details, see app. 9, Item 2, p. 271.

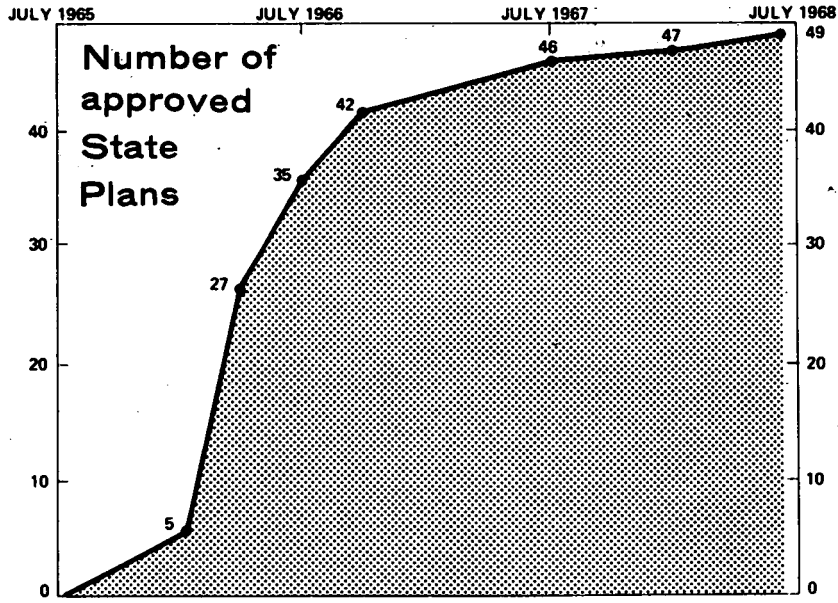
CHAPTER XIII

STATE ACTIONS ON AGING

One of the purposes of the Older Americans Act was to develop a Federal-State working relationship that would establish, coordinate, and develop programs of direct meaning and help to our steadily rising population of elderly individuals. Progress toward that goal could be seen during the past year in terms of state action under the Older Americans Act and state increases in expenditures for programs on aging. In addition, several States enacted laws of direct importance to the elderly.

I. PROGRESS UNDER TITLE III OF THE OLDER AMERICANS ACT

As can be seen in the chart below, within a little over 3 years after passage of the Older Americans Act, almost every State [1] in the Union had adopted a plan approved under title III of that Act.



Source: "Communities in Action, a Report of Progress Under Title III of the Older Americans Act," Administration on Aging, Publication 258 July, 1968.

[1] On February 13, 1969 Secretary of Health, Education, and Welfare Robert Finch announced that the State of Mississippi had become the 50th jurisdiction for which plans have been approved under the Older Americans Act. Among these 50 jurisdictions are the District of Columbia, Puerto Rico, and the Virgin Islands. Only Alabama, Indiana, Wyoming, Guam, and American Samoa do not have plans under the Act.

Title III is the Administration on Aging program which makes Federal funds available to States to help communities initiate a wide variety of direct service programs in the neighborhoods and homes where older persons live. In each State with an approved plan, a permanent full-time agency is charged with:

- The sole responsibility for administering the Older Americans program.
- The authority to coordinate all other State activities on aging related to this (the title III) program.
- The initiation of local service programs in accordance with the priorities established by the State.[2]

Expenditure Levels Rise: Reporting on findings from a nationwide survey, the Council of State Governments made these observations late in 1968:

> Significant changes in State appropriations have occurred in many States. Until 1965, or even later, several never had any funds appropriated especially for an aging program except money allocated in preparation for the 1961 White House Conference on Aging. In other States which had earlier appropriations, these have risen considerably. Thus in Connecticut the appropriation increased from $12,500 in 1962–63 to $52,000 in 1968–69, in Georgia from $15,000 in 1963–64 to $39,000 in 1967–68, in Massachusetts from $48,420 to $107,000 in the same span of years, in New Jersey from $95,000 to $135,800, and in Rhode Island from $23,000 to $43,800. In Washington the appropriation rose from $31,500 in 1964–65 to an estimated $150,700 in 1967–68, and in Wisconsin from $35,400 in 1963–64 to $112,800 in 1968–69.[3]

Budgetary increases have made it possible to increase the size of staffs.

> Among 26 units recently reporting numbers of staff, only one reported no more than two staff members; 23 had between three and 11; one had 14. In Pennsylvania the Office for the Aging had 68 employees, but it carries an unusually broad scope of responsibilities, including supervision of nursing homes and related facilities; thus the number included 29 inspectors alone.[4]

II. ACTIONS BY STATE LEGISLATURES[5]

Of the 47 States and the District of Columbia and Puerto Rico for which we could secure information, 15 had no legislative session in 1968 and eight had sessions but passed no legislation of special interest in aging. The following analysis of the areas of legislative action is therefore, based on the accomplishments in 25 State legislatures: (Note: Numbers in parentheses identify States enacting the provision. See codes on page 108–109.)

[2] P. 12, "Communities in Action, A Report of Progress under Title III of the Older Americans Act." Administration on Aging, Publication 258, July, 1968.
[3] P. 378, "The Book of States 1968–69", vol XVII, The Council of State Governments, Chicago, Ill.
[4] Ibid.
[5] This report was provided by Herman B. Brotman, administration on aging chief of reports and analysis. As chairman of the Committee on Legislation of the Psychological and Social Sciences Section of the Gerontological Society, Mr. Brotman made this report at the annual conference of the society on Oct. 31 in Denver, Colo.

ORGANIZATIONAL

Directs preparation of an over-all State plan (8, 53).
Makes initial appropriation for a State agency (25).
Moves agency into an umbrella department (6, 22, 40).
Provides funds to umbrella department for loans to facilitate local use of Federal resources and grants (40).
Establishes or regulates State agency (6, 50).
Authorizes local or regional commissions (47).

PUBLIC ASSISTANCE

Improves Old Age Assistance (3, 5, 19, 22, 23, 26, 37, 47, 49, 50).
Requests no cut in OAA due to social security increase (18).
Establishes or expands services to recipients of OAA or Medicaid (5, 8, 11).
Removes or liberalizes filial responsibility of older adult children (31, 47).
Extends eligibility for a year to recipients who move out of State while they establish eligibility in another State (47).

TAXATION

Improves administration or liberalizes property tax treatment (5, 10, 12, 31, 40, 50).
Improves income tax treatment (5, 22).
Improves treatment of residual pensions in inheritance and estate taxes (12).

MEDICAID

Enacts enabling legislation (23, 43, 47).
Makes initial appropriation (41).
Improves benefits (3, 49).
Improves eligibility (5).
Establishes reserve fund (32).

HEALTH SERVICES AND INSTITUTIONS

Earmarks tobacco excise tax for support of community health (32).
Establishes licensing of nursing homes (49).
Establishes licensing of nursing home administrators (37).
Appropriates funds for training of personnel of homes and nursing homes (39).
Establishes special programs for construction and financing of institutions (8, 33).
Requires annual re-evaluation of involuntary commitments to mental institutions (50).

HOUSING

Establishes State department (8).
Permits Commission on Aging to request establishment of local housing authority (50).
Requires housing authorities to consult with aging agency (22).
Establishes a State commission for standards for low cost housing (5).
State provides technical assistance and cooperation for projects preparing to apply for Federal financial assistance (5).

State provides loans for the development of such projects (12, 33, 49).
State reimburses city for revenue losses for real estate tax exemptions on middle-income nonprofit housing (23).
Cooperative housing companies exempted from excise tax (12).
Improves property tax exemption for housing projects (12).
Rent control in low-income housing (22).
Expands State construction loan program (22).

EMPLOYMENT

Makes age discrimination unlawful and provides penalities (21).
Merges older worker division into State aging agency (22).
Authorizes study of problems (22).
Establishes special programs (8, 19).

EDUCATION AND RECREATION

Provides for studies and recommendations (22, 31).
Establishes programs and funds (8, 19).
Earmarks tobacco excise tax for support (32).
Authorizes use of school facilities after school hours (22).

OTHER

Authorizes and subsidizes program for serving of lunch to older persons using school facilities (22).
Protects renewal of automobile insurance (33, 50).
Protects renewal of driver license except for proven disability (5).
Truth in lending (33).
Provides "cooling off period" in door-to-door installment or home improvement sales or contracts (31).
Eliminates architectural barriers in public buildings (5).

STATE RETIREMENT SYSTEMS

Improves existing benefits or requirements (21, 31, 33, 37, 40, 49, 53).
Liberalizes mandatory retirement provisions (37, 49).
Expands coverage or voluntary schemes (37, 40).
Provides for retirees who re-enter State employment or State legislature (5, 40).

STATES WHICH ENACTED LEGISLATION

3 Arizona
5 California
6 Colorado
8 Delaware
10 Florida
11 Georgia
12 Hawaii
18 Kentucky
19 Louisiana
21 Maryland
22 Massachusetts
23 Michigan
25 Mississippi
26 Missouri
31 New Jersey
32 New Mexico
33 New York
37 Oklahoma
39 Pennsylvania
40 Rhode Island
41 South Carolina
43 Tennessee
47 Virginia
49 West Virginia
50 Wisconsin
53 Puerto Rico

STATES WITH SESSIONS BUT NO LEGISLATION IN AGING

1 Alabama
4 Arkansas
9 District of Columbia
13 Idaho
20 Maine
30 New Hampshire
44 Texas
46 Vermont

STATES WITH NO SESSION

7 Connecticut
14 Illinois
15 Indiana
16 Iowa
17 Kansas
24 Minnesota
27 Montana
28 Nebraska
34 North Carolina
35 North Dakota
36 Ohio
42 South Dakota
45 Utah
48 Washington
51 Wyoming

STATES NOT REPORTING

2 Alaska
29 Nevada
38 Oregon
52 Guam
54 Virgin Islands
55 American Samoa

CHAPTER XIV

COPING WITH A "RETIREMENT REVOLUTION"

Mid-year in 1968, historian Keith Berwick made this observation about the place of older Americans in our society today:

> The elderly population is becoming increasingly isolated and useless and their wisdom and experience are being wasted. We have reduced the elderly to an obsolete minority stuck off in ghettos of greater or lesser degrees of luxury and deprived of a concern for the problems of the day.[1]

In an earlier study [2] Dr. Berwick discussed unplanned obsolescence of the elderly and concluded:

> Their age and experience, their very lives, have become increasingly irrelevant in a world of rapidly changing values and accelerating technology. But for precisely the reasons that make them seem obsolete, the aged are in fact indispensible if human society is to remain truly human. The aged are the repository of traditional human values; their wisdom and experience represent the one possible counterweight to the dehumanizing tendencies of modern times.

Similar observations have been made at Committee on Aging hearings and elsewhere, as awareness of what has been called a retirement revolution[3] becomes more widespread. There seems to be a growing agreement:

—That as more Americans spend more years in retirement, there will be a need for more recreational and leisure resources, and perhaps greater opportunity to participate in voluntary or paid programs to provide much-needed services in their own communities or elsewhere.

—That many Americans are unprepared for retirement, and for the first few years at least, have a difficult period of adjustment.

—That much more information is needed about retirement and its effect on society and the individual.

—That the Federal Government can help cope with the retirement revolution by sponsoring research to provide the information we need and by becoming a model employer in terms of providing more adequate preretirement training and in experimenting with new kinds of work lifetime patterns for its employees.

I. PRERETIREMENT TRAINING

It has become increasingly evident that employees are generally poorly prepared for retirement. The average retiree knows that he will

[1] Dr. Berwick, Professor of History at the University of California, made his comments during an interview printed in the July issue of Geriatrics Magazine.

[2] The Senior Citizen in America: A Study in Unplanned Obsolescence, The Gerontologist, Vol. 7, No. 4, Dec. 1967.

[3] See Developments in Aging—1967, ch. VIII, for discussion of hearings conducted by the Subcommittee on Retirement and the Individual, Senator Walter F. Mondale, Chairman.

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have to learn to live on a substantially reduced income. What he does not know and what he suddenly discovers is that retirement involves a psychological adjustment far greater than he had anticipated. He comes to learn that our society is work oriented and youth oriented; and too soon, he loses his identity and his incentive; and finally, too often, his reason for living.

A number of universities have directed a great deal of attention to the problems of adjustment to retirement. Organized labor, industry, and business have begun to recognize the need and desirability of adequate preretirement planning and many have established retirement programs. The Federal Government, however, has no overall policy on preretirement counseling.

A study concluded in June 1967, by the American Association of Retired Persons disclosed that relatively few Federal employees had access to an adequate program of preretirement counseling.[4] Another study concluded by George Washington University for the Civil Service Commission in January, 1968 disclosed that preretirement planning programs were available to less than 18 percent of Federal employees and that more than 90 percent of those questioned believe that a good retirement planning program could help them enjoy retirement more.

Survey findings.—In June 1968 the Division of Gerontology, University of Michigan, concluded a 2-year study of preretirement education under a research grant from HEW. The study included a control group, and it was the first time that an attempt had been made to study longitudinally the effects of preretirement education. The subjects were limited to UAW manual workers and their wives who lived in Detroit, Mich. The program consisted of 10 weekly sessions of 2½ hours each, held in the evening, to groups ranging in size from 20 to 30 participants, including the wives. The study concluded that the program established significant results. It found that during the first year of retirement the program resulted in appreciably reducing dissatisfaction with retirement and worry over health, and in encouraging those who had participated to engage in all kinds of activity including social activity with friends and members of the family. In addition, it found that these gains persisted into the second year, but at a somewhat diminished level.

Pilot program at Drake University.—Another program that has generated much attention is one conducted by the Drake University Preretirement Planning Center. The center, jointly funded by the AoA and the Department of Labor, became operational on September 1, 1967. It was created to prepare individuals emotionally and intellectually for the adjustments retirement requires. Another objective is to study the effects of preretirement programs on attitudes toward retirement and also the general quality of the adjustment to retirement.

In its first year 503 men and women representing a wide range of occupations participated in its program. The group comprised industrial "blue collar" workers; private business "white collar" workers; governmental employees from local, State, and Federal agencies; professionals such as physicians, dentists, and nurses; and individuals

[4] As a result of this study the AARP published in November 1968 a guide entitled "Preparation for Retirement" designed to assist agencies in developing appropriate programs for government employees. It offers an outline of the subjects and factors that should be considered.

from the "community-at-large" who were recruited through the mass media.

As the program progresses the Center will begin training company and agency personnel to assume many of the Center's functions, with the center serving as technical consultant.

Preretirement counseling can be of great significance and and assistance to men and women about to make far-reaching adjustments to an entirely new role in life. The Federal Government should take the lead in providing action programs within its own agencies to serve as models for application elsewhere.[5]

II. CHANGES IN WORK LIFETIME PATTERNS

Many Americans feel that they are too young to retire at age 65. Others may feel that retirement would be welcome years earlier. There is a need for widespread experimentation that would adjust career patterns to individual needs and desires. Among the possible innovations are more widespread use of "sabbaticals," long before retirement begins, "trial retirement," and part-time work in later years.

Several pilot projects for such purposes are now in existence. Among them:

1. The Professional and Executive Corps at the Department of Health, Education, and Welfare.—Mrs. Elsa Porter, gave this description of the project at a recent hearing:[6]

> What we are trying to do through the Professional and Executive Corps is to make the best possible use of the talents and skills available to us in this area. Like all other organizations today, HEW has critical manpower needs. There are simply not enough highly trained people to go around.
>
> At the same time, we know that large numbers of people—most of them women—who have the skills and talents we need are not using them because they can't work the conventional 40-hour week. They may be mothers with home responsibilities that prevent them from working all day every day. Yet they could work during the hours that their children are in school or on days when help is available.
>
> Many older people, men and women, would like to work on a less-than-full-time schedule. They, too, are often forced to choose between full-time work or no work at all.
>
> Our aim is to expand their choices by providing an opportunity for part-time work. We are a very large organization with many different kinds of skill requirements. And it seemed to us that our agencies could adjust themselves to flexible work schedules more easily than these individuals could meet the requirement for full-time work.
>
> By going out of way a little to design jobs for people, we expected that we would find a rich new source of talent. And

[5] A bill, S. 2295, introduced by Senator Walter F. Mondale on August 15, 1967, would make it mandatory for Federal agencies to establish preretirement training programs.

[6] P. 218, testimony from hearing on "Adequacy of Services for Older Workers, Washington, D.C., July 24, 25, and 29, 1968, U.S. Senate Special Committee on Aging.

those expectations have been fully realized during the months that the program has been in existence.

We started last summer with a mandate from former Secretary Gardner to identify the kinds of jobs that needed to be done and could be done on a part-time basis. More than 60 different assignments of a professional or technical nature were identified in that survey.

2. *Trial retirement at the Department of Agriculture.*—Employees there may now choose either of two trial retirement options: Full retirement with job restoration rights within 365 days, or a part-time tour of duty of less than 40 hours a week. At the end of 365 days of part-time work, they must either return to full-time duty or exercise optional retirement. This program has since been adopted by the Agency for International Development and the Air Force Systems Command.

3. *Gradual retirement.*—The Civil Service Commission has considered several plans for such a purpose but has not yet made recommendations.

There is room for much additional experimentation by the Federal Government in terms of new work arrangements that could counter ill-effects of arbitrary retirement ages. Close attention should be given to this subject by Federal officials in the near future.

III. FEDERALLY-SUPPORTED RESEARCH AND OTHER PROJECTS

The National Institutes of Child Health and Human Development are conducting several studies related to retirement. In addition, the NICHD has begun a series of conferences and published a book on "The Retirement Process." (For a full report on NICHD projects, see app. 1.)

Several Administration on Aging projects (see app. 1 for a full report on AoA activities) are directly related to resources for retirement. In Minnesota, for example, the State agency on aging and a statewide five-station educational television network are demonstrating a system which provides useful information to older people and which is intended to give participants "a sense of common interest—a sense of being part of a larger significant population group." It is estimated that a weekly program for seniors reaches 85 percent of the elderly within the area.

A report from the U.S. Office of Education (see app. 1) reports that title I of the Higher Education Act has been employed to establish a number of programs designed to assist older Americans. The report says:

> Recognizing that early retirement and advances in medical science have provided the senior citizen with many years available for useful activities, this program is attempting to find solutions to the problems which confront the older adult and to increase the possibilities for effective utilization of this potential reservoir of knowledge, manpower and experience. Programs with these objectives include:

Consumer education for the elderly through telecasts and counseling services;

Training programs for administrators of care facilities for the elderly;

Interdisciplinary courses in social gerontology, home nursing, health, recreation, and employment for professionals, volunteers, and community leaders to aid them in working with the aged;

Job counseling, retirement counseling, educational programs, and discussion groups for the elderly to enable them to be more productive and useful citizens of the community;

Training programs for volunteers who counsel the aging and who supervise leisure-time programs for the elderly in nursing homes and homes for the elderly;

Educational programs for senior citizens designed to help them adjust mentally and physically to a new style of life, to enable them to qualify for leadership roles in community service projects.

MINORITY VIEWS

Minority Views of Messrs. Dirksen, Prouty, Fong, Miller, Hansen, Murphy, Fannin, Gurney, and Saxbe

Numerous recommendations calling for improvements in, and expansion of, opportunities for older Americans to participate more fully in our Nation's life with dignity, honor and independence have been offered in previous Special Committee on Aging reports.

It is self-evident that needs of older persons vary greatly from group to group and from individual to individual. There are also common problems, such as those created by inflation, which are confronted by almost all older Americans.

Equally clear is the fact that too many persons past 65 are prevented from meaningful participation in the mainstream of American life because of inadequate incomes. We believe that correction of such deficiencies should be given highest priority in National, State, and local policies affecting the aging. To this task should be brought the best abilities of both public and private sectors of society.

We reiterate our view that vital approaches to meeting the needs of older people recommended by previous minority reports of this committee should be followed by the Congress in its consideration of new legislation and by the executive branch in its administration of programs affecting older people.

It is appropriate, therefore, to summarize briefly the recommendations to which earlier Special Committee on Aging minority reports have addressed themselves. They included calls for:

1. Vigorous efforts to stop the accelerating inflation which in recent years has been the most common source of trouble for older Americans;
2. Provision for automatic cost-of-living increases in Old Age, Survivors and Disability Insurance (OASDI) benefits under social security and in Railroad Retirement Act pensions;
3. Liberalization of the OASDI earnings test to permit social security beneficiaries to earn substantially more money without penalty;
4. Payment of 100 percent of primary OASDI benefits to aged widows instead of the present 82½ percent of the amount payable to surviving husbands;
5. Across-the-board increases to all OASDI beneficiaries;
6. Higher minimum OASDI payments;
7. Upward adjustments in OASDI benefits for persons who, because they do not retire at 65, abstain from receipt of OASDI benefits at that age, but who now receive no significant recognition for their added years of contribution to social security and society.
8. Upward adjustments in OASDI benefits for married couples both of whom work and thus pay dual social security taxes with-

out receiving higher payments when they become OASDI beneficiaries;

9. Extension of OASDI on a properly funded basis to more people not covered by an adequate retirement program;

10. Vigorous efforts to expand and improve America's unique private pension system;

11. Adequate old age assistance programs in every State;

12. Expansion of job opportunities, full time and parttime, for older persons desiring employment;

13. Institution of a study in depth of the economics of aging for the purpose of developing sound national policies which will provide better opportunities for all Americans to achieve decent living standards in their later years;

14. Development of appropriate tax relief measures for older people at all levels of government;

15. More liberal income tax considerations for persons who make substantial contributions to support of needy elderly relatives;

16. Development of effective "sheltered care" programs for the aged who may require such services by reason of physical, social or psychological infirmities, and

17. Implementation of more comprehensive State and local programs for older people such as were envisioned when the Congress gave virtually unanimous support to the Older Americans Act of 1965 and subsequent amendments to it.

It is evident that Federal budgetary problems and burdens imposed by the costly war in Vietnam and competition for tax dollars generated by recent domestic strife have made it difficult for the Congress to act on much of what needs to be done for the elderly.

At the same time the failure of our hopes on behalf of older Americans rests in good measure on the inability of the Congress to act favorably on many of our recommendations and the further fact that the executive branch has not always adequately implemented Congressional intent behind some of the legislation already enacted.

Since previous minority reports of this committee have discussed such shortcomings, we will not labor them now.

It is clear, however, that the Nation needs effective coordination of legislative and executive actions at Federal, State, and local levels if the needs of older Americans are to be met.

We trust that the 91st Congress and the new national administration, in a spirit of cooperation, will act together with all reasonable speed so that the Federal government may discharge its most pressing responsibilities to older people effectively.

To this must be added the importance of State and community exercise of responsibility and wholehearted participation in aging programs by the private sector of our society. The latter includes, of course, acceptance of appropriate leadership obligations by qualified individuals and all types of organizations.

While in no way intended as a deterrent to prompt action on other proposals to help older people, including those we ourselves have advocated, there are several items we recommend for immediate favorable consideration by the Congress.

First among these is adoption of a provision for automatic cost-of-living increases in Old Age, Survivors and Disability Insurance bene-

fits under the Social Security Act and in Railroad Retirement Act pensions. This has long been advocated by minority members of the Senate and House of Representatives.

It should be emphasized that assignment of priority to this proposal does not derogate from the need for other improvements in social security benefit levels, and we repeat our advocacy of such upward adjustments and numerous other improvements in the Social Security Act as will eliminate current deficiencies as fully as possible.

We recognize that the Congress, in fulfilling its duty to all the people, should approach changes in the Social Security Act with responsible care to insure that its integrity is never jeopardized at the expense of either young or old.

Provision of automatic cost-of-living adjustments in OASDI benefits, however, is both a simple proposal, involving no threat to the system, and one which should not be delayed. It has been established that enactment of such legislation would require no increase in social security tax rates. It has received, we are pleased to note, bipartisan support in recent months.

Inflation has continued at an accelerated pace since the last report by this committee. The forces contributing to the problem of inflation have reached such magnitude that it is hardly conceivable that rising costs of living can be stopped overnight without adverse affects on employment—especially of those in the low income and poverty areas.

No matter how valiant the efforts by Congress and the National Administration to meet this number one economic problem in the months immediately ahead, inflation in the cost of living probably will be with us for some time, destroying the value of dollars in the hands of older Americans.

This loss of purchasing power, as it has in the past, is doing grave injury to the ability of most retirees to provide for necessities and comforts of life regardless of their income sources.

Whether income is derived from social security, private pensions, life-time savings, insurance, employment, or any other source, its loss in value impairs the capacity of almost all older Americans to live with dignity and independence because they are almost totally defenseless against inflation. Many, regrettable as it is, by reason of limited years or months remaining in their lives, simply cannot wait for help.

In urging prompt action on the automatic cost-of-living benefit proposal, we fully recognize that the help it would give is only part of the answer. This becomes most obvious when it is noted that less than one-third of the income received by persons past 65 comes from social security benefits.

It does appear, however, that such action is a minimum obligation of the Federal government. It should be followed as soon as practicable by other measures to improve and maintain incomes of older Americans, including, we repeat, vigorous efforts to stop inflation itself.

Another item of legislative business we recommend for early consideration by the Congress relates to the 1971 White House Conference on Aging and appropriation of funds necessary to a meaningful session based on broad preconference activities by the States and local communities of the Nation.

President Nixon has stated his belief that a White House Conference on Aging is important. Such a conference can have great value in appraisal of needs among older Americans and development of broad, sound approaches to the variety of problems confronting older persons. The President's statement of his intention to call a conference indicates the high priority to this project which may be expected from the Nixon administration.

Congressional support for a 1971 White House Conference on Aging was made clear during the 90th Congress when it enacted Public Law 90–526. This was introduced with bipartisan sponsorship as a Joint Resolution and passed by unanimous votes in both the Senate and House of Representatives.

This Act authorized $1,900,000 for implementing the conference, with part of such funds to go to the States for development of their several activities necessary and pertinent to a successful conference.

Until such money as is necessary to carry out the Congressional intent of Public Law 90–526 is made available, neither the Secretary of Health, Education, and Welfare, nor the States and communities can institute fully the careful planning and action required for the conference. We recommend, therefore, prompt action by the Congress in appropriating such funds.

Extension of the Older Americans Act, which created the Administration on Aging in the Department of Health, Education, and Welfare, is another matter which should be given priority by Congress.

We are confident that the purposes for which the Administration on Aging was created by virtually unanimous votes in the House of Representatives and the Senate in the Older Americans Act of 1965 and of 1967 continue to have full bipartisan support of Congress.

We urge that such support be reflected in legislative action.

While covered in some detail in the full Committee on Aging report, it is appropriate that these minority views should include a brief comment about hearings held during 1968.

As reported elsewhere, the committee held such hearings on adequacy of services for older workers, cost and delivery of health services, usefulness of the model cities program to the elderly, and government programs as they affect older Mexican-Americans.

These hearings, which were conducted across the Nation and in the Capitol, provided information which should help enlarge understanding of the problems besetting older Americans and the programs developed to solve such problems. We recommend review of the hearing proceedings by all Members of the Congress.

The hearings on needs of older Mexican-Americans, held in Los Angeles, El Paso, San Antonio, and Washington, D.C., were especially valuable in two ways. They afforded better understanding of the unique problems of the Nation's large number of Spanish-speaking older Americans. Beyond this, however, they, and other field studies, underscored the great differences found in unmet needs of the elderly when they are examined group by group and community by community.

All of the field investigations by the committee during 1968 point up the difficulties inherent in rigid national policies and programs for older persons.

Important as Federal action is in developing service for older Americans—and it cannot be minimized—such hearings show that,

at best, the Federal programs can only provide a sound base for community response to existing needs.

In the final analysis, the best solutions depend on effective partnership between national, State and local agencies, both public and private. This is possible only when national policy makes full allowance for differences among the States, and among groups and communities within the States, and only when States and communities fully meet their responsibilities in tailoring service programs to the variables found at the grassroots of our society.

EVERETT MCKINLEY DIRKSEN
WINSTON L. PROUTY
HIRAM L. FONG
JACK MILLER
CLIFFORD P. HANSEN
GEORGE MURPHY
PAUL J. FANNIN
EDWARD J. GURNEY
WILLIAM B. SAXBE

APPENDIXES

Appendix 1

REPORTS FROM FEDERAL DEPARTMENTS AND AGENCIES

ITEM 1: ADMINISTRATION ON AGING

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
ADMINISTRATION ON AGING,
Washington, D.C., December 6, 1968.

DEAR MR. CHAIRMAN: In response to your letter of October 22, I am enclosing a summary of the activities of the Administration on Aging during 1968.

Please let me know if you would like any additional information.

Sincerely,

WILLIAM D. BECHILL,
Commissioner.

[Enclosure]

THE ADMINISTRATION ON AGING—1968

After 3 years of operation under the Older Americans Act, the Administration on Aging can record significant progress in its effort to help solve both the long and short range problems of older persons. This has been a period of action, accomplishment, and dedicated efforts at the Federal, State, and local levels. A good foundation has been laid upon which we can now build toward the goal of assuring each older American a share in the Nation's economic and social well-being.

OLDER AMERICANS SERVICES

Efforts have focused on the delivery of services to aged persons of all walks of life. To this end, the Older Americans Services Division of the Administration on Aging administers the title III program of the Older Americans Act as well as developing the social services to be made available to eligible older persons covered under the provisions of titles I, XVI, and XIX of the Social Security Act. It has also assumed an active role in assuring that the guidelines for model cities would take into consideration the special needs of the aged and would include programs for them. Finally, this Division has given increasing attention to assessing the growing number of community projects and services for the aged relative to their effectiveness in meeting existing needs and contributing toward the meeting of the objectives set forth in the Older Americans Act.

In fiscal year 1968, title III of the Older Americans Act served 580,780 persons through 688 projects.* Forty-nine States or jurisdictions had plans approved under title III by the end of the fiscal year. This title provides allotments to the States so that they can make grants for—

1. Community planning and coordination of programs in aging,
2. Demonstration of new programs or activities beneficial to older people.
3. Establishment of new programs or expansion of existing programs, including senior centers, which contribute to opportunities for a better life for older persons.
4. Training of special personnel to carry out such programs.

*All title III data for fiscal year 1968.

The grants are intended to strengthen State and community services to the aging and to stimulate new interest and commitment on the part of the States and communities to meeting the needs of their older residents.

Projects funded by these grants provided a variety of services which helped to maintain independent living. These services played an important part in helping older persons to remain in the community, in surroundings familiar and congenial to them, and at considerably less cost than the more expensive alternatives of nursing home and institutional care. Homemaker-home health aide assistance was provided by 62 projects to 6,178 persons. Through 207 projects, 82,743 persons were helped with home maintenance, friendly visiting, and regular telephone reassurance calls (frequently provided by older volunteers). Seventeen innovative projects assisted 968 older persons to find foster home care. Protective services were provided to 7,901 older individuals through 49 projects. Meals were served to 17,341 aged individuals via 44 projects. Finally, 107 projects extended health screening services to 15,330 older persons and other health services to 24,784.

One project in Missouri is delivering health related services for the aged in four small town and rural areas through the offices of a physician in each of these localities. The project is utilizing the services of medical social aides. The aides, all of whom are older persons, perform tasks to supplement those of the physician and social worker. Social services are provided by graduate social work students. The project will develop community interest in providing services for the aged on a permanent basis, as well as extending the plan of delivery of services from physician's offices to patients of all ages.

Another category of service rendered by title III projects provides opportunities to continue engagement in community life. These services included placing 10,916 older persons in jobs through the auspices of 160 projects. Adult education was offered through 170 projects to 52,482 persons. A very large number of older persons, 288,545, participated in recreation- and leisure-type activities in 375 projects. Counseling was offered to 46,766 persons in 199 projects. Transportation for the older person is often a major obstacle to continuing activity in the community. Its lack can represent the barrier to his shopping, conducting business affairs, receiving medical treatment, and participating in community life. Title III funds have been used in 206 communities to provide special transportation services for 41,472 individuals.

Many of the above services were provided through the approximately 250 multipurpose senior centers which receive support from title III grants. The center can become for the community in which it operates a focal point for planning, developing, and delivering services to the aged. It is the channel through which contact is made and maintained with the elderly and through which they, in turn, are integrated into and connected with the community and its broad range of resources. Multipurpose senior centers funded by title III were utilized by over 225,000 persons during the year.

In North Dakota such a center provides a varied recreation program for its 350 members. The center has arranged for regular service from the library bookmobile and one of its membes has provided employment counseling and referral services for other members. Hearing and eye examinations are conducted, with glasses provided by a service club for those needing them but unable to afford them. Meaningful volunteer activities were developed both for the members to work at the center and in the community and for high school students interested in serving older persons. Counseling of older persons on their problems and referral to appropriate community agencies for specialized assistance is provided by the center director.

A senior center in Ohio which had been operating for several years received a title III grant to extend its services. This permitted expansion of its program to residents of nearby housing projects and isolated older persons living in their own homes. This center has also established a new job opportunities service to help older persons find full- or part-time employment.

The increasing number of volunteer opportunities available to older persons through title III projects has been of major significance. It is noteworthy that 493 projects have made it possible for 28,974 older persons to contribute volunteer services. The tasks involved have been varied and the beneficiaries of the time, interest, and skills of the older volunteers have included the aged, youth, families, and community projects. In one California town, 1,954 older persons have given more than 75,000 hours of volunteer service.

This has included assisting in direction of leisure time activities, providing information and referral in response to questions about available programs and

services, and helping the homebound. In Kentucky, volunteer efforts were effectively directed toward providing tutoring services for failing students at two junior high schools.

In Florida, 46 senior citizens volunteer as friendly visitors to provide companionship for isolated and frail aged persons. They also offer transportation to keep medical appointments, to go shopping, and to attend church. In one Massachusetts community, 184 older volunteers work with the health, educational, cultural, social, and welfare agencies in bringing services to over 2,000 elderly persons.

Training projects in 64 communities utilized title III funds to train 5,980 persons. These projects fund short-term courses which help to prepare specialized personnel to serve the elderly. Included are projects which prepare community leaders to initiate and conduct programs for the aging, prepare nursing home personnel to better serve aged patients, and train homemakers to help the elderly in their own homes. These projects are, however, only beginning to meet acute need for institutional and rehabilitative personnel adequately prepared to work with older persons.

In Virginia, a significant title III training program is helping to meet the lack of qualified dietitians to fill food services positions in the increasing numbers of nursing homes. Two 5-day workshops have been conducted for 30 staff members of nursing homes and homes for the aged. They have been given training in nutrition for the aged, menu planning, food buying, quantity food preparation, sanitation, and such food management subjects as buying procedures and food cost control.

Planning projects serve a vital purpose in the development and coordination of service for the aged. Such projects enable a community to assess the human needs of its aging population as well as its resources to meet those needs. In many areas, aged persons have participated actively in this planning process. Planning projects were operational under title III in 133 communities.

In one Kansas community, a planning project has successfully coordinated a variety of needed programs for the aging. It has developed a plan for a geriatric clinic at a local medical center, coordinated efforts of church groups to reach older persons, involved nonprofit organizations in providing special services for the aged, and provided information and referral service to the aged, including publication of a directory of services.

Information and referral services funded through 335 projects reach 227,000 older persons. These services constitute a vital aspect of the planning process. Through the programs both the community resources and gaps in services for the aged become most clearly known.

The Older Americans Services Division has worked to obtain for the aged adequate recognition and inclusion of their needs in model cities planning. It has prepared materials on the special problems and needs of older persons for inclusion in model city kits. Since the program began, 115 title III projects have been funded in the first 55 cities selected as model cities. Data available on 77 of these projects indicates that: nine are located in model neighborhoods, 39 serve but are not located in model neighborhoods, 10 are areawide projects which encompass model neighborhoods, five do not serve model neighborhood residents but are likely to be expanded to serve them and only 14 do not serve model neighborhood residents and are not likely to be expanded to serve them.

Finally, the Division, through its Individual Services Branch, has had the responsibility of developing the social services policies applicable to older persons eligible under the public assistance titles of the Social Security Act.

A revision and updating of current social services policy is underway and will be issued early in 1969. This revision reflects an effort to identify new areas for supportive social services which help older persons to avoid institutionalization and maintain independent living.

Research and Development

Research and development grants under the Older Americans Act are contributing significantly to knowledge and improved practices in aging. During 1968, 69 new and continuation projects were funded at a cost of approximately $4,155,000. The projects are funded through grants or contracts with public or nonprofit private agencies, organizations, and institutions.

Empirical evidence is being accumulated for differentiating among older people—which older persons need services; which older persons do and do not use available community services; and why individuals do or do not use the services.

The dimensions of the problem of developing new services (protective services for example) are being defined. Techniques to organize and operate programs which provide part-time service roles in retirement on both a paid and volunteer basis and which add meaning and enjoyment to the life of the older person and those he serves have been tested. New service roles in schools and other health, education, and welfare settings have been tested and proven.

The findings and lessons of the research and development grants projects are being disseminated to States, communities, and professional groups as quickly as possible. Summaries have been reported in the AOA's monthly magazine, Aging. Many project directors have discussed their projects at national or regional conferences or submitted articles to professional journals. A summary of the projects under this program has been completed. The knowledge and experience from these research and demonstration projects will be used as a feed-in to the title III program to produce more effective programs, more extensive and readily usable services, and more appropriate activities, and to make these available at reasonable cost.

The competition for title IV funds has been severe. Only one-fourth of the applications that have been submitted for formal review have been funded. These grants have been targeted into priority areas.

The first priority area has centered on nutrition and meal patterns. Twenty-nine grants for over $2 million have been made for projects designed to attack the social problems underlying inadequate and/or poor diets among older people. These projects attack such problems as loneliness, inability to market and prepare meals on the part of the homebound, lack of motivation for eating, and inadequate knowledge of food purchasing and meal preparation. They are testing a series of carefully selected approaches for providing older people with information and a range of nutrition services in settings conducive to sociability, education, and good eating habits. The end objective is the promotion of independent living and the avoidance of institutionalization.

A few statistics on the 29 nutrition projects serve to illustrate the dimensions of this program:

1. Twenty-three are demonstration grants—20 in urban areas, three in rural areas.
2. Three are research projects and one is a development project.
3. Nine are totally or in part located in model neighborhoods of the model cities program.
4. Projects are located in all nine regions and in 17 States.
5. Two have been completed, the others are active.

The demonstration projects are testing and exhibiting a variety of delivery systems.

Examples of some of the systems being demonstrated are:

1. Food preparation in a central facility with distribution to satellite centers.
2. Food preparation in several separate sites under single management.
3. Food catered by a commercial and industrial company, or a public or private institution.
4. Food preparation in private homes for daily and weekend dining clubs.

Many different types of public and private facilities for meal services are represented: senior centers, public schools, homes for the aged, nursing homes, day-care centers, recreation centers, public housing, and church social halls.

Operationally, these programs vary considerably. Meals are served from 1 to 6 days a week; some serve one, others more than one meal per day; some include take-home meals; some include home delivery meals; and some provide for meal companions. Fees range from 25 cents to $1.50 per meal.

Staffing patterns are generally designed to include volunteers and paid employees, part time and full time, elderly and younger persons.

Other related elements are built onto the meal service. These include consumer and nutrition education; nutrition counseling to meet individual needs; cooperative purchasing; commercial mobile marketing service; transportation; recreational activities; health services (both medical and dental); and social and referral services.

The research projects are providing comprehensive data and knowledge related to nutritional status, knowledge of nutritional principles and practices, and of social interaction patterns among the elderly; as well as cost and acceptance of different delivery systems.

Early data indicates that the task of improving nutrition among the aged is a complex one, not only because of inadequate funds and social isolation, but

because of the paucity of knowledge concerning nutritional value of foods and of community resources.

The research and development program's second priority area includes an intensive, long-range attack on the problems of coordinating comprehensive community services. This attack is being implemented at various levels of the public and private sectors. It implements priorities of the Social and Rehabilitation Service, the Department of Health, Education, and Welfare, and the model cities program.

Effective coordination of services must first be preceded by a set of viable services. Therefore, the approach includes emphasis on both improving services and on the development of services to fill current gaps. The latter priority includes studies and demonstrations of special transportation services, retirement planning and counseling, services to extend independent living for those threatened with institutionalization or dependency, part-time paid and volunteer service opportunities, and the facilities, staff and other resources for conducting meal and food services projects. Some of the Nation's outstanding gerontologists are becoming involved in the design and testing of coordinating mechanisms for insuring efficient administration and delivery of the services being improved and developed in various types of communities.

As a result of this program, more will be known about the nature and extent of the need for various services among older Americans and about ways in which to better utilize existing facilities for senior citizens (including senior centers and public housing). For example, a whole new area of knowledge is being opened by exploring the dynamics of the relationship between transportation and older people's ability to utilize medical, social, and welfare services. The projects are testing the effects of model cities neighborhood programs on older people in inner city-neighborhoods and methods for decreasing social isolation among the elderly in rural and urban areas.

In Minnesota, the State agency on aging and a statewide five-station educational television network are demonstrating an effective system which not only gets important information to older people, but also gives them a sense of common interest—a sense of being part of a larger significant population group. A weekly program especially for seniors has been estimated to reach 85 percent of the elderly within the viewership area. This is a phenomenally high percentage for any kind of programing. Both group and individual viewing is encouraged, and off-the-air interpretation is provided through a localized telephone answering system and a network of field representatives who work with and through local and State senior citizens' organizations.

A nutrition project in New York City is breaking barriers between multiethnic, socially isolated older persons and improving diets at the same time. The project is accumulating important information on techniques for improving the diets of older persons through a very active educational program, competitive preparation of model meals, posters in six languages placed in strategic places, and outreach teams. It is successfully enlisting the hard to reach, including the lone male.

In San Francisco, the Langley-Porter Neuropsychiatric Institute has multiplied the older people's opportunities to receive psychiatric treatment without being institutionalized. When the project began less than 2 years ago, a fourth of the patients in mental hospitals, but less than 2 percent of the outpatients, were 65 years of age or over. The institute's director observed that, "This indicates that the older person is being sent off to State hospitals on the false ground that they are not helped by clinic care."

Now, instead of 2 percent, 13 percent of the outpatient clinic's clients are over 65 years of age and there is a long waiting list. The project is demonstrating that large numbers of older persons in the community can benefit from psychiatric services without being hospitalized or placed in an institution.

Although the first concern of the title IV program is to generate and test knowledge, to demonstrate applications of this knowledge, and to seek improvements in current programs and practices, the Administration on Aging is also interested in seeing successful projects continued beyond the Federal support period. An example of this: Last year, a grant of $42,000 to the Dade County schools to develop a part-time service role in retirement for older people as teacher aides generated $35,000 in income for older persons. This year, the people are still serving but with local, rather than Federal funds paying the costs. As the program continues, the social and income benefits to older people will be multiplied many times over the initial title IV investment.

TRAINING

Title V of the Older Americans Act authorizes grants and contracts for the specialized training of professional, technical, and lay personnel to plan for and serve older people in programs related to the broad purposes of the act.

In 1968, 15 grants and contracts were awarded for a total of 48 grants since title V of the Older Americans Act became operational. Approximately 3,647 persons had received short- and long-term training at the end of the year.

Broad objectives of the program are: (1) To develop and maintain an adequate supply of personnel trained for meeting the demands for manpower in services to the aging and related fields, and (2) to provide currently employed professional and technical personnel in appropriate fields with better understanding of older people and of methods for working with them.

The Administration on Aging training program has maintained its focus on areas within which there is desperate need for personnel and for which existing support has been inadequate or lacking. Training is now being offered in several professions for the first time. Priority occupations upon which the program is focusing are as follows:

1. Broad planning and administration in aging for work in public and voluntary programs at Federal, State, and local levels. Career training is needed at master's and doctoral levels; short-term training for the currently employed persons seeking to develop competency for work in the field of aging.

2. Planning, administrative, and management training in the field of retirement housing, villages, and homes for the aged. Career training at the master's level and a variety of short courses for employed persons are indicated.

3. Planning, administration, and program supervision for personnel of multiservice centers for older people. This field, like the two preceding, is expanding rapidly. The need is great for both career and short-term training.

4. Training for specialists in aging within such professions as recreation, counseling, adult education, architecture, library work, home economics, and retirement preparation. There are urgent needs in both the career preparation and short-course area.

5. Preparation of faculty personnel broadly trained in applied social gerontology and preparation of specialists in aging within established professions. This is really the key to the production of all other types of personnel. Hundreds of members of professional school, college, and community college faculties should have indoctrination in aging or career preparation for teaching in the field.

6. Leadership training for members of State and community committees on aging and for older adults who wish to become active in their communities.

7. Training for semiprofessional and technical personnel to serve under professional direction as library and recreation aids; aids in housing projects, senior centers, homes for the aged, and institutions; in homemaking and meal services, and a host of other ways, when support for such training is not available under other grant programs, such as vocational education.

Nearly twice as many short-term training projects as long-term projects were funded by the Administration on Aging in 1968; these were career preparation courses, curriculum development projects, seminars, and conferences.

The impact of title V is growing each year. An adequate measure of this impact is the number of trained personnel becoming available from programs supported by title V funds. Through a major practicum experience as part of the traineeships, students have been able to learn from and contribute to various programs serving the needs of older people; also, potential employers are made aware of the availability of competent, trained personnel.

The Older Americans Act Amendments of 1967 authorized the Secretary of Health, Education, and Welfare to undertake a study and evaluation of the existing and foreseeable needs for trained personnel in various programs and services related to the objectives of the Older Americans Act and to report his findings to the President.

The Senate report on the amendments, in noting the need for this study, stated: "The comprehensiveness of legislative programs for older people has created a tremendous need for a pool of professional and technical personnel * * * in the field. According to expert testimony received by the committee, this pool of manpower is currently nonexistent. * * *"

The Administration on Aging began preparation for the study in July of 1967. Projections were made on the numbers of older people in 1970 and 1980, their incomes, life expectancies, participation in the labor force, and other aspects of

the older population. Three studies were made in which these projections were used by all grantees and/or contractors for background data. The studies have now been completed and the report will be issued before January 1. The preliminary indicators show a great need for additional trained personnel.

Foster Grandparents Program

The foster grandparent program which is administered by the Administration on Aging under contract with the Office of Economic Opportunity has proven to be a most successful method to provide meaningful person to person service roles for older people. This program now provides such roles for 4,000 low-income men and women over 60 years of age. The program recruits, trains, and sponsors foster grandparents to provide personal attention to deprived, dependent, neglected, or mentally retarded children. Each foster grandparent spends 2 hours a day with each of two children, 5 days a week, giving the children individual attention and care. Today, these foster grandparents work with a minimum of 8,000 children on any given day in 166 institutions, day care centers, hospitals, and schools, in 40 States and Puerto Rico. The projects are supported by $9,800,000 in Federal funds.

Foster grandparents have demonstrated that they have much to give as a result of their years of living and they have shown ability to adapt, to change, to be flexible, and to give of themselves to children in need. Their love, compassion, warmth, tenderness, patience, and calm acceptance make them invaluable to the program, bringing new life and hope to the children they serve.

With the establishment of this continuing 1-to-1 relationship, children are walking who never walked, children are talking who never talked. Even the most profoundly retarded respond to the warm care of foster grandparents and faces glow with recognition and anticipation, who before have "turned their faces to the wall." At the same time, the program enables the "grandparent" to remain active in the community, to gain a sense of dignity in this service role, and add supplementary income. The program provides incentive and purpose for more meaningful living as these elderly persons seek to help others who are less fortunate. It enhances self-esteem and brings an increased sense of security as a contributor to society.

The foster grandparent program recently marked its third anniversary, having been authorized in 1965. From the initial 21 projects, it has expanded to a total of 68. Two thousand five hundred and sixteen foster grandparents, over half of the total, are working with retarded children in 71 different settings.

One hundred percent of the foster grandparents are over 60 years of age and under the poverty guideline of income. Twenty-three percent are black, 77 percent are white. Eighteen percent come from cities with 250,000 or over population, 44.5 percent from other urban areas, and 37.5 percent from rural settings.

A national evaluation of the foster grandparents program was made in 1966. The evaluation was financed by the Office of Economic Opportunity and conducted by Greenleigh Associates of New York. The report recommended a study to determine the long-term viability of the program and spoke of the "dual function," service roles for the aged and service to children. "To see the program in operation, to observe the hunger of deprived, handicapped, and sick children for love, warmth, and attention, to learn of the reborn feelings and usefulness on the part of the older people who had been cast aside by society—these are the essential human aspects of the program. The program has demonstrated its main objective—the utilization of previously wasted human resources to improve the lives of children and older people, and thereby to strengthen the quality of our society."

Other more recent research studies have been made which affirm the viability of the program, such as those of the University of Utah by Gray and Kastler; Denton, Tex., research report by Dr. Hiram Friedson; the Northeastern State College, Tahlequah, Okla.; Thames Valley Council for Community Action, Inc., Norwich, Conn.; and two studies by the Merrill-Palmer Institute, Detroit, Mich., the second of which has just been released.

Perhaps the most important finding of this latter study is "that the foster grandparents have indeed proven able to fulfill the personalized quasi-family function for the infants and young children in their care that was the most innovative feature of the foster grandparents program plan. The rich emotional interchange between the foster grandparents and "their" children has proven to be, in fact, the most distinctive and important contribution of the foster grandparents to the institutional routine." One of the foster grandparents, after 2 years

of employment at the Sarah Fisher Home, Detroit, said in reference to her foster grandchild, "I love him and he loves me. We help each other."

The future potentials for this program are great. There are long waiting lists of potential foster grandparents over the Nation who are requesting a part in the program. There are thousands of children who need love, care, and the supportive role of an adult in their lives. It is the coming together of a great need and a great resource.

Activities and Relationships With Other Agencies and Groups

As focal point for the Federal concern for the needs and problems of the aging, the Administration on Aging is charged with stimulating more effective use of existing resources and available services for the benefit of older people. In carrying out this responsibility, the Administration on Aging engages in many joint activities and programs with other agencies of Federal, State, and local government and voluntary and religious organizations active in the field of aging.

Coordinated programs and cooperative activities over the past year were achieved in three major ways:

First, through the established channels and the individual staff relationship developed by the Administration on Aging in its day-to-day contact with other organizations and groups concerned with matters related to older people;

Second, through the formal mechanism of the President's Council on Aging, on which 11 major departments and agencies are represented; and

Third, through the interest and participation of the Advisory Committee on Older Americans whose members are involved in activities in aging in many areas and with many segments of the population.

In 1968, the Administration on Aging continued its operation of the foster grandparent program in cooperation with the Office of Economic Opportunity. It also continued to review applications for model cities and to prepare models and guidelines for programs in aging for use by model city demonstration agencies.

A 28-page booklet, "The Fitness Challenge in the Later Years," was published in cooperation with the President's Council on Physical Fitness and Sports. With the cooperation of the President's Committee on Consumer Interests, the Administration on Aging published and distributed 700,000 wallet-sized consumer guides for older people.

The Administration on Aging worked with the Public Health Service in the development of suitable training programs for nursing home administrators in pilot projects for home health aides, in planning a national nutritional survey, and in developing model nutritional programs.

Consultations were held with the Department of Agriculture in the development of demonstration programs in nutrition for older people, and we participated on the interagency task force on rural health pilot projects. The Administration on Aging provided the President's Committee on Mental Retardation with information on the impact of foster grandparents in institutions, day centers, special classes and homebound programs for the mentally retarded. The Administration on Aging joined the Rehabilitation Services Administration in the issuance of a joint State letter to State agencies on aging, vocational rehabilitation agencies, and agencies for the blind, urging closer cooperation and the exploration of new programs. It has joined with the National Institutes of Child Health and Human Development in the development of basic concepts for the study of retirement.

Close working relationships are maintained with those groups which represent older people or have aging divisions such as the American Association of Retired Persons, The National Council of Senior Citizens, The National Council on the Aging, The American Public Welfare Association, The American Medical Association, The National Farmers Union and the Gerontological Society. The Administration on Aging and other agencies worked with the National Medical Association on integrating comprehensive health care, housing and senior center services into the District of Columbia's pilot program.

Special addresses, consultation, or technical assistance were provided during the past year for the National Parks and Recreation Association, The General Federation of Women's Clubs, The Kiwanis Club, The American Geriatric Society, The American Society for Public Administration, The American Optometric Association, The National Conference on Social Welfare, to name only a few.

The interest and activity of religious groups has increased. In answer to requests, the Administration on Aging has assisted in seminars, workshops and conferences, held by the Methodist Division of Christian Education; The United Church of Christ; Unitarian Universalist Association; The National Conference of Catholic Charities; The National Presbyterian Church and Center, The National Catholic Women's Clubs and several workshops for the clergy sponsored by lay groups or agencies on aging.

National religious denominations are putting greater emphasis on training of the practicing clergy to understand the problems of older adults and to stimulate the development of services to enable the elderly to live independently outside institutions. The Administration on Aging is working with the denominations toward these ends.

Plans are being made to include the voluntary and religious organizations in activities relating to the proposed White House Conference on Aging in 1971.

INFORMATION ACTIVITIES

Charged with responsibility to serve as Federal clearinghouse of information on matters related to the aged and aging, the information program of the Administration on Aging serves a variety of "publics"—older people themselves, professionals working with and for them, Federal and State agencies and officials, and the public in general.

The Division develops publications, fact sheets, press releases, publishes a monthly news magazine, Aging, and works closely with media in development of radio and TV programs, magazine articles, and newspaper series.

During 1968, the Administration on Aging handled more than 22,500 inquiries from Members of Congress, from public and other private organizations, other government agencies, the press, and members of the public, including many older people themselves.

There were several major publications during the year. AOA published the President's Council on Aging report, "A Time of Progress for Older Americans," which reviewed the activities of Federal agencies with programs benefiting older people and progress that has been made from 1965 through 1967. In May 1968, the Administration on Aging published "The Fitness Challenge in the Later Years." The booklet presents an exercise program for older people at three levels of difficulty according to the amount of stress involved.

Another major publication was "Communities in Action for Older Americans," a report of progress under title III of the Older Americans Act in developing planning, service, and training programs at the local level.

Four major speeches by AOA officials, containing basic discussions on the needs of, and services for, older people were published in booklet form to make their information widely available. A new, categorical list of AOA publications also was printed during the year.

Two church programs—one concerned with housing for the elderly and the other with an interfaith center—became the fourth and fifth publications in the "Designs for Action" series. A one-page flyer of statistical data, "It's Happening Today in Programs of the Administration on Aging" was published twice, once in January and once on July 14, to mark the third anniversary of the Older Americans Act. "Aging in the News," reproductions of local newspaper clippings about projects funded under the Older Americans Act, was printed five times during the year.

Seven publications in the "Federal Financial Assistance for Projects in Aging" series were published in 1968. They explained support available for programs in aging under the research and training grant programs of the National Institute of Mental Health, the vocational education, continuing education, and the adult basic education programs of the Office of Education, the manpower development and training programs of the Office of Education and the Department of Labor, and the joint research and demonstration program of the Social and Rehabilitation Service and the Social Security Administration.

One of the most popular publications ever put out by the Administration on Aging is the 16-panel, folding wallet card of tips on consumer buying and avoiding frauds and swindles, the "Consumer Guide for Older People." It was developed by the Administration on Aging in cooperation with the President's Committee on Consumer Interests, and the Food and Drug Administration. More than half a million of the guides were distributed in response to requests in 2 months and a third printing of 250,000 was ordered to fill the steadily mounting orders from older people, senior citizens organizations, and State agencies.

SENIOR CITIZENS MONTH

May 1968 appears to be the most successful yet in the 6-year history of a presidentially proclaimed "Senior Citizens Month" to promote interest in helping older citizens and in recognition of their talents and experience as a national resource. "Meeting the Challenge of the Later Years," the 1967 theme, was selected as a continuing theme and, in 1968, special emphasis within this broad theme was placed on the contributions older people are making to their communities. Well over a million copies of informational materials were mailed out to national organizations, State and local aging units, and to individuals. Local newspaper interest in older people, their activities and their contributions, was substantially greater than in previous years and hundreds of news items, feature articles, photographs, and editorials concerning older people were printed in newspapers throughout the country during May.

Publications developed for Senior Citizens Month, in addition to the wallet card, and the physical fitness booklet, were the proclamation, the poster in two colors with a matching envelope for mailing; the "What Churches Can Do" housing booklet; "How Communities Observed Senior Citizens Month, 1967," a collection of local newspaper clippings; and "To Tell the Story, A Public Information Guide for Project Directors."

"Aging," the official magazine of the Administration on Aging, continued to be a major informational medium for professionals in the field. Monthly circulation during the year was 14,600, of which 6,100 were paid subscriptions and sales. Changes in format were introduced to make it more easily readable and improve its appearance. A special two-color Senior Citizens Month issue was printed for May. Several reprints were made of major articles, including one on the University of Michigan milieu therapy project and another on Texas programs conducted under the Older Americans Act.

ITEM 2: ATOMIC ENERGY COMMISSION

U.S. ATOMIC ENERGY COMMISSION,
Washington, D.C., December 6, 1968.

DEAR SENATOR WILLIAMS: We are pleased to again have the opportunity to provide your committee with a summary of the activities of the Atomic Energy Commission which we consider to be oriented toward the elucidation of the problem of aging. The fiscal year 1968 cost of this research was approximately $5,315,909.

As we have pointed out in previous reports to your committee, the overall plan for support of research on the aging process by the Commission is directed to determining the mechanisms whereby radiation interacts at the molecular and cellular level to bring about loss of functional adaptation by the individual or species with passage of time. This would include studies that are directed to determining those parameters that are characteristic of the aging phenomenon and are accelerated by irradiation; emphasis is also placed on identifying the physical and physiological phenomena associated with the aging process and on studies of molecular and attendant cellular changes that can be used to predict the onset of an aging process in the hope that this process may be controlled or altered in rate.

It has been demonstrated as a result of Commission-sponsored research that an important factor in aging is a decreased capability of the body's defense against foreign substances, such as germs and pollutants. As a result of this research, it appears that aged mice raised in a clean environment are better able to respond to foreign substances than are mice which have been exposed to germs and pollution during aging. This continuing research program is attempting to determine if the decreased capability of the immune system in aged mice could be one of the reasons why the death rate due to infectious agents is high among the aging.

A large beagle dog colony is maintained by the Commission for studies of the long-term effects of various radioisotopes. A significant segment of these dogs has not received any form of radioisotopes and serves as a control population. These control dogs are followed throughout their lifespan and represent a major resource currently being exploited for establishing the process of aging in an animal population more closely corresponding to man than the rodent. This study of the lifespan in pedigreed beagles represents the only quantitative evaluation of

age-related changes in animals other than laboratory rodents. As a part of the research program, each control dog receives a thorough physical examination, including radiographic survey, at least once each year. This extensive documentation of age-related changes will represent a unique contribution to human gerontology.

Human data bearing on the irradiation-induced reduction in lifespan (accelerated aging) are few. The largest study of humans is the research program carried out by the Atomic Bomb Casualty Commission (ABCC). This study includes 50,000 selected exposed Japanese and their 50,000 matched controls. A subsample of 20,000 of the above 100,000 people is being examined intensively on a biennial schedule because the patterns of morbidity and mortality rates are shifting in Japan as elsewhere. Data from these 20,000 people are finding value as baselines and controls for numerous other medical studies. As yet, there is no sign of a life-shortening effect of irradiation although all animal studies point to its eventual appearance. The life-shortening should become evident in those parts of the population which were irradiated in their youth or young adulthood. These cohorts are just now entering that phase of life where morbidity from the degenerative diseases increases. Because of the prolonged latency between insult, induction, and the appearance of neoplasms, two decades are too short a time to permit conclusions on the carcinogenicity of exposure to weapon radiations. There is evidence of increased incidence of thyroid and gastric cancer, and it is possible that other forms of cancer associated with an aging population will appear in greater than control frequency.

These major studies of aging are supported by a significant research effort in the related area of somatic and genetic effects of irradiation. Basic studies at the sub-cellular level and studies of irradiation induced life-shortening in animals, such as the mouse, have furnished exprimental data suggesting specific lines of research to be undertaken with large animals with longer life spans.

We hope this information will be of assistance to the committee.

Cordially,

GLENN S. SEABORG, *Chairman.*

ITEM 3: FEDERAL TRADE COMMISSION

FEDERAL TRADE COMMISSION,
Washington, D.C., November 12, 1968.

DEAR MR. CHAIRMAN: This is in response to your letter of October 23, 1968, requesting information on our activities this year in behalf of consumer interests of the elderly.

I am pleased to comply with your request and, in accordance with your desire, I am enclosing a comparable summary to that which was transmitted to you on January 4, 1968. You may be assured that your continued interest in our activities is appreciated.

With best wishes, I am

Sincerely yours,

PAUL RAND DIXON, *Chairman.*

[Enclosure]

REPORT FROM THE FEDERAL TRADE COMMISSION

The prevention of the elderly from being victimized by frauds and misrepresentations in the marketplace is of continuing concern to the Federal Trade Commission. The Commission has a deep sense of responsibility for protecting our elderly citizens from unfair and deceptive practices prohibited by its statutes. Not long ago, in an opinion accompanying a cease and desist order, the Commission publicly proclaimed the urgency of protection where misrepresentations are made respecting health claims, particularly because their appeal is directed to those in distress, frequently the aged and infirm. Chairman Paul Rand Dixon has also pointed to the fact that many elder citizens past the income producing age who depend upon meager pensions and savings are ofttimes the victims of deceptions which would mislead them into thinking that some scheme—some proposal—would increase their financial resources, only to have them woefully deleted. The Chairman has made it clear that the Commission also attaches high importance to economic deceptions of the retired and aged citizenry.

DRUGS

Last year the Commission reported some significant corrective actions it had taken or proposed in the health field in individual cases, and by broad approach through the institution of a Trade Regulation Rule proceeding with respect to oral analegsics. Needless to say those measures have continued. Cases were being considered involving alleged false claims for such products as external rheumatic remedies, mouth washes, cold remedies, dentifrices and dental products, female remedies, and health books.

The most significant broad measure in the health field the Commission took in 1968 was to update its liaison agreement with the Food and Drug Administration in January so as to bring about increased cooperation with that Agency particularly in connection with evaluation of drug claims in labeling and advertising.

The 1962 amendments to the Food, Drug and Cosmetic Act meant that subsequent to October 10, 1962, new drugs were to be reviewed and approved from the standpoint of both safety and effectiveness by FDA. They also included a so-called grandfather clause to the effect that those new drugs passed on for safety but not effectiveness between 1938–62 would have a period of 2 years within which to establish the effectiveness of the drugs. Needless to say much more time was required for the monumental task.

FDA planning now anticipates that by May 1969 final orders will have been published in the Federal Register respecting the efficacy of some 150 drugs. Considering that for each basic drug product there are, conservatively, an average of five "me too" products, this means that with its program already underway the Federal Trade Commission can anticipate that by July 1969 it will have monitored and given legal and medical review to the advertising of more than 750 over-the-counter drugs.

FOOD

A large portion of the Commission's work on behalf of the elderly is in the food field and has to do not only with false advertising and other deceptive practices promoting food sales but also with trade restraints bearing on food prices.

The main types of food products receiving attention in 1968 from the standpoint of deception were freezer meat misrepresentations as to price, quality, and grade, and vitamin-mineral preparations misrepresented as to efficacy and the need for their addition to the diet.

One broad-based study related to the use of games of chance and other appeals to the gambling instinct in the retailing of food to determine not only whether such schemes were unfair or deceptive but also their effect on the economy.

A large part of the Commission's work in the merger and trade restraints field to prevent practices and arrangements tending to destroy competition or to create monopoly is devoted to the food industry—the producer of necessaries of life of particular concern to the aged and those in the low-income brackets. Food products covered by pending or planned investigations include milk, bread, frozen foods, cereals, macaroni, coffee, and honey.

INSURANCE

The regulation of insurance lies principally with the States. Nevertheless the Commission has continued to receive numerous complaints involving insurance matters. Many came from the elderly. They generally related to dissatisfaction with cancellations or settlements under health, life, and automobile policies rather than mail-order insurance promotions into States where such companies were not licensed and regulated as was the prior case. Perhaps this was due to the Commission's drive against these latter promotions and its issuance of the public bulletin warning of pitfall to watch for in mail-order insurance policies. Because of the nature generally of the more recent complaints it has been necessary for the Commission to explain to the complainants that these were matters which were subject from a regulatory standpoint to consideration by State insurance authorities. The Commission is cooperating with the Department of Transportation in the investigation of certain phases of the automobile insurance industry which the Congress authorized that Department to make.

EARNINGS SCHEMES

The elderly are among those people seeking, and in most instances, needing, to increase their incomes. The Commission's efforts to protect these consumers

from deception has continued to fall into two main categories, namely, the sale of chinchilla breeding stock on the false promise of "getting rich quick," and the franchise scheme where earnings potentialities are highly exaggerated and the seller fails to provide assistance promised in both getting the business underway and in subsequently operating it.

TRUTH IN PACKAGING

The nature of the packaging of products is of vital concern to the elderly. The Commission has the responsibility for dealing with the packaging of those consumer commodities subject to the provisions of the Fair Packaging and Labeling Act with the exception of food, drugs, therapeutic devices, and cosmetics, the responsibility for which was delegated to the Food and Drug Administration.

In 1968 the Commission issued mandatory regulations under the act respecting those commodities for which it is responsible including provisions dealing with net quantity of contents disclosures, identity of product and name of manufacturer or distributor. A series of regional meetings were sponsored jointly with the Food and Drug Administration to develop working arrangements with State agencies which will be involved with enforcement of the act. Consideration was being given to possible issuance of regulations under discretionary provisions of the act. Action was also being considered under section 5 of the Federal Trade Commission Act respecting packaging and labeling deceptions not covered by the Fair Packaging and Labeling Act.

TRUTH IN LENDING

Preliminary planning was being completed toward carrying out the Commission duties under the Consumer Credit Protection Act, including consultation with the Federal Reserve Board respecting issuance of regulations required under the act.

NATIONAL CONSUMER PROTECTION HEARINGS

The Commission held public hearings on national consumer protection for several days in November 1968. They were not limited to problems of the elderly but the interests of our aged citizens were of major concern along with those of citizens in general in the low-income brackets. The views of representatives of the consuming public were invited together with comments from officials at the State, local, and Federal levels, representatives of educational institutions, and members of trade associations, concerning national consumer protection and education. The data and views received were under intense study at year's end.

FEDERAL-STATE COOPERATION

The Commission has continued to carry on its active program designed to encourage enactment and effective administration at the State level of model laws to prevent deceptive and unfair practices. Nine States have enacted such laws in recent years and about 30 States either have such legislation or a consumer protection bureau to deal with these practices.

CONSUMER EDUCATION

The Commission maintains a program of consumer education, publishing information regarding its consumer protection activities and furnishing literature and speakers for participation in consumer conferences and workshops designed to explore ways and means of coping with deception in the marketplace. It works closely with other agencies in the development and implementation of educational effort designed to present to the public a well-rounded and a comprehensive picture of Federal consumer programs available.

ITEM 4: FOOD AND DRUG ADMINISTRATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE,
Washington, D.C., November 27, 1968.

DEAR MR. CHAIRMAN: This replies to the request in your letter of October 23, for a progress report concerning the Food and Drug Administration's consumer

education program, with specific reference to the aging. The answers to the questions as asked are as follows:

1. Has the report on susceptibility to health fallacies and misrepresentations moved past the pretest screening phase?

Yes. Depth interviews (phase II) have been completed.

2. What have been the notable effects of the Fair Packaging and Labeling Act during 1968? Is there any specific data relating to the elderly?

Regulations for the labeling of food products under the Fair Packaging and Labeling Act took effect July 1, 1968.

Regulations for labeling of over-the-counter drugs, medical devices, and cosmetics will take effect July 1, 1969. There has not been sufficient experience since the regulations for food products took effect to accumulate meaningful data on their impact, although it is apparent that the food industry is complying with the new regulations as rapidly as possible. Extension requests have been granted only after a company has demonstrated that, despite good faith efforts to comply, it was unable to relabel its entire product line prior to last July 1.

Since the act applies to the universe of consumer commodities, we do not have specific data on benefits it affords the aging. The act and implementing regulations are intended, however, to provide labeling information helpful to the consumer in making value judgments. Because economical shopping is of special importance to elderly citizens on fixed incomes, particular emphasis is given to the labeling requirements and how to make use of them at consumer workshops and other FDA programs focused on the needs of the aged.

The annual report required under section 8 of the act is now in preparation and will be filed with the President of the Senate at the beginning of next year.

If we can be of further assistance, please let us know.

Sincerely yours,

(S) MORTON M. SCHNEIDER,
PAUL A. PUMPIAN,
Director, Office of Legislative and Governmental Services.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
CONSUMER PROTECTION AND ENVIRONMENTAL HEALTH SERVICE,
Washington, D.C., March 18, 1969.

DEAR MR. CHAIRMAN: This is in reply to your letter of February 26, requesting some further information about our activities in 1968 which might be pertinent for inclusion in your report, "Development in Aging—1968."

The Consumer Specialists in each of FDA's seventeen District Offices continued to work with the older Americans in a variety of educational programs. The Specialists worked directly with older citizens in many instances, and also participated in educational efforts aimed at training local leaders whose primary responsibilities lie with the problems of the elderly. Local and area Golden Age Clubs, Senior Citizens Clubs and Centers, the American Association of Retired Persons, and retirees of various unions and industries were reached directly. FDA worked with personnel representing State and local departments and commissions as well as with Administration on Aging and other Federal agencies in an effort to assure more complete education of the older American.

The main emphasis of the programs directed toward the elderly was upon health education, especially as it relates to health fallacies and misinformation. Other topics covered included general health education in the safe and effective use of drugs and optimum use of information carried on the labels of foods and drugs.

Interviews for the nation-wide Study of Health Practices and Opinions, undertaken on recommendation by this Committee (or the Chairman of this Committee) are expected to be completed this year. The study is an outcome of the hearings held in 1964 by the Subcommittee on Frauds and Misrepresentations Affecting the Elderly. While it covers all age groups it has been designed especially to disclose attitudes, beliefs and experiences which affect the health practices of elderly consumers. Seven agencies of the government joined in sponsoring the study which is being coordinated by the Food and Drug Administration in the Department of Health, Education and Welfare.

If we may be of further assistance, please let us know.

Sincerely yours,

MORTON M. SCHNEIDER,
(For Paul A. Pumpian, Director, Office of Legislative and Governmental Services).

ITEM 5: DEPARTMENT OF LABOR

U.S. DEPARTMENT OF LABOR,
Washington, December 23, 1968.

DEAR MR. CHAIRMAN: I enclose herewith, pursuant to your request, information regarding "Developments in Aging—1968." This does not include the report on the Age Discrimination in Employment Act which will be sent to you when it is available.

Also enclosed is material regarding the "Retired Couples Budget" and the answers to the questions which you posed.

Sincerely,

W. WILLARD WIRTZ,
Secretary of Labor.

[Enclosures]

BLS RETIRED COUPLE'S BUDGET AND RELATED QUESTIONS

1. Are there any current figures, especially pertaining to food, shelter, clothing, medical aid, dental care, and recreation, which would update those of the last edition of Retired Couple's Budget?

The most recent cost estimates for the retired couple's budget are those for a moderate living standard in autumn 1966, contained in BLS Bulletin No. 1570–4, attached.* This report contains the first such estimates to be released since the interim budget for a retired couple was published in November 1960, based on autumn 1959 prices.

The new budget continues to represent a moderate living standard for a husband age 65 or over and his wife, who are presumed to be self-supporting and living independently. The report summarizes the costs of the budget in urban areas; provides a brief analysis of intercity differences in living costs; discusses the changes that have occurred in the concept of a moderate living standard in the last 15 years; and describes the sources of data and methods of estimating costs. Separate cost estimates are shown by major components of the budget for 39 metropolitan areas, and for nonmetropolitan areas (populations from 2,500 to 50,000) in the four major census regions. A moderate standard of living for a self-supporting, retired couple in U.S. urban areas in the autumn 1966, required an annual expenditure of $3,869. These figures represent a range from $4,434 in Honolulu to $3,246 in smaller cities in the South. Main items in the budget are food costs averaging $1,072, shelter, $771 for homeowners and $950 for renters, clothing and personal care, $346, medical care, $284, and transportation, $345.

In the spring of 1969, the Bureau of Labor Statistics expects to issue estimates of April 1967 costs, not only for the moderate standard, but for a lower and a higher standard as well.

2. Is there any way to utilize these budgets to implement a program of consumer education?

Both the budgets and the Bureau of Labor Statistics Survey of Consumer Expenditures, 1960–61 contain a gold mine of information which could be incorporated in a series of pamphlets, written in popular form, to implement a program of consumer education. These pamphlets could deal with such topics as "the cost of running a house," "the cost of owning and operating a car," "living on a low-cost budget," etc. Another type of pamphlet might provide a "norm" against which individual couples could measure their own spending for various goods and services. Funds to initiate such a program would be needed.

3. Have any steps been taken toward a separate consumer price index which would indicate purchasing patterns of the elderly?

No specific steps have been taken toward the construction of a consumer price index for the elderly, although the desirability of such an index for retired persons has been considered at various times. The question is again under consideration as part of the long-range program for the Bureau. Investigations would have to be made to determine whether the trend in the price changes of a Consumer Price Index for the elderly would differ significantly from that of the currently published Consumer Price Index. Data needed for weighting patterns are already available from the Bureau's comprehensive consumer expenditure surveys, but it probably would be necessary to collect prices for additional items in order to construct an index for retired persons.

4. Is any information available to show how an average retired couple spends its money, or how a couple should spend its money?

*Retained in committee files.

Data from the BLS Survey of Consumer Expeditures, 1960–61 are available which show how retired couples actually spend their money. These data describe spending patterns for retired couples at various income levels, in different age groups (65 to 74, 75 and over), and at different education levels. * * * While the information in both the expenditure study and the budgets could be used in counseling families, the BLS does not attempt in either report to suggest how couples should spend their money. The next national expenditure study, which would collect information for 1971–72, is now in the planning stage.

5. Is consideration being given to a "cost of retirement living" regularly computed by the Bureau?

The Bureau of Labor Statistics plans to reprice the new retired couple's budgets for three living standards (lower, moderate, and higher) in the spring of selected years. The next repricing is scheduled for April 1969. Hence, estimates of the costs of retirement living will be available at regular intervals.

BUREAU OF WORK-TRAINING PROGRAMS

Operation Mainstream, the program to provide job opportunities for unemployed adult poor persons in activities which improve the social and physical environment of their communities, enjoys good acceptance wherever it operates, according to a 1968 survey completed for the Department of Labor by a private research firm. Conducted mainly in small communities and rural areas, the program provides highly beneficial and much needed work that communities lack the means to do themselves; thus, mayors, members of the chamber of commerce and other civic leaders have high praise for this program. More dollars flow back into the community as well, from the paychecks of men and women who are able, through Mainstream participation, to purchase for their families the necessary food and clothing they formerly lacked. As reported in the same survey, enrollees have gained dignity and self-respect, are uniformly enthusiastic and proud of the work they have accomplished, and have a high ability to get along with one another.

In fiscal year 1968, the Bureau of Work-Training Programs funded 168 Operation Mainstream projects, which provided jobs for 12,183 enrollees, at a cost of $22.4 million. Forty-four and six-tenths percent of the participants were age 45 and over. New guidelines for this program, which are soon to be issued by the Bureau, will make it a requirement that at least 40 percent of the persons enrolled be over 55 years of age.

During this year, the Bureau of Work-Training Programs has also instituted two new pilot projects, collectively known as the Community Senior Service Corps program, but individually sponsored by the National Council on Aging and the National Council of Senior Citizens. Together, these projects, funded for slightly over $1 million each, serve 800 enrollees, age 55 and over, in 20 localities across the Nation. Working 20 hours a week, enrollees provide a variety of social, health, and educational services to their communities in such ways as delivering meals to homebound aged persons, acting as escorts to the elderly who have no means of reaching doctors' offices or social welfare agencies, doing followups on hospital discharges, serving as teachers in the Headstart program, or helping to implement the food stamp program.

The National Council on the Aging's project was late getting started, however, the parallel program conducted by the National Council of Senior Citizens employed its first senior aide on July 1, 1968, and by October 31 had filled 386 of its 400 allocated positions. Of equal importance, 2,744 seniors had applied for the 400 positions, a ratio of approximately 7 to 1. Fortunately, for some, their exposure to the local employment security office enabled the professional employment specialists to evaluate their abilities and place them in vacancies available within the private business sector.

Although the brevity of this program precludes an in-depth evaluation, some evaluation measures reflected have been:

a. Older people have responded beyond our expectation to offers of part-time employment in community services. For example, in Allegheny County, Pa., and in New Bedford, Mass., there were 500 and 400 applicants, respectively, who applied for the 40 jobs in each community within 48 hours of the announcement.

b. Senior aides recruited for part-time jobs, in many cases idle for many years, have been able to build sufficient confidence in themselves and to refresh their skills to the extent of finding regular jobs in the competitive labor market. In Washington, D.C., for example, after serving 1 week as a senior aide in the local public employment service office, a 64-year-old man was offered regular employ-

ment under civil service to fill an opening in that office. In New Bedford, one out of each five senior aides has moved into regular competitive employment after a short period in the project. When this has happened, new aides have been hired to fill the jobs in part-time community service.

c. The program has spurred an increase in the employment of older persons in part-time and full-time jobs in private business and industry. For example, in Dade County, Fla. (Miami), as a result of the senior aides program, employers learning of the success of senior aides in the community service programs requested several senior citizens to fill full- and part-time jobs in restaurants and private industry. As a further outgrowth of the project, the private business sector has set up a training program for switchboard operators which currently has 400 senior citizens enrolled to fill the longstanding vacancies in hotels in the Miami Beach area.

d. Local offices of the State employment service, recruiting applicants for this program, found unemployed and retired older persons whom they were also able to place in longstanding vacancies in sectors of private industry.

e. The favorable reaction to the senior aides program indicates that many additional communities have a need for the kind of assistance that this program permits them to use and that they are extremely anxious to participate in it.

f. The emotional uplifting it has meant to so many of our senior citizens. Indicative of this are the following unsolicited comments received by the National Council of Senior Citizens from seniors employed on their program:

"Now I'm meeting new people, a new life has opened up for me. I am productive, I see life in a more purposeful way. I want to help others and by helping them I am also helping myself. The extra money that I earn makes me feel more independent, and I don't have to deny myself the little things that I need and did so much without because I couldn't afford them. This is the best thing that could have happened to our senior citizens. Only in our country and our kind of government could we achieve such a goal."

"I enjoy it so much and am helping to support myself as my income is very small. We are all very earnest about our job and hope it will continue for a long time."

"It gives the senior citizen an opportunity to be of use and also to have the personal feeling of being useful in life."

"I now have a job here that I enjoy so much. It has brought me peace of mind, a sense of worth and purpose, and most of all a chance to be of service to others."

The Bureau of Work-Training Programs also expanded the Green Thumb project in 1968. This popular project, which employs disadvantaged males over the age of 55 in beautification and conservation activities, now serves 2,044 enrollees in 14 States (Arkansas, Indiana, Kentucky, Minnesota, Nebraska, New Jersey, New York, Oklahoma, Oregon, Pennsylvania, South Dakota, Utah, Virginia, and Wisconsin). In Green Thumb, enrollee applications and demands from park and highway departments for work crews from this project far outrun the Bureau's funding capabilities. The nature of the activities was described in last year's report and also has been reported in the New York Times. Therefore, it will not be repeated here.

Projects other than Green Thumb and Senior Aides are also very worthy of mention.

One of the most spectacular achievements of the Mainstream program in 1968 arose from the emergency conditions of the Fairbanks, Alaska, flooding of the Chena River. In an area where there is high unemployment under normal conditions, a parks and rehabilitation project gave employment to 253 enrollees who cleaned and rehabilitated 17 parks and numerous public buildings. The purpose of the project was twofold: to reconstruct Fairbanks' public recreation capacity, thus revitalizing the community and its emerging tourism capability and to provide employment for the low-income residents whose economic disruption was effected by the flood. As the project progressed, community interest and enthusiasm grew, and many local service clubs, contractors, merchants, and others contributed materials and assistance to assure the project's success. By the project's end, the community well exceeded the contribution in local funds originally called for in the contract. The enrollees' newly acquired skills greatly improved their chances for permanent employment and it was unanimously agreed by the civic leaders that "programs of this type are beneficial to the people of a community when they provide those participating workers an opportunity to earn a living and receive some training, practice good work habits, and at the same time perform some worthwhile job that contributes to the betterment of the community."

Work to prevent the occurrence of floods was done by the Mainstream project in Stockdale, Tex., where enrollees cleared a flood diversion ditch overgrown with weeds and thus, according to local spokesmen, saved the community from inundation during the aftermath of one of the tropical hurricanes. In seven other communities in Texas, Mainstreamers built and repaired homes wrecked by floods.

Home repair for low-income persons is also being carried out by Mainstream enrollees in Mingo County, W. Va., Kansas City, Kans., and Norwich, Conn. In the latter project, the local CAP agency purchased abandoned World War II homes of seamen and are refurbishing them for public housing, with Mainstreamers doing all of the carpentry, plumbing, and floor tiling. When completed, the homes will be resold to low-income people for only the cost of the materials used in the repairs.

One of the most interesting projects now underway at many Indian reservations is construction of "transitional housing," with funds supplied by the Department of Housing and Urban Development. These funds are used to purchase precut lumber, plumbing, and electrical supplies, which are then prefabricated on the reservations and installed by Mainstream enrollees.

Mainstream enrollees from the San Carlos Tribe in Arizona built picnic sites and boat launching facilities in a recreation area at Coolidge Dam. When these and other recreation facilities are completed, there will be regular employment for upward of 100 San Carlos Apache people.

In Falls City, Tex., Mainstreamers blacktopped every street in the community.

In Meigs County, Ohio—deep in the Appalachian region—local efforts have been highly successful in placing 50 enrollees in permanent jobs as a result of the skills they have learned in beautification and conservation activities for the Ohio Department of Natural Resources. This has had a significant effect on reducing the apathy and despair of the region.

Selected enrollees in the rural manpower development program in New Jersey drive buses, bringing other enrollees from their rural, end-of-the-dirt road homes to evaluation centers, to MDTA skill training centers, to private sector work, or to Mainstream and Neighborhood Youth Corps worksites.

Women enrollees in a consumer education project in Kansas City, Mo., are working as visiting homemakers or as teachers in neighborhood centers, to acquaint low-income people with better home management techniques and thus help them conserve their incomes.

In Phoenix, Ariz., women Mainstreamers are providing outreach to low-income women interested in birth control information.

They refer them to planned parenthood clinics, show films, and maintain contact with community organizations and leaders on behalf of the clinics. Women are also working in child development centers or with retarded children in Paducah, Ky.

Other programs administered by the Bureau of Work-Training Programs do not show as high a percentage of enrollment of those persons over the age of 45 as does the Operation Mainstream program. Nonetheless, there is a fairly substantial participation by this age group. In the new careers program, a program to train the underemployed for subprofessional jobs in the human service fields, there were 14⅒ percent over the age of 45 in fiscal year 1968. All other programs, including the concentrated employment program, job opportunities in the business sector, and both the MDTA institutional and on-the-job training programs, showed a 9- to 11-percent range of participation by those over 45 for the same period.

U.S. Employment Service and Affiliated State Employment Service Agents

During 1968, there were no additional resources specifically allocated for expansion of older worker services within the Employment Service. However, this does not mean that the program remained at a standstill. Significant progress was noted in two areas: the operations of the older worker service units, and the research efforts of the National Institute of Industrial Gerontology (funded by the USES).

Employment Service activities for the age-45-plus applicant for the Nation as a whole remained approximately the same as a year ago. Statistically, there was a decline; however, it should be remembered that with the continuing high employment rate, a drop in the number of applicants can be expected. Furthermore, those applicants requiring service are, increasingly, the more difficult to place who require more intensified, and consequently more time-consuming service.

Following is a summarization of overall Employment Service activities for older workers for the period January through September 1968, the most recent statistics available. For comparison purposes, the same period in 1967 is included.

	1967 (January through September)			1968 (January through September)				
	Total	Age 45-plus	Percent of Total	Total	Age 45-plus	Percent of total	Change	Percent of 45-plus change
New applications	8,451,606	1,286,260	15.0	8,264,943	1,209,394	14.6	—3.0	—5.9
Initial counseling	957,163	96,448	10.0	919,636	93,732	10.1	—3.9	—2.8
Nonagricultural placements	4,436,505	921,449	20.7	4,407,006	882,190	20.0	—.6	—4.2

OLDER WORKER SERVICE UNITS

In the local Employment Service offices of 27 cities, "older worker service units" are currently operating. These units were established through special allocations of staff which were made in fiscal year 1966 and fiscal year 1967 for that express purpose. The units are functional entities, and in most cities the staff specialists are deployed throughout an office's operating sections where they can be used most effectively to provide specialized services to older workers. The applicants they serve are those age 45 and over who are having difficulty obtaining employment due to their age or factors associated with age. In most cases, these applicants have complex problems, and require highly intensified and individualized service.

In addition to providing the usual employment services on an intensified basis, these units have been able to develop innovative service methods and techniques for improving services to older workers. Many of them have conducted group sessions to provide such services as work orientation and the teaching of job-seeking skills for older workers. In Van Nuys, Calif., the unit operates an activity called Project 45 in which they have not only established an excellent and effective community and employer liaison on behalf of the older worker, but have also set up a program for using older workers, as volunteers, within the Employment Service. This volunteer experience helps to instill new confidence, and update working skills for these age-45-plus applicants, increasing significantly their opportunities for regular employment.

The cities in which older worker service units are located are as follows:

Baltimore, Cleveland, New Orleans, Providence, Washington, D.C., St. Louis, Boston, Dallas, New York City, San Antonio, Detroit, Rochester, N.Y., Buffalo, Long Beach, Oakland, San Diego, Houston, Chicago, Los Angeles, Pittsburgh, Van Nuys, Kansas City, Cincinnati, Milwaukee, Philadelphia, San Francisco, Minneapolis-St. Paul.

Following are data for the period January–June 1968, summarized from reports from the 27 cities, which reflect some of the activities of the older worker service units:

Total intake	33,146
New applicants	16,545
Initial counseling	8,438
Placements	8,264

Starting in the latter half of 1967, the USES made brief reviews of the operations of each of the older workers service units. Staff and time limitations prevented making an "in depth" evaluation of the operations, but the visits did permit some identification of both the accomplishments and the problems of the units. It was generally conceded that where the units were functioning properly, they were making a significant contribution to providing appropriate employment services to older workers. The noteworthy factor was that the staff had the time to devote to the complex problems the applicants faced. Countless case histories illustrated unusual placement accomplishments made through persistent and resourceful effort on the part of unit staff members.

Not all of the units were operating well. Some had staffing problems, particularly in the recruitment of counselors; some had administrative problems, stemming largely from a misconception of the role of the unit. Wherever problems were noted, technical assistance was provided to help solve them. Since the

reviews, the USES has sought to maintain a continuing program of visits to the unit cities.

THE NATIONAL INSTITUTE OF INDUSTRIAL GERONTOLOGY

This project, which is expected to have a profound impact on future employment services for older workers, was established through a contract awarded to the National Council on the Aging by the USES in 1967. The purpose of the National Institute of Industrial Gerontology is to help improve employment services to middle aged and older workers by improving the training of specialists who work in this field; by encouraging research on this subject; and by developing and distributing material on industrial gerontology.

The institute has been operating since June 1967. Noteworthy accomplishments include meetings held between educational specialists and Employment Service practitioners to determine how best to improve the professional training of older worker services practitioners. As a result, a specialized body of knowledge on the middle aged and older worker has been assembled and produced in a document entitled "Industrial Gerontology Curriculum Materials."

A seminar, bringing together research specialists and older worker practitioners, was held in April 1968.

NCOA has published "Industrial Gerontology: An Annotated Bibliography on Industrial Change and Aging in the Work Force."

A "Journal of Industrial Gerontology" has been established and the first issue is scheduled for publication in February or March 1969.

A seminar on Industrial Gerontology for the directors of 20 of the State employment service agencies will be held December 1–6, 1968. The purpose of this seminar is to bring to the State directors knowledge on industrial gerontology and to secure their involvement in solving problems of middle-aged and older workers in their State agencies, through the development of strong, active programs in this area.

EXPERIMENTAL AND DEMONSTRATION PROJECT ACTIVITIES

An E. & D. project, experimenting with the use of volunteers in providing employment services to older workers in a neighborhood setting, was conducted in Louisville, Ky., and Sacramento, Calif. The project operated from August 1966 to January 1968. Results were very encouraging, and instructions have now been sent to all State agencies providing guidelines for establishing similar services.

In those cities where the National Council on the Aging and the National Council of Senior Citizens are operating senior aide projects, local employment service offices are participating in the recruitment, selection, and referral of older worker applicants who are potential project participants. Employment Service offices have also been active in the recruitment of applicants for the foster grandparents, Green Thumb, and similar programs and projects.

ITEM 6: OFFICE OF EDUCATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF EDUCATION,
Washington, D.C., November 29, 1968.

DEAR SENATOR WILLIAMS: This is in reply to your request for a summary of developments and activities during 1968 affecting older Americans.

I am pleased to supply information on adult basic education, public library services, and manpower development and training programs which are administered by this Bureau.

ADULT BASIC EDUCATION AND COMMUNITY SERVICES

The adult basic education program authorized under the Adult Education Act of 1966, as amended, provides instruction in basic skills—reading, writing, speech, comprehension, computation—up to and including the eighth-grade level for persons 16 years of age and older who need and desire such skills. Adults enroll because they want to prepare for a job or job promotion; they want to be able to follow their children's progress in school; they want to be more functioning citizens. The program is administered by State education agencies according to

State plans submitted to the U.S. Office of Education and approved by the U.S. Commissioner of Education. Facilities and resources of local public school systems are utilized where available. Approximately 33 percent of the students currently enrolled in adult basic education classes are 45 years of age or older.

Community service and continuing education programs, title I of the Higher Education Act of 1965, have established a number of programs designed to assist the older Americans.

Recognizing that early retirement and advances in medical science have provided the senior citizen with many years available for useful activities, this program is attempting to find solutions to the problems which confront the older adult and to increase the possibilities for effective utilization of this potential reservoir of knowledge, manpower, and experience. Programs with these objectives include—

Consumer education for the elderly through telecasts and counseling services;

Training programs for administrators of care facilities for the elderly;

Interdisciplinary courses in social gerontology, home nursing, health, recreation, and employment for professionals, volunteers, and community leaders to aid them in working with the aged;

Job counseling, retirement counseling, educational programs, and discussion groups for the elderly to enable them to be more productive and useful citizens of the community;

Training programs for volunteers who counsel the aging and who supervise leisure-time programs for the elderly in nursing homes and homes for the elderly;

Educational programs for senior citizens designed to help them adjust mentally and physically to a new style of life, to enable them to qualify for leadership roles in community service projects.

Mature women face problems similar to the retiree due to their changing status in the economic, political, sociological, psychological, and intellectual milieu of our society. There is a need to enlarge their horizons to help them assess their capabilities and define new goals, and to reorient themselves to the needs of the labor market and the community. Programs directed to meeting these needs include counseling for individual development and self-improvement; programs designed to help women assess their present status and their potential; programs to assist women in securing gainful employment, more education, and satisfying participation in civic affairs; and courses to prepare women for leadership roles as volunteers.

PUBLIC LIBRARY SERVICES

The Division of Library Services and Educational Facilities during the past year has maintained liaison with the Administration on Aging. Staff have been particularly concerned with the public library's role as part of the total community effort in the field of aging. With increased free time, older adults are now making greater use of their public libraries—for information, inspiration, and leisure-time reading. Many kinds of library-sponsored adult education programs are in evidence. These include film series, lectures, forums, television programs, and discussion groups.

Under the Library Services and Construction Act, title I, "Public Library Services," special projects for the aging are being continued in St. Louis, Mo., and Los Angeles, Calif. In Tucson, Ariz., the public library has developed a pilot program of library services to patients confined in nursing homes. Many other public libraries include services to the aging as part of their total special group services. Under title IV, "Specialized State Library Services," of the same act, libraries are expanding collections and developing new services for the handicapped—many of whom are aged—who cannot read conventional printed matter. These services include: (1) building up collections of large-print books, materials for the new literate, picture collections, films, and recordings; (2) acquiring special equipment such as magnifiers and automatic page turners; and (3) working with regional libraries for the blind and physically handicapped in providing eligible persons with "talking books" (recordings on discs and magnetic tapes), "talking books" machines, and braille books. Libraries and library services in State institutions—including soldiers' and veterans' homes and other institutions for the aged—are also being improved under this title.

MANPOWER DEVELOPMENT AND TRAINING

Training under the Manpower Development and Training Act has continued its efforts for older workers in line with the 1966 amendment to the act (title II, pt. A, sec. 202). Nationally, the percent of trainees in institutional training programs has remained the same as the previous year and the percent of the trainees in on-the-job training programs 45 and over has increased slightly.

Because many of the older trainees need more time than younger trainees, open-ended programing which is being tried in the manpower training skill centers promises to be an ideal means of providing this adjustment in the schedule of these trainees.

Another new approach to training which is evident in some skill centers is the cluster or galaxy concept. This also relates especially to the need of the older person for a broad range of training opportunities. Under this concept, a group of similar occupations is combined into one basic component, thus offering the trainees basic training in a broad area with opportunity to proceed into the specific phase of training he finds he is most qualified to perform.

A national MDTA contract with the Board for Fundamental Education to provide basic education for steelworkers offered a new outlook to many older workers. The cooperative steel project was designed to involve presently employed steelworkers who, if their academic base were significantly increased, could—

1. Perform their present job more efficiently,
2. Be utilized in more responsible jobs, as such were available, or
3. Be trained for other job opportunities.

The selection of participants was the joint responsibility of union and management in the steel mills. The mean-age workers involved was 42 years. The oldest worker in the program was 66 years of age and the youngest 21.

The older worker group benefited greatly from this program, both from a personal and occupational standpoint.

If we can be of further assistance, please let me know.

Sincerely yours,

GRANT VENN,
Associate Commissioner for Adult, Vocational, and Library Programs.

ITEM 7: POST OFFICE DEPARTMENT

POST OFFICE DEPARTMENT,
CHIEF POSTAL INSPECTOR,
Washington, D.C., December 2, 1968.

DEAR MR. CHAIRMAN: In response to your request of October 28, 1968, the following summary of Post Office Department activities to protect the elderly during fiscal year 1968 is furnished for your consideration in preparing your annual report on legislative and executive developments.

INVESTIGATIVE ENFORCEMENT OF THE MAIL FRAUD STATUTES (18 U.S.C. 1341 AND 39 U.S.C. 4005)

General.—The maintenance of public confidence in business transacted by mail is essential to the national welfare. Since the enactment of the mail fraud statutes nearly a hundred years ago, the Department has been committed to the protection of the consumer, as well as the businessman, from an infinite variety of fraudulent promotions facilitated through use of the U.S. mails.

Statistical.—Fraud is a criminal offense, the impact of which is poorly conveyed by statistics. In the broad sense all citizens, regardless of age, are adversely affected when fraud is practiced. The full impact of fraud, in terms of economic loss, physical and mental suffering, and the growth of cynicism and general erosion of moral standards that accompany violations of this nature, is statistically immeasurable. Nevertheless, the effectiveness of our enforcement of the mail fraud statutes in fiscal year 1968 is illustrated by the graph which is attached hereto.*

Arrests and convictions were the highest in history—up 52.5 percent and 22.26 percent, respectively, over the previous year. A total of 5,083 outright fraudulent or highly suspect promotions were discontinued as a result of the 8,851 investi-

*Retained in committee files.

gations made. A total of $9,483,720 was restored to the public treasury or to victims as a result of fines, court ordered and voluntary restitutions, and recoveries—a total far exceeding the budgetary cost of our entire fraud investigative program. A record 146,847 complaints were received from the public with respect to alleged fraudulent schemes.

Statistics in this area take on color and meaning only when amplified by specific examples. For this reason, I am briefing a series of cases handled this past year which are typical of the numerous cases investigated under each category.

Medical frauds.—The soaring cost of medical care is but one of the many reasons the poor, elderly, and illiterate too often fall prey to the eye-catching advertisements of the medical quack. Quick cures are offered to the obese, the bald, the chain smoker, and to those afflicted with such diseases as cancer and arthritis. The Arthritis Foundation estimates that over $300 million is spent annually on worthless and misrepresented drugs and treatments by the victim of this one disease alone.

By their nature, medical frauds probably affect the elderly more than any other segment of our populace, and postal inspectors completed 244 investigations in this area during fiscal year 1968. A total of 24 arrests were made, and the courts convicted 20 persons and/or firms of using the mails unlawfully in promoting these schemes. Investigations coupled with administrative action initiated by the General Counsel caused the discontinuance of 173 suspect or outright fraudulent operations and the judicial officer of the Department issued a total of 34 fraud orders which preclude the receipt of remittances by the promoter through the mails. Typical examples of medical cases follow.

In April 1968, Dr. Bernaar Zovluck, chiropractor, and two associates received sentences totaling 8 years and 8 months for using the mails in the 3-year operation of a spurious "medical" clinic in New York City. Allegedly, free medical service was advertised by radio, telephone, direct mail, and in newspapers. Literally thousands of educationally and economically disadvantaged persons, including many Negroes and Puerto Ricans, were then frightened through false medical diagnoses into signing long term payment contracts for unneeded and worthless medical products and treatments. Debt collectors hired by the promoters later coerced payments from victims by stating they represented various Federal, State, or city health agencies. The promoters obtained an estimated $1,300,000 from low income and welfare families in the greater New York City area during the life of the promotion.

The operator of a mail order testing laboratory in Texas claimed he had perfected an effective urine test for cancer. Over 15,000 tests were made at $10 each to patients before an investigation disclosed the fake and spurious nature of the tests. The operator was convicted and sentenced on October 30, 1967.

William E. Sheehan and two accomplices, using trade styles of Stereophonic Sound Co., Central Iowa Hearing Aid Co., Electronic Hearing Aid Co., and Transistor Hearing Aid Co., were convicted at Des Moines, Iowa, of mail fraud in the sale of hearing aids to the elderly. The court announced that this was the worst case of mail fraud it had ever seen, and that the callousness of the defendants in defrauding the elderly was revolting. Several Government witnesses were partially blind, one was confined to a wheelchair, and several had had disabling strokes which made it difficult for them to speak. Investigation disclosed that one victim paid over $7,000 for a hearing aid, and four others paid more than $2,000 each.

In Los Angeles, Calif., Edward I. Winkler, doing business as Vib-Erect Co., was sentenced to serve 6 months, fined $6,000, and placed on probation for 5 years on condition that he not engage in any mail-order business. Winkler geared his nationwide advertising to appeal to the impotent male in the sale of worthless sex-aid devices.

Peter J. Modde, chiropractor, and five accomplices (mostly students) were each placed on probation for 3 years for using the mails to secure test questions in advance of the examinations to be given by basic science boards in various States. A seventh was placed on probation for 2 years. They charged fees of up to $3,000 to obtain licenses to practice for students of chiropractic schools, and took in between $75,000 and $100,000 before the scheme was halted. Had the students received their licenses, unfit practitioners would be operating and probably causing irreparable damage to patients, particularly elderly people seeking their services to alleviate pain and discomfort.

In addition to medical frauds, there are numerous other schemes promoted through the mails which are beamed primarily toward that segment of our population who are homeowners, and of a benevolent and charitable disposition. Some of these frauds are summarized below.

Chain referral schemes.—These schemes are aimed directly at low-income consumers and, although the 45 major convictions obtained in the past 5 years, coupled with the public warnings issued, have served to stem the further rapid spread of these schemes, they continue to ensnare the unwary. Fast-talking salesmen pass off desirable but grossly overpriced appliance and home improvement items under the misrepresentation that the product will actually cost nothing if the victim will but supply names of friends and associates as potential purchasers and thereby earn commissions. In one such nationwide promotion, halted this year by convictions, an estimated $110 million had been fraudulently obtained from persons who were thus persuaded to purchase vastly overpriced vacuum cleaners.

Home improvement, debt consolidation, and mortgage rackets.—The Department shares the public's concern with the increasing incidence of frauds in which families on the fringe of poverty are tricked into signing binding contracts for expensive home improvements. Under the guise of offering second mortgage, and at times debt consolidation loans, various ruses are used to fraudulently conceal the true terms of the contracts at the time they are signed. Eight major convictions occurred in this area in 1968 and 63 cases are currently under investigation.

Business opportunities.—For investigative and recordkeeping purposes, this description has been adopted to include suspect promotions involving distributorships, franchises, job opportunities, and vending machines. These rackets frequently victimize older people who hope to profitably put to use their dwindling resources.

In June 1968, Leo Carl Martin was sentenced to serve 3½ years for selling worthless distributorships and materials for manufacturing cultured marble products. Profits promised, including purchases to be made on a "buy-back" agreement, did not materalize and investors lost some $75,000 during the 4-month period Martin was operating. As of June 30, 1969, a total of 54 persons and firms were under indictment for promoting allegedly fraudulent schemes in this area.

Land frauds.—Millions of dollars worth of so-called "retirement havens" have been sold by mail order to many elderly and/or retired persons despite the fact that such land may be worthless for the purpose for which it was purchased.

A typical case resulted in the conviction of Dory Auerbach, David Randell, and Irving Gottlieb on April 25, 1968, at Miami, Fla. As you may recall, Auerbach of questionable land deals over the years. The group had sold land in this instance in Arizona labeled "Lake Mead Rancheros" to the extent of some $1,800,000, representing it as "suitable for retirement now," whereas none of the necessary utilities was available in the remote area.

The public loss in land fraud cases investigated by the Postal Inspection Service during the past 6 years is estimatel at $50 million, and the savings to the public has been estimated at $128 million. This latter estimate is based on the amount of land still available for sale by the promoters when the schemes were discontinued as a result of our investigations.

Public education and fraud preventive programs.—Convinced that it is manifestly more desirable to prevent frauds from occurring whenever possible than to prosecute those that have, the Department expanded its program to prevent frauds through developing greater public awareness as to its danger signals. Postal inspectors made over 1,000 speaking appearances before law enforcement, civic, educational, and consumer groups this fiscal year and over 100,000 copies of the Mail Fraud Pamphlet were disseminated. A copy of this brochure is enclosed herewith for your information.*

Close liaison is maintained and mutually helpful data and intelligence are exchanged with the Office of the Special Assistant to the President for Consumer Affairs and other Federal, State, and local agencies concerned with consumer protection.

Included among the numerous legislative enactments this calendar year of protective interest to the elderly consumer was that represented by H.R. 1411 (Public Law 90–590) approved October 17, 1968. You need no introduction into the details

*Retained in committee files.

of this legislation, which amends 39 U.S.C. 4005 (the administrative postal fraud statute), for you were highly instrumental in sponsoring its enactment.

I hope that this summary will be helpful to you and your committee. If we can be of any further assistance, please do not hesitate to call upon us.

With kind regards.

Sincerely,

H. B. MONTAGUE,
Chief Inspector.

ITEM 8: PRESIDENT'S COUNCIL ON AGING

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., November 29, 1968.

DEAR MR. CHAIRMAN: This is in response to your letter of October 23, 1968, requesting information on the activities of the President's Council on Aging during 1968. The Executive Committee of the President's Council on Aging, chaired by the Commissioner on Aging, Mr. William D. Bechill, met eight times during 1968, to discuss mutual problems and cooperative action on behalf of older Americans. There were a total of 19 meetings of the six working committees of the Council.

The major accomplishment of the PCA was the publication in April of a report to the President entitled "A Time of Progress for Older Americans—1965–1967." The report reviewed the programs serving older people of the 10 Federal departments and agencies repreesnted on the PCA. In his letter transmitting the report to the President, Secretary John W. Gardner said: "The legislative advances that took place during the period covered by this report have marked the beginning of a new era for the Nation's older people. New programs in the field of health, housing, and hospital insurance are bringing fresh hope and purpose to the lives of millions of older Americans."

Discussions of the full executive committee centered on the following: need for supportive services to occupants of special housing for the elderly, and the importance of housing services in implementing the law providing intermediate care for the recipients of old age assistance; State laws providing relief in payment of property taxes; problems of income maintenance; retirement and preretirement programs; and the 1971 White House Conference on Aging.

One meeting of the full committee was devoted to a demonstration and explanation of the information retrieval center at the National Institute for Child Health and Human Development and a discussion of ways the center might serve the needs of the PCA agencies.

Some objectives of the PCA were assigned to working committees. One committee has developed a proposal for the cooperation of the Veterans' Administration, the Department of Housing and Urban Development, and the Department of Health, Education, and Welfare, in a project using surplus VA land to build housing for needy older veterans and incorporating in it, research on the health care of veterans. Another committee is working on a joint effort to stimulate public housing for the rural elderly.

A committee on group services to the elderly, composed of 12 representatives from nine agencies, has been studying the several kinds of services to groups given by Federal agencies, attempting to identify gaps, and to develop recommendations for interagency cooperation.

An ad hoc committee on expenditures for the elderly worked with the Bureau of the Budget and agreed on a procedure for collecting and analyzing expenditures for older people of all agencies of Government. These expenditures and the analysis of them will be published in the annual report.

At the October meeting of the Executive Committee of the PCA, a committee was established to explore the transportation needs of older people, to identify barriers in the design of transportation systems and institutional factors, and to develop a set of specific recommendations for action.

Sincerely,

WILBUR J. COHEN, *Secretary.*

ITEM 9: PUBLIC HEALTH SERVICE, COMMUNITY HEALTH SERVICE, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION,
December 3, 1968.

DEAR SENATOR WILLIAMS: In response to your request of October 28, 1968, for a summary of activities on health services for the aged which have been conducted by the Division of Medical Care Administration during this calendar year, we are submitting the enclosed report.

As you are undoubtedly aware, many reorganizations within the Public Health Service in recent years have resulted in shifts of location and focus of the health of the aged program. For purposes of clarity, a brief review of such organizational changes is included in the report. Inasmuch as automated multiphasic health screening activities as well as responsibility for research activities relating to health of the aged have been transferred to the National Center for Health Services Research and Development, we took the liberty of including in our report a summary of the aging activities of that agency.

Sincerely yours,

JOHN W. CASHMAN, M.D.,
Assistant Surgeon General, Director, Community Health Service.

[Enclosure]

REPORT OF THE HEALTH OF THE AGED ACTIVITIES IN THE PUBLIC HEALTH SERVICE

BACKGROUND ON CHANGING PATTERN OF PUBLIC HEALTH SERVICE HEALTH OF THE AGED PROGRAM

In the fall of 1962, growing awareness of the need to develop positive action programs to meet the health needs of the aged led to the creation of the Gerontology Branch within the Division of Chronic Diseases. This marked the first time that an operating program in the Public Health Service had been concerned exclusively with health problems of the aged.

Soon after the new branch was established, an ad hoc advisory committee met to recommend priority areas of needs. Top priority was placed by this committee on action to develop resource material and training activities for the orientation of health practitioners who serve the aged; particularly emphasized was the need for continuing education programs in applied gerontology for physicians. Accordingly, a contract was negotiated with the Gerontological Society for the creation of a comprehensive body of knowledge in applied gerontology, along with the development of education and training programs to utilize this resource material.

Other activities of the branch included intramural and extramural research projects in aging and community demonstrations of health maintenance services specifically geared to protect the health of the aged. The branch also served as a focal point for the various health of the aging activities conducted by other operating units within the Public Health Service, and for other governmental agencies as well as for the interested public.

It soon became evident that the lack of health protection services for the aged represented a serious gap in health programs for the aging and this, in turn, pointed to the need for early disease detection services as a preventive measure. In the light of this recognized need, the Gerontology Branch provided the support for four adult health protection centers using automated multiphasic screening as a tool for the early detection of chronic diseases.

As these four demonstrations developed, increasing proportions of staff time and operating funds of the Gerontology Branch were diverted to these activities and, as a result, less emphasis was placed on activities relating to other types of health services for the aged. Tangible evidence of this change in focus was the January 1967 change of the name of the Gerontology Branch to Adult Health Protection and Aging Branch; at about that time the program was transferred from the Division of Chronic Diseases to the Division of Medical Care Administration. Within the new administrative framework, emphasis with regard to screening activities was placed on the delivery of health services.

In the February 1968 reorganization of the Division of Medical Care Administration, the Adult Health Protection and Aging Activities was administratively

placed in the newly created Health Services Organization Branch. The National Center for Health Services Research and Development was established in May 1968, and at that time all research and developmental activities related to automated multiphasic screening in the Adult Health Protection and Aging activity were transferred to the Center, along with responsibility for administration of grants and contracts relating to research and developmental activities in health services for the aged.

In October 1968, the Division of Medical Care Administration was merged with the Office of Comprehensive Health Planning to form the Community Health Service. As a result of this reorganization, responsibility for activities relating to health of the aged was placed in the Division of Health Care Services.

Aging Activities in the National Center for Health Services Research and Development

The mission of this newly formed Center is to perform and support research, development, demonstration, and evaluation of the organization and delivery of health services for the total population. Significantly, top priority has been placed by the Center on finding a way to increase the availability of high-quality medical care to the disadvantaged in inner cities and rural areas, and the aged are included in the category of the disadvantaged.

AUTOMATED MULTIPHASIC HEALTH SCREENING

Support is being provided by the National Center for Health Services Research and Development for four model projects in automated multiphasic health screening. These projects are conducted under the following auspices: Tulane University School of Medicine (New Orleans, La.); City of Milwaukee (Wis.) Health Department; Brookdale Hospital Center (Brooklyn, N.Y.); and the Rhode Island Department of Health in conjunction with the Rhode Island Hospital (Providence).

In addition to the four demonstration programs, the Center is providing support for investigations in other aspects of screening. Grant support has been given to the Kaiser Permanente Foundation and the Straud Medical Research Institute of Hawaii. The Kaiser Permanente Foundation is conducting a longitudinal study to evaluate the effectiveness of periodic health examinations through an investigation of how this procedure affects such factors as hospital utilization, morbidity, and mortality. The Straud Institute is investigating a new method for periodic health examinations, adding the element of physician review of test findings as a part of the screening process.

Through a contractual arrangement, support is being given to investigations conducted by the Palo Alto Medical Clinic and the Denver Department of Health and Hospitals. The Palo Alto program is aimed at developing a plan for assessing the effect of an automated screening program in a group practice. In Denver, work is being conducted on development of a plan and systems design for an adult health maintenance program to provide service for an OEO-funded neighborhood health center.

The objectives of the program are: (1) to develop and refine operational methodology for providing automated multiphasic health screening/health assessment services, and (2) to conduct evaluative research on effectiveness and efficiency of automated multiphasic health screening in terms of its impact on the health status of the population screened. Moreover, it is hoped that after a few years, when many representative population groups have been screened, the available data will yield fundamental information about the natural history of chronic diseases.

During 1968, the following conferences were held at which outside consultants worked with central office personnel and key staff members of the demonstration projects to investigate in depth various aspects of the screening program: two conferences on quality control in the laboratory; the second annual project directors meeting; a conference on data processing and automation; and the second annual conference on evaluation. Work is progressing on plans for a conference to be held in January 1969, to consider possible approaches to be taken with regard to studies on cost effectiveness, cost analysis, and cost-benefit analysis.

OTHER ACTIVITIES IN AGING

An active program of research relating to the delivery of high-quality medical services to the aged is being supported by grants and contracts administered

by the center. Currently, approximately $1 million is being distributed by the center through 20 research and development grants which directly relate to the aging.

In addition to its interest in investigations relating to health screening programs utilizing automated techniques, the center is providing support to programs designed to test the effectiveness of traditional screening programs for the aged. In New Jersey, a demonstration is attempting to determine whether such a program can be effectively conducted by a local health department in an urban area. In New Orleans, a program now in its second year offers traditional health screening and clinic services in a high-rise public housing complex to the residents who are predominantly aged Negroes. This study is geared to determining to what extent this procedure can reduce the heavy load on existing facilities that serve the medically indigent.

A final report was received from a project originally funded by the gerontology branch through a contract with Washington University in St. Louis to conduct a national survey of physicians' attitudes toward aging and preventive health care for adult and aged patients. Among other factors, this report revealed that while health testing techniques are utilized by an appreciable number of physicians, for the most part such tests are used for diagnostic purposes rather than for health maintenance examinations of apparently well persons. The survey also indicated that the concept of adult health maintenance is accepted by more young physicians than older physicians, and by more internists than general practitioners.

Supported by a research grant, Community Studies, Inc., of Kansas City, Mo., is conducting a study on the effect of changing socioeconomic forces on the utilization and provision of health services for the aged. A publication is currently being developed on the utilization and provision of health services for the aged prior to the advent of medicare. Final preparation is underway for the collection of data on postmedicare experience.

Now in its second year is a program at Meharry Medical College through which clinical experience is provided for dental and medical students in a community adult health maintenance program. A serious hindrance to this program was lack of transportation by the elderly to the screening facility. Donation of a station wagon for this purpose eased the problem and resulted in a substantial increase of participants.

Other problems being investigated include such diversified subjects as "The Screening of Elderly in Nursing Homes," "Changing Community Patterns of Health Services for the Aging," "A Coordinated Approach to Protective Services to the Aged," "Prosthetic Architecture for Mentally Impaired Aged," "Medical Care of the Very Aged," "Home Aides Service and the Aged," "Health Adjustment of Older People in Small Towns," and "Medical Care Use of 1,000 Insured Aged, 1965 and 1968."

Protective Services

A National Institute in Protective Services for the Aged conducted on contract by the National Council on the Aging was cosponsored by the Adult Health Protection and Aging Branch along with eight other governmental and voluntary agencies. The purpose of the workshop was to identify barriers to the provision of protective health services in communities, assess the experience of protective services now furnished by a variety of State and local health and welfare agencies, and on the basis of this knowledge, develop a framework for action. The proceedings of this workshop were incorporated in a publication entitled "Overcoming Barriers to Protective Services for the Aged" and distributed to appropriate agencies.

Public Health Support of Health of the Aging Activities

The Partnership for Health legislation, enacted 2 years ago, broadened the emphasis of Public Health Service activities from programs of a categorical nature to a broad approach encompassing the total spectrum of comprehensive health services. In the new approach, two action thrusts are being made: (1) to remove inequities and inadequacies in access to and quality of personnel health care; and (2) to assure maximum protection against preventible disease and hazards in the environment.

Full recognition is given to the fact that the unique health needs of the aged often necessitate health services specially designed to meet these needs. At the

same time, with the current emphasis on planning for comprehensive health services, many individual activities which formerly would have been developed as free-standing programs for the aged are now being incorporated into comprehensive health programs for wider populations.

The budget request for appropriations for fiscal 1969 reflects the new approach. In recent years, budget requests contained a line item for programs for the chronically ill and aging. This categorical designation is no longer included. Instead, in the development of programs for general populations, due consideration is given by the Community Health Service and the National Center for Health Services Research and Development to applicability of such programs to the aging within these same populations. In the case of more narrowly applicable programs, however, the Community Health Service and the National Center for Health Services Research and Development weigh priorities for aging activities in relation to priorities for other target populations, and on the basis of such consideration, decisions are made on how much of the budgets of these agencies is to be channeled into health of the aging activities as such.

REPORT ON POSSIBLE COVERAGE OF PREVENTIVE HEALTH SERVICES UNDER MEDICARE

The Secretary of the Department of Health, Education, and Welfare was instructed by the Senate Committee on Finance to report to Congress by January 1, 1969, his findings and recommendations on the "possible coverage under medicare of the cost of comprehensive health screening services and other preventive services designed to contribute to the early detection and prevention of disease in old age, and the feasibility of instituting and conducting informational and educational programs designed to reduce illness among medicare beneficiaries and to aid them in obtaining medical treatment." (Note: such preventive measures, including immunizations and routine health examinations, are presently excluded from medicare.)

The National Center for Health Services Research and Development was given responsibility for collection, analysis and evaluation of essential data relating to the feasibility of including under medicare comprehensive health screening and other preventive services. The community health service was assigned the task of preparing that part of the report dealing with the feasibility of instituting and conducing informational and educational programs designed to improve the health status of the elderly. For both parts of the total report, staff efforts have been supplemented with consultative services from outstanding authorities representing many disciplines.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION,
Arlington, Va., March 5, 1969.

DEAR SENATOR WILLIAMS: This is in response to your letter of February 26, 1969, providing us with the opportunity to add to the "Report on Health of The Aged Activities in Public Health Service" originally submitted by us on December 3, 1968, to the Senate Special Committee on Aging for inclusion in "Development in Aging—1968."

An expanded version of that segment of the original report entitled "Aging Activities in the Community Health Service" is enclosed. We believe that the additional information contained in this portion of the report will be of interest to you, and we thank you for the opportunity to submit this material.

Sincerely yours,

KENNETH W. REVELL,
(For John W. Cashman, M.D., Assistant Surgeon General, Director, Community Health Service).

[Enclosure]

AGING ACTIVITIES IN THE COMMUNITY HEALTH SERVICE

The Partnership for Health legislation, enacted two years ago, broadened the emphasis of Public Health Service activities from programs of a categorical nature to a broad approach encompassing the total spectrum of comprehensive health services. In the new approach, two action thrusts are being made: (1) to remove inequities and inadequacies in access to the quality of personal health

care; and (2) to assure maximum protection against preventable diseases and hazards in the environment.

Full recognition is given to the fact that the unique health needs of the aged often necessitate health services especially designed to meet these needs. At the same time, with the current emphasis on planning for comprehensive health services, many individual activities which formerly would have been developed as free-standing programs for the aged are now incorporated into comprehensive health programs for wider populations.

In October 1968, the Division of Medical Care Administration was merged with the Office of Comprehensive Health Planning to form the Community Health Service. It brought to the Community Health Service a significant program commitment to the health needs of the aging, especially, because of its responsibilities in the professional health aspects of Medicare. The Division of Medical Care Administration was particularly active in the areas of standards development for providers, certification of health service providers, and assistance to providers to enable them to meet Medicare standards. By the end of fiscal year 1968, 6,966 hospitals, 2,181 home health agencies and 6,048 extended care facilities had been certified to participate in Medicare.

The Community Health Service carries out programs designed to meet the unique health needs of the aged through stimulation and improvement of community services, development of educational materials and through the conduct of information programs.

The Division of Health Resources in the Community Health Service is concerned with the development of activities to improve services provided in hospitals and in nursing homes and related facilities, and to stimulate the development of a broad range of home health services to meet the health needs of the population, including the aged living in the community.

Responsibility for the development of additional activities for the aged, as appropriate and feasible, has been delegated to the Division of Health Care Services. The component programs of the Division are giving consideration to the needs of the aged in the process of developing comprehensive health services for communities and for groups with special needs, such as the rural and urban poor, residents of underdeveloped and developing areas, and agricultural migrant workers.

To coordinate, stimulate, and provide a focal point for the diverse Public Health Service efforts and resources in health services for the aged, a position has been established for a Coordinator for Aging in the Division of Health Care Services. The Coordinator for Aging has responsibility for keeping constantly aware of all the health and health-related activities for the aged conducted by operating units within the Department of Health, Education, and Welfare, and by other governmental agencies.

HOME HEALTH

The Public Health Service collaborated with the Office of Economic Opportunity and with the Administration on Aging in developing a group of pilot training projects to train poor, older individuals to become home health aides. Seventeen completed community projects trained 974 persons, and all but 151 were immediately employed in a variety of health facilities. To date, 2,000 copies of an advanced version of guidelines for recruitment, selection, training, employment and utilization of home health aides have been distributed to interested programmers.

The year's numerous activities served to provide information on home health care and home health agency development. A new film strip on home health services was produced and copies sent to the Public Health Service Regional Offices for their use in promotion of home health services. An exhibit on home health aid services was developed and used for the first time at the May meeting of the National Social Welfare Conference in San Francisco. A publication entitled "Tri-Hospital Home Care," depicting how Passaic, New Jersey, developed a home care program, was produced and given extensive distribution to State health, welfare and nursing departments, voluntary and professional organizations, schools of public health, and Public Health Service regional offices.

LONG-TERM CARE FACILITIES

A pilot program for using nursing homes to teach undergraduate medical students selected elements of geriatric and community medicine was implemented with the University of Vermont College of Medicine. The first quarter

project report indicates that 18 of the 44 fourth-year students elected to participate in the program and that the Director considers the project to be valuable and successful, in excess of their anticipation, and that they look forward to continuing growth.

A State-Public Health Service Cooperative Improvement Program for nursing home inspection was initiated at a national meeting in Dallas, Texas, in May 1968. This program was subsequently implemented through Regional Conferences and through the appointment of an ad hoc committee composed of State personnel responsible for licensure of health care facilities. The committees are developing a uniform nursing home survey form and model State licensure regulations. Training programs for State surveyors and consultants are also being developed.

New legislation in the form of an amendment to Title XIX of the Social Security Act requiring the licensing of nursing home administrators by July 1, 1970 has increased activity in the area of training nursing home administrators.

To assist States in preparing for the development of more extensive educational programs to improve the quality of long-term care administrators, continued emphasis was placed on university-based seminars. Eight State universities held seminars with approximately 400 participants representing 15 States. A project was developed with the Professional Examination Service of APHA to prepare examination questions and core examinations for State licensure of nursing home administrators and for the selection of qualified surveyors by State and local authorities.

Close working relationships have been maintained with the Division of Allied Health Manpower in the development of a curriculum offering more extensive educational opportunities for community-based education of long-term facility administrators. Direct staff support is being provided to the National Advisory Council on Nursing Home Administration to assist the Council in carrying out its functions.

A total of 39 short-term training grants were stimulated in 27 States to enhance the professional competence of personnel (i.e., administrators, pharmacists, therapists, dietitians, nurses, social workers, etc.) working in long-term care facilities.

PROFESSIONAL EDUCATION

The paucity of teaching programs and resources required to train health professionals oriented to comprehensive health care is of particular importance to the aging and aged in the population. For while this inadequacy adversely affects the health status of the total population, the impact is especially sharp among the aging and aged who are more vulnerable to illness and disability.

As a means of stimulating interest in developing undergraduate medical curricula that provide orientation in comprehensive patient management, the Public Health Service last year negotiated contracts with three medical schools to develop "blueprints" for teaching programs in this subject area. These were the School of Medicine of the University of Missouri, the School of Medicine of Tufts University, and Mount Sinai School of Medicine of the University of New York City. This year two additional contracts for planning of model teaching programs in comprehensive patient management were negotiated with the schools of medicine of Boston University and the University of Southern California.

Supported by a contract negotiated with the Public Health Service, the University of Pennsylvania School of Social Work completed the third and final year of providing its students with supervised field experience in work with the aged. This demonstration of social work within a nursing home conducted under the auspices of the Philadelphia Welfare Department was so successful that a supervisor of social work and four additional social work positions involving work with the aged were put into the City budget.

EDUCATIONAL MATERIALS

The development under contract of a comprehensive body of knowledge in applied gerontology was completed by the Gerontological Society to be released by the Community Health Service as a four-volume series entitled "Working With Older People: A Guide to Practice."

Volume I, "The Practitioner and the Elderly" has received enthusiastic reception from the medical profession as well as from other health practitioners and educational institutions. More than 20,000 copies have been distributed or sold, and requests for copies continue to be received daily. Attesting to the usefulness of

the volume as a training resource are the highly commendatory reports submitted to the Public Health Service by medical organizations, schools of nursing and social work, and other organizations concerned with the training or orientation of individuals who work with the aged.

Volume II, "Biological, Psychological and Sociological Aspects of Aging," Volume III, "The Aging Person: Needs and Services," and Volume IV, "Clinical Aspects of Aging," will be available within the next year.

Hopefully with the availability of all four volumes, efforts will be directed toward the development of specially designed training programs that will utilize this valuable resource material for continuing education in applied gerontology for physicians, nurses, therapists, social workers, and the many other professionals who work with the aged.

Particular emphasis will be placed on use of this resource material in the development of orientation programs for the practicing physician, for it is he who is the key member of the team at the primary care level. "Working With Older People: A Guide to Practice" alerts the physician to the need to consider psychological and social factors along with physical factors in the treatment of the elderly patient. Treatment of the whole person rather than the symptom is a philosophy the Community Health Service is attempting to engender among physicians for patients of all ages.

OTHER ACTIVITIES

During 1968, two health counseling projects supported by the Public Health Service in cooperation with the Social Security Administration were completed.

Located in Milwaukee, Wisconsin, and Peoria, Illinois, the projects were designed to develop and test a method of providing personal health counseling which will motivate older adults to take positive action to protect their health. One new project begun in 1968 in Fresno, California, will continue through July 1969; the New Orleans project, which was started in 1967, is nearing completion. All of these contracts are utilizing a similar population sample, individuals 62 years of age or older who are applicants for Social Security retirement benefits. Preliminary data indicate an increase in adequate health maintenance routines after counseling.

Reports from the National Audiovisual Center in Atlanta, Georgia, reveal continued high interest in the two Public Health Service films which relate to health of the aging. "The Critical Decades" focuses on the need for health protection for individuals in their forties and fifties to insure good health in the later years. "Ready for Edna" gives historical perspective on development of health services through the years, and describes the broad range of health services which ideally should be available in communities throughout the nation. The films were loaned for showing to 1,000 organizations in 1968. Such organizations included: voluntary and governmental health agencies; a broad range of teaching institutions including schools of medicine, nursing, public health and pharmacology; hospitals; professional and voluntary medical organizations; and commercial and educational television.

ITEM 10: PUBLIC HEALTH SERVICE, DIVISION OF REGIONAL MEDICAL PROGRAMS, HEALTH SERVICES, AND MENTAL HEALTH ADMINISTRATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION,
Bethesda, Md., December 20, 1968.

DEAR SENATOR WILLIAMS: I was pleased to receive your letter of November 25 and to learn of your further interest in regional medical programs. . . .

As you requested, I am attaching a brief statement on regional medical programs and its relationship to preventive medicine and the elderly, for inclusion as an appendix to the annual report of the Senate Special Committee on Aging.

We hope this is helpful to you. If we can be of further assistance, please let me know.

Sincerely yours,

STANLEY W. OLSON, M.D.,
Director, Division of Regional Medical Programs.

[Enclosure]

REGIONAL MEDICAL PROGRAMS

The purpose of regional medical programs is, through grants, to assist the Nation's health institutions and professions in putting into widespread practice the most recent and effective advances of scientific medicine in the prevention, diagnosis, treatment and rehabilitation of heart disease, cancer, stroke, and related diseases; and thereby to improve the quality of care provided patients suffering from, or those threatened by, these diseases. The enabling legislation (Public Law 89-239) requires that this be accomplished through a process of voluntary regional cooperative arrangements among medical schools, hospitals, practitioners, and other health resources.

The efforts of regional medical programs to improve health care in the areas of heart disease, cancer, stroke, and related diseases include prevention (especially secondary prevention and early diagnosis) as well as treatment and rehabilitation. Many of the regional programs have already initiated activities concerned with prevention and preventive health services, and more are being planned. These activities should be particularly beneficial to the elderly population whose high susceptibility to the health threats posed by heart disease, cancer, stroke and related diseases suggests the need for a broad range of preventive services.

The activities developed and supported under RMP to date are diverse and broad, and reflect local initiative, decisionmaking and control which are characteristic of regional medical programs. They include continuing education and training programs for health professionals in prevention and screening methods, multiphasic screening programs, detection programs for specific disease entities, and public education programs. Though these activities are not aimed solely at the elderly population, it is anticipated that many elderly persons within these regions will particularly benefit from many of these services.

Regional medical programs are still in the developmental stages, with most regions just now making the transition from the planning to the operational phase. It is anticipated that as more regional programs become operational and continue to grow and develop, many more activities related to preventive health services relating to heart disease, cancer, stroke, and related diseases will be initiated.

ITEM 11: PUBLIC HEALTH SERVICE, ADULT DEVELOPMENT AND AGING BRANCH, NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
NATIONAL INSTITUTES OF HEALTH,
Bethesda, Md., December 30, 1968.

DEAR MR. CHAIRMAN: The summary of the activities of the National Institutes of Child Health and Human Development on behalf of the elderly that you requested for inclusion in your annual report is attached.

It is a pleasure to supply you with this information.

Sincerely yours,

LEROY E. DUNCAN, Jr., M.D.,
Chief, Adult Development and Aging Branch, National Institute of Child Health and Human Development.

[Enclosure]

ADULT DEVELOPMENT AND AGING BRANCH, NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

The Adult Development and Aging Branch (ADAB) is responsible for the stimulation and support of a program of studies on the biological, medical, psychological, and social aspects of life from early adulthood through senescence. With increasing age, changes occur in many of the physiological and biological systems of humans. Studies of these changes at the cellular and organismic level with age and the variables that influence them constitute prime areas of programmatic interest. The analysis of problems of aging by the behavioral and social scientists is also of great concern to the ADAB.

During fiscal year 1968 the NICHD supported 68 research grants on problems related to aging at a cost of $3,549,331 and 23 training grants at $1,955,880. There were four fellowships funded at $61,017 and seven research career development awards at $154,594. In addition to this support of research in universities and institutions throughout the country, the NICHD conducts direct research on the problems of aging at the Gerontology Research Center located at the Baltimore City Hospital. During 1968 the Gerontology Research Center moved into a new building which provides expanded facilities for conducting research. The staff of the Center is concerned with cellular, physiological, and phychological changes with age.

An International Directory of Gerontology has been prepared and is being published. This directory which was prepared under contract by the Gerontological Society should fill a longstanding need for a source that provides information on persons and institutions involved in research on aging. It consists of listings and biographical descriptions of personnel, listings of institutions with major commitments to research and training in gerontology, scientific and professional organizations in the field, and resources of value in aging research. The directory is expected to be available to the public early in 1969.

The Aging Information Center of the NICHD is in full operation and the first issue of the Aging Abstract Journal is to be published during January 1969. The journal will be published periodically and will contain abstracts of articles on problems relevant to aging in various fields. The abstracts will also be stored on computer tapes which can be easily searched to obtain specific types of information.

The NICHD continues to place emphasis on the development of university-based training programs. These programs support graduate and postgraduate students who are learning to conduct research that bears on the problem of aging. Because of the importance of training to the future development of research, considerable importance is attached to planning for future training. The Gerontological Society has prepared, under contract, a report on "Training Needs in Gerontology." Information for this report was collected through conferences of scientists and educators interested in aging and by interviews at selected training sites. The report identifies the need for increases in number and diversity of research projects in order to assure an increase in the number and diversity of training opportunities.

The longitudinal study is a very valuable means of looking at the changes—physiological, psychological, and social—which occur with the passage of time. Such studies provide unique opportunities to study these changes within individuals as well as among individuals. The NICHD held a small planning conference attended mainly by biostaticians in preparation for a larger conference which will deal with the statistical design and related problems of longitudinal studies. At the larger conference there will be representatives from each of the federally sponsored longitudinal studies on aging. This will be the second in a series of conferences concerned with the problems of longitudinal studies. The first was held at Duke University and provided the opportunity for a discussion of the similarities and differences of the goals, populations, and methodology involved in the different studies.

It has been discovered that normal cells in tissue culture do not live indefinitely. In order to focus on this finding the Institute sponsored a workshop during which discussion centered around this discovery. The implications and significance of the discovery were explored. It may prove possible to use tissue culture as a greatly simplified experimental model of one aspect of human aging.

During 1965, NICHD began a series of conferences on varied aspects of retirement. In the first four of the conferences emphasis was placed on the psychological impact of retirement on the individual and on the interrelations of chronic disease and retirement. The papers of the first conference have been published as a book titled "The Retirement Process." The ADAB has a contract with the American Institutes for Research to prepare a report which presents 12 theoretical models of the retirement process. The models will consider several aspects of retirement—biological, psychological, and social. Such models can serve to guide research on retirement by providing hypotheses and theories which research can then test. The conference held during 1968 was concerned with adult socialization and retirement. Aspects and conditions for socializing persons to an aged role and to retirement were considered.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
March 5, 1969.

DEAR MR. CHAIRMAN: Thank you for your letter of February 26 offering me the opportunity to add additional information to NICHD's contribution to "Developments in Aging—1968." I believe it would be worthwhile to add the following paragraph to our report.

"Plans have been made to support by contract a Summer Course in the Basic Biology of Aging at the University of California at San Diego in the summer of 1969. This course will last three weeks and will be conducted by a faculty selected from a number of universities. The students will come from many universities. Most of them will be persons currently working toward a doctorate in one of the life sciences. It is hoped that this course and subsequent ones will help create foci concerned with this basic biology of aging within the academic world."

I particularly appreciate the opportunity to add this information since I believe the type of course planned will prove to be very useful in the development of this area of research.

Sincerely,

LEROY E. DUNCAN, Jr., M.D.,
Chief, Adult Development and Aging Branch,
National Institute of Child Health and Human Development.

ITEM 12: PUBLIC HEALTH SERVICE, NATIONAL INSTITUTE OF MENTAL HEALTH

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
NATIONAL INSTITUTE OF MENTAL HEALTH,
Chevy Chase, Md., December 18, 1968.

DEAR SENATOR WILLIAMS: In reply to your request of October 23, 1968, I am enclosing a report summarizing the activities of the National Institute of Mental Health in the field of aging during 1968.

If I can be of further help, please let me know.

Sincerely yours,

STANLEY F. YOLLES, M.D., *Director.*

[Enclosure]

REPORT OF ACTIVITIES, NATIONAL INSTITUTE OF MENTAL HEALTH, DURING FISCAL YEAR 1968 IN THE FIELD OF AGING

Within the National Institute of Mental Health's overall goal of improving the mental health of the people of the United States, it has a specific interest in aging persons, in view of the fact that persons of advanced years are particularly vulnerable to disabling mental impairment. Though, in 1965, the estimated proportion of the population 65 years of age and over was 9.4 percent, the elderly comprised 29 percent of all residents in mental hospitals in that year and 19 percent of their first admissions. An estimated 55 percent of the patients in nursing homes and other facilities serving the chronically ill are mentally impaired persons. Further, various studies have estimated that anywhere from 15 to 25 percent of elderly persons living in their own residences have some degree of mental impairment. Hardly a person in this country remains untouched by the plight of an old person who is either a relative, friend, or neighbor, with some chronic illness, frequently in combination with a degree of mental disability.

NIMH has focused its concern for the aging in gathering knowledge through research into treatment and rehabilitation of those elderly persons who are already mentally disabled, the development of information and methods to help persons in advanced years sustain their mental health in a rapidly changing world, the training of manpower to serve the aging, and the gathering of information to learn more about the processes of aging including the effects of social and environmental factors and the life crises of retirement. NIMH has further used its resources of personnel and funds in the improvement of mental hospital services for the aging, the development of specialized services for the aging in the community mental health center programs, and, though the medicare and medicaid

programs are the administrative responsibility of the Social Security Administration and the Social and Rehabilitation Service, NIMH has offered consultation, standards and policy development for the psychiatric mental health aspects of these programs.

The Division of Special Mental Health Programs is responsible for coordinating the Institute's efforts for the aging and stands in the role of advocate for research and other programs for improving and sustaining the mental health of the aging not only outside the Institute but also within its several divisions. The Division has a specific program responsibility for the development of knowledge and innovative services for the mentally impaired and the improvement and sustaining of the mental health of the aging person.

The research studies on aging funded in 1968 throughout NIMH total over $2 million. Among these studies are research into the factors which may affect intelligence, including the extent to which the structure of human intellect changes with age, methods for choosing the best drug for geriatric patients, and the measurement of physiological change which takes place in response to psychological factors, in the hope that methods can be devised to reverse the excessive physical reactions to emotionality in the aged as well as in the young.

The Division of Special Mental Health Programs in fiscal year 1968 had program responsibility for 18 extramural applied research studies which amounted to $1,365,000. These studies can be divided into those concerned with the mentally impaired aged in both institutions and the community and those concerned with sustaining and developing knowledge of the processes of aging, including the effect of social and environmental factors.

RESEARCH FOR THE MENTALLY IMPAIRED AGED

NIMH has been particularly interested in developing innovative methods of care for aged persons in institutions which will improve their adjustment and/or rehabilitate them for a return to the community. One such study at the University of Michigan includes a 2-year study of four alternative treatment programs in a mental hospital using 200 male and 200 female patients, and a concurrent followup investigation of 120 patients discharged for further care to three types of community facility. One of its major aims is the determination of the technology of milieu therapy for recently admitted and chronic mental patients. Results already indicate the superiority of certain activities such as the sheltered workshop program and ward chores over more conventional activity therapy for motivating patients to healthier behavior. This program has raised patient and staff expectations for improvements in even very chronic patients.

Another research project which is attempting to develop a new way of improving the mental health of the aged is being carried out at the Hebrew Home for the Aged in the Bronx through a sheltered workshop program for mentally impaired residents. Residents with different levels of mental disability are provided with a workshop experience plus supporting services. Medical, psychiatric, and psychological tests and case conference evaluations are being used to determine if these residents have a capacity to sustain participation in a work program and to derive therapeutic benefits from it as measured by maintenance of their functional health situation and better adjustment to the infirmary environment.

Studies of alternatives to care in the State mental hospital for aged mentally disabled patients, where appropriate, are being conducted including one study examining the utilization of nursing homes by ex-mental patients. This type of placement has been increasingly used by mental hospitals. Research carried out at Northeastern University in Boston included the examination of several factors involved in the successful transition of patients from mental hospitals to nursing homes. The findings indicate the most critical period for the patient is within the first month of placement. Two major factors appear to enter into the successful transition of patients from mental hospitals into nursing homes, the patient's attitude toward the placement, and the effectiveness of the nursing home staff in dealing with the patient's problems of adjustment. This study also found that a community oriented program of therapeutic intervention with a team of a psychiatrist, nurse, and social worker as well as others working with the nursing home staff in the case of the ex-mental patient, resulted in a significant reduction in the number of deaths and rehospitalization in the first 6 months of placement in comparison with another group not having these services. However, such intervention did not reverse the course of the patient's illness.

Baylor University in Houston is developing knowledge on the care of the mentally impaired aged person. This project was undertaken to show that if comprehensive services are provided, mental hospitalization of the mentally disabled aged is not always necessary. One hundred consecutive applicants 65 years of age and over are being studied and served by an interdisciplinary geriatric diagnostic team. Existing community resources and the services of the team are being utilized for rehabilitation and treatment. This group of patients is being compared with a group of 100 patients who applied for admission prior to the study. Thus far quite striking differences have been found between the physical living arrangements of the experimental and control group after discharge from the diagnostic center. Only 41 of the patients who had the benefit of the geriatric team went to a mental hospital, as contrasted with 72 patients in the comparison group.

Another project is investigating how to care for the mentally disabled aged person living in the community. The National Council on Aging is examining the possible ways of developing an integrated approach to services and care of such persons. Evaluation is now in progress of one year's experience in demonstration service centers in Houston, San Diego, and Philadelphia. Preliminary findings stress the value of availability of legal, medical and psychiatric services and consultation for decision making concerning the care of the aging person in the community who appears to be in need of services for his own protection.

RESEARCH ON DEVELOPING KNOWLEDGE AND SERVICES TO SUSTAIN THE MENTAL HEALTH OF THE AGING

These studies are concerned with identifying factors which may affect the mental health of aging persons and the development of supportive services to help aged people sustain their mental health.

Funds have been awarded to the University of Southern California to investigate the specific types of housing which the aged perceive as ideal. This study includes the measurement of functions which the elderly would like housing to perform and the patterns of relationship of need, need fulfillment and satisfaction with personal characteristics and specified types of housing arrangements. The Philadelphia Geriatric Center is examining the effects of various kinds of services offered in group housing arrangements for aged individuals. Several group housing settings are being surveyed including public housing, nonprofit and commercial housing. Sites offering one or more services will be compared with those offering none, in terms of significant changes in the tenant's social adjustment and mental and physical health.

Other research is examining the crisis of retirement and its impact on the aged person. The Harvard Medical School aims to identify recognizable patterns of behavioral response to loss of occupation through retirement. Five hundred male and female Boston residents up to 67 years of age who have been retired for less than 3 years are to be included. This research may contribute to our understanding of the factors which influence the nature of individual responses to retirement.

Another study being carried out at Nova University in Fort Lauderdale is making a survey of retired scientists and is directed toward learning what their present interests are and their reactions to retirement. Findings may indicate that the retired scientists are a neglected resource for the use of industry and government.

Other studies of methods to sustain the aged person's mental health in the community through supportive services are being carried out. The Community Service Society in New York City is demonstrating that mature nonprofessional workers can provide information and referral services to help elderly persons in public housing sustain their emotional, social, and physical functions. Senior advisory workers were made available in four public housing projects to 955 residents, 60 years or older. Preliminary findings of this study indicate that 87 percent of the aged persons living in the projects were seen or directly affected by the service. Their major problems were their inability to utilize community resources independently, physical health, and inadequate incomes. Among the major services given by this project were that of information and helping the aged person get to the agencies as well as the giving of advice and reassurance on problems.

The Family Service Association of America in five member agencies throughout the country is using a social work team, consisting of a trained caseworker and a social work assistant, who is agency trained, to carry cases. Where appro-

priate, continuing services to the client are assigned to the assistant. In view of the short supply of trained personnel, the determination of the areas in which the untrained nonprofessional worker may appropriately function is expected to contribute to services for the aging.

TRAINING

The shortage of trained personnel to care for the mental health needs of the aging continues to be a critical problem. More than $500,000 was expended by NIMH for the development of manpower for the aging in fiscal year 1968. Seventeen training program grants were awarded to universities specifically for assistance in training professional manpower in social work, psychiatry, nursing and psychology. Fourteen of these programs were in social work schools and included a total of 74 trainee stipends. Many of these program encourage prospective social work students who have an interest in working with older people to pursue that interest through appropriate field placements and later employment.

A grant for the continuing education of professional persons working with the aging has been awarded to the University of Southern California. Its objective is to increase the competence of professional personnel in dealing with the mental health problems of the aging through the presentation of current research findings and information on the problems involved in terms of individual and community processes and the provision of an interdisciplinary approach to basic information. Three types of professional personnel will be involved in this project: those who work directly with the aging; for example, psychiatrists, psychologists; those who have administrative or planning activities with the aging; for example, nursing home administrators, lawyers, certain local government officials; and those whose knowledge of mental health problems will help their supervisory functions including ministers and adult educators.

Six research fellowships were also awarded in the area of aging, five of which went to graduate students at the Ph. D. level in anthropology, social welfare, human development, and psychology. One fellowship was given to a psychiatrist for research development of psychiatric treatment modes which will prevent or forestall mental hospitalization of the aging.

HOSPITAL IMPROVEMENT PROGRAM

The hospital improvement grant program is specifically focused on the introduction of current knowledge and techniques to units in individual State mental hospitals demonstrating improved services and care with the ultimate goal of improved patient care throughout the entire institution receiving the grant.

Eighteen HIP grants totaling more than $1,300,000 were given to mental institutions in fiscal year 1968 where the major focus was on aged patients.

Most of the projects aimed to reduce the length of stay for aged patients in mental hospitals through placement in the community and/or to restore a greater degree of social functioning and/or to provide physical rehabilitation services and/or to develop more adequate means of screening the aged inpatient population. One project at the Mental Health Institute in Iowa has established a semi-autonomous treatment unit under a psychiatrist for geriatric patients. Services within this project include physiotherapy and social work. Preliminary reports indicate that this program has greatly improved the care of geriatric patients and that the average length of stay for geriatric patients has been reduced from 122 days to 71 days. Another project at the Madison State Hospital in Indiana has upgraded the treatment of geriatric patients through offering the aged patient a milieu which places emphasis on the social aspects of normal life through group therapy, community participation, vocational remotivation, and training where indicated and physical therapy. Privacy for the patient has been accented, as, for example, tubs now have shower curtains and toilets are enclosed in stalls. Patients have been taught to use modern electrical equipment such as washers and dryers, and offground trips are planned weekly, and have proved to be most popular with patients. At present 45 patients have been discharged through this program, 50 patients are on leave, and 34 patients are still in residence.

A project at the Eastern Shore State Hospital in Maryland aims to prevent the further mental deterioration of newly admitted aging patients already under care. The basis of this program is a therapeutically oriented treatment team headed by a psychiatrist with nursing service personnel, social workers, and rehabilitation workers which emphasizes the development of a strong interpersonal relationship between staff and patient. A 24-bed unit with an equal number of men and women is being used for this project. In the first 18 months of the

project, 99 patients, whose average age was 79, participated. Fifty-one patients have been placed outside the hospital, of which number eight patients have been returned. This project is being used to orient new personnel in a positive way toward the elderly patients in the hospital.

COMMUNITY MENTAL HEALTH CENTERS

Thirty community mental health centers throughout this country have specialized geriatric services. One of these programs, in area C of the District of Columbia, has a unit in which patients over 65 can obtain inpatient, outpatient, whole or partial day care treatment as well as medications. Nearly half of the 168 patients seen in a 1-year period were able to continue to live in the community. Most attended a day care program a few days each week. Use of the center avoided unnecessary admittance to mental hospitals.

The Appalachian Comprehensive Care Center in Ashland, Ky., offers a program to help sustain mental health of the aged living in a high rise apartment project for the elderly. This program consists of group activities, individual counseling and social and diversional programs conducted by volunteers under the leadership of professionals from the center. The Massachusetts Mental Health Center at Boston has a geriatric team composed of a psychiatrist, psychologist, social worker, and nurse. Its catchment area has a population of approximately 14 percent over 65 years of age and also has a high proportion of persons between the ages of 55 and 64. This geriatric team will provide consultation and education within all levels of the community. Target groups for consultation are nursing homes, golden age groups, and housing projects, general hospitals, and churches.

HEALTH INSURANCE AND MEDICAL ASSISTANCE PROGRAM

The National Institute of Mental Health is concerned with the development and extension of mental health services through the health insurance and medical assistance programs—titles XVIII and XIX—Public Law 89-97. The primary goal is to make the benefits for the mentally ill comparable to those available to persons who experience other kinds of illness. Implementation of standards for delivery of quality care, encouragement of additional resources, and new approaches to services delivery are major concerns.

The utilization review procedures for psychiatric facilities required of all providers of health services under medicare have been explored in depth at a conference NIMH jointly sponsored with the American Psychiatric Association. A monograph has been printed and distributed to assist psychiatric facilities in utilizing this procedure for the upgrading of patient care. NIMH consults with the State mental health agencies to further effect collaboration with the single State agency administration of the title XIX plans. Two workshops have been held for NIMH regional office staff to inform them about the health insurance and medical assistance programs. Resource materials have been distributed to both regional offices and State mental health authorities concerning policies and standards of care.

Three State conferences were held by NIMH in cooperation with the American Hospital Association to encourage general hospitals to become more involved in a community mental health program. A study is in process to examine possible new resources for care of the mentally disabled within the community. State and local programs that appear to be successful in providing treatment for the aged mentally impaired in their homes are under study.

A study of preventive care is under way to develop mental health screening services designed to contribute to early detection and prevention of mental illness. Screening mechanisms could be extremely important in determining alternatives to institutional care for elderly persons and in making early treatment possible.

ITEM 13: SOCIAL AND REHABILITATION SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL AND REHABILITATION SERVICE,
OFFICE OF THE ADMINISTRATOR,
Washington, D.C., November 29, 1968.

DEAR MR. CHAIRMAN: In response to your letter of October 22, I am enclosing a summary of the activities of the Social and Rehabilitation Service during 1968

affecting older Americans. As requested, activities of the Administration on Aging and the President's Council on Aging are not included in this part of the report.

Please let me know if you would like any additional information.

Sincerely,

JOSEPH H. MEYERS, *Acting Administrator.*

[Enclosure]

ACTIVITIES OF THE SOCIAL AND REHABILITATION SERVICE DURING 1968 AFFECTING OLDER AMERICANS

The Social and Rehabilitation Service administers a variety of programs of great significance to older Americans. It is responsible for the income support programs for needy Americans of the Department of Health, Education, and Welfare as well as the social services and rehabilitation programs.

Within the Social and Rehabilitation Service, the Administration on Aging, the Assistance Payments Administration, the Medical Services Administration, and the Rehabilitation Services Administration all have responsibilities for programs serving older persons. The Administration on Aging is submitting a separate report on its activities during 1968. The program activities undertaken during the past year by the other components of SRS include the following:

OLD-AGE ASSISTANCE

Through the old-age assistance program, the Assistance Payments Administration served about 2,019,000 persons 65 and over in June 1968. This is a marked decline from the alltime high of 2,810,000 in September 1950, despite the steady increase in the number of aged people in our population. The decline is due to the rapid increase in the number of persons receiving old-age, survivors, and disability insurance (OASDI).

All 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands have OAA programs. The national average in June 1968 was about $68 for maintenance.

To encourage dependent people to make a greater effort to earn at least a part of the money they need, new provisions in Federal legislation, effective October 1, 1965, permitted States to allow OAA recipients to keep up to $50 a month in earnings without having their public assistance payments reduced, in addition to $5 a month from any source. Effective January 2, 1968, Federal legislation increased the amount of income from any source that a State may disregard from $5 to $7.50 a month. In all, 33 jurisdictions permit some income to be retained by aged recipients.

According to a 1965 study, the median age of old-age assistance recipients was nearly 77 years, an increase of about 2 years over the median age in 1953. The proportion of those living alone in their own homes increased from 27 percent in 1958 to 35 percent in 1965. During the same period, however, the proportion requiring help from others rose from 18 to 27 percent, including a rise from 5 to 9 percent for those living in institutions. In 1965, recipients were older, less mobile, and were increasingly the victims of chronic illness. More than two-thirds of the recipients were women.

MEDICAL ASSISTANCE

The Medical Services Administration is responsible for providing medical assistance for the aged under any of three programs: Medical assistance under title XIX (medicaid), medical assistance for the aged (Kerr-Mills), or medical-vendor payments paid out of public assistance grants.

In 1968 the number of States and jurisdictions operating medicaid programs rose to 42. South Carolina, the District of Columbia, and Guam began programs this year. In these 38 States and four jurisdictions live 79 percent of the population over 65. In 27 medicaid programs the "medically needy" aged as well as the "needy" aged are included. In 15 medicaid programs only the needy aged are included. The needy are those who are receiving public assistance payments; the medically needy are those who have enough income or resources for their daily needs but not enough to pay for their medical bills. This group was first given medical assistance in 1960 under the provisions of the Kerr-Mills program, also known as medical assistance for the aged (MAA). Of the States that do not yet have medicaid, nine States have MAA programs, and three make medical-vendor payments under their old-age assistance programs (OAA).

As States adopt the medicaid program which was authorized in 1965 by title XIX of the Social Security Act, that program supercedes all other medical assistance programs paid for out of public assistance grants. States must adopt medicaid by January 1, 1970, or they will lose the funds they now receive from those grants.

In fiscal 1968, approximately $1,837 million of Federal funds was spent for medical services under medicaid.

Among the benefits of medicaid is that it permits the Federal Government to contribute to the cost of the care of aged individuals in institutions for mental diseases and tuberculosis. Some 28 States have programs for assistance to the aged in institutions for mental diseases and during fiscal year 1968 over 67,000 mental patients over 65 were enrolled in the program. The States involved received about $140 million of Federal funds to help them improve the care of the patients and to develop comprehensive mental health programs.

States with medical assistance programs under title XIX (medicaid):

California	Maryland	Oregon
Connecticut	Massachusetts	Pennsylvania
Delaware	Michigan	Puerto Rico
District of Columbia	Minnesota	Rhode Island
Georgia	Missouri	South Carolina
Guam	Montana	South Dakota
Hawaii	Nebraska	Texas
Idaho	New Hampshire	Utah
Illinois	Nevada	Vermont
Iowa	New Mexico	Virgin Islands
Kansas	New York	Washington
Kentucky	North Dakota	West Virginia
Louisiana	Ohio	Wisconsin
Maine	Oklahoma	Wyoming

States with medical assistance for the aged programs:

Alabama	Colorado	North Carolina
Arizona	Indiana	Tennessee
Arkansas	New Jersey	Virginia

States making medical vendor payments under old age assistance programs:

Alaska	Florida	Mississippi

The 1967 amendments to title XIX of the Social Security Act include several provisions designed to improve the care of aged people. After July 1, 1968, nursing homes were required to be licensed in their States. In addition, the legislation spells out standards for medical review, nursing care, sanitary, safety, record-keeping and other services that must be met by skilled nursing homes (under staggered deadlines) if they are to receive funds under title XIX.

Another provision requires nursing home administrators to be licensed by the States under their Healing Arts Acts after January 1, 1970. A National Advisory Council on Nursing Home Administration has been appointed, in accordance with the legislation, to advise the Secretary of Health, Education, and Welfare and the States on the licensing of administrators and the kind of education and training they need before being licensed.

After July 1, 1970, States must also provide home health services for all those who are eligible for skilled nursing home care.

The legislation also recognizes a new form of long-term care—an intermediate care facility. Such a facility does not come under title XIX, but under title I. However, States may be reimbursed for care of needy people in these homes under the same formula as is used for care given medicaid patients in skilled nursing homes. Intermediate care facilities are meant to serve patients who require institutional care but do not require hospital or skilled nursing care. Only public assistance recipients may qualify for this facility.

DEMONSTRATION PROJECTS UNDER SECTION 1115 OF THE SOCIAL SECURITY ACT

The demonstration projects program in public assistance under section 1115 of the Social Security Act provided grants for at least 14 different projects during the calendar year 1968 which were totally or partially concerned with providing a variety of services to elderly recipients of public welfare. These projects were carried out under the auspices of State public welfare agencies.

Two States participated in model projects under a National Plan for Protective Services to the Aged. One State carried out its protective services program in a metropolitan area, serving the elderly through two district offices. The second State experimented with the delivery of protective services in several rural counties. These projects are designed to increase knowledge and skills in the provision of protective social and legal services to older adults; to demonstrate the process and values of a multi-discipline approach in providing protective services on the part of a local department of public welfare; and to develop specific criteria to identify and define protective services as well as the roles of the respective disciplines participating in the provisions of such services.

The Texas State Department of Public Welfare continued to carry out a demonstration in the provision of comprehensive services to the aged, ill, and handicapped recipients in public housing in Dallas and Houston. Through this project gaps in service to the elderly were identified; staff attempted to eliminate these gaps by more adequately meeting the needs of the elderly for social services; and valuable data was collected for projecting administrative and service costs involved in extending adult services on a broader basis.

The Mississippi Department of Public Welfare has had a project to extend services to the elderly on the public assistance caseload from a few selected counties to the broad statewide program. As an integral part of this project a consultant on services to aging was employed by the State agency. The major focus on the project's efforts has been on the identification and study of the potentials for improved family and individual functioning of elderly recipients and for reducing and eliminating dependency.

A number of States have been demonstrating the value of providing homemaker services to elderly public welfare recipients. Through the homemaker projects many elderly clients have been helped to either remain in their own home or return to their home following hospitalization. This would not have been possible in most of the cases if such homemaker service were not available. Several States have been experimenting with the use of the group method in working with clients. The establishment of OAA groups has proved to be most effective in encouraging many elderly to participate in community life and to maintain, renew, or enter into, new and meaningful friendships. Group participation has also stimulated interest in activities which might have been abandoned if there had not been this kind of motivation and encouragement.

Two States are demonstrating the use of foster homes for older adults. These projects are particularly valuable in helping to find the criteria for the use of foster homes for adults, to determine the differences between foster homes used successfully for children and those which are used for adults; and to establish successful home finding technique. The foster home for adult projects are designed to postpone, and in some instances, negate the need of some individuals to enter a nursing home or institution. Emphasis is on finding ways of keeping the elderly recipient in their own homes and permitting them to continue in more normal living patterns, generally within their own community. In addition, the foster homes provide a resource for persons presently in nursing homes who might not otherwise have an opportunity to return to their own communities.

REHABILITATION SERVICES

The primary objective of the Rehabilitation Services Administration's program for the aging is to rehabilitate as many older handicapped individuals as possible into gainful employment. This objective not only benefits the individuals themselves, but also the taxpayers and the community by making available various types of talents and work skills, reducing public and private welfare expenditures, and relieving growing burdens on institutions. In addition, other family members are able to return to work as the result of rehabilitation services for the aged involving self-help and household management.

The Rehabilitation Services Administration is uniquely qualified because of the individualized basic services it offers through the State-Federal rehabilitation program to meet the needs of those older Americans requiring rehabilitation.

During calendar year 1968, a number of research and demonstration projects served the aging. For instance, an agency in New York City is undertaking a long-term examination of the vocational rehabilitation problems of the homebound. A broad look will be taken at what has been accomplished to date and conceptual thinking will be done to develop a framework for attacking those problems having the highest priority. A new population of homebound will be selected and their adjustment studied from a longitudinal standpoint.

A university in Ohio has begun a long-term study that will examine the relationships of disability and handicap. Hopefully a theoretical conceptualization of disability should provide a basis for understanding how chronic illness affects individuals.

The program continues support of a research and demonstration project in Ohio on protective services for older persons, a project in California analyzing the office of public guardian in Berkeley, and an exploratory study of the use of inpatient hospital services in a hospital in New York City.

During calendar year 1968, the research and training centers have made a significant effort to meet the Secretary's priority of coordinated services for the aged through research in such areas as improvement in the delivery of specialized services and development of physical restoration techniques leading to the achievement of independent living by the aged.

Examples of studies being conducted by various universities include:

"Regulation of Regional Intracerebral Circulation During Injury and Aging" (New York).

Purpose: To examine methods by which regional flows may be enhanced reducing fringe injury and functioned impairment.

"Sensory Perception and Spatial Orientation Among the Elderly Brain Damaged" (New York).

Purpose: A comprehensive study of the various factors involved in sensory perception and spatial orientation of the aged person with brain damage.

"Development of an Arthritis Rehabilitation Center" (Pennsylvania).

Purpose: To demonstrate that no form of arthritis need prevent gainful employment.

"An Evaluation of the Speech Intelligibility of Stroke Patients" (Washington, D.C.).

Purpose: To determine the reliability and validity of a test of speech articulation and to gain a better understanding of speech intelligibility parameters.

"Rehabilitative Classification of Patients With Intermitten Claudication" (Washington, D.C.).

Purpose: To obtain objective information on patients with IC, not only in the laboratory but in his normal environment (e.g., home, job) to permit, for the first time, a grade classification of patients with IC.

"Avascular Necrosis of the Head of the Femur After Hip Fractures in the Elderly Patient" (California).

Purpose: To solve unanswered questions concerning the lack of progress in the treatment of the aged person with a hip fracture.

Although most of the agencies receiving grants for rehabilitation facilities have a segment of client population that would qualify as aged, the following three projects have specific programs for this group:

In Ohio, a grant was awarded to assist in the purchase of land and the construction of a new vocational rehabilitation center. Through cooperation with the local metropolitan housing authority, the project will demonstrate the desirability of constructing a public housing development for handicapped and senior citizens in conjunction with a vocational rehabilitation facility. The proposed new vocational rehabilitation center will be adjacent to the housing project.

In Missouri, a workshop improvement grant has added three staff members and leased space to develop a more meaningful program for the current clients as well as long-term chronic clients from nearby county and State hospitals. More than 50 percent of the client load has been identified as aged or too severely handicapped to be employable in competitive employment.

In Nebraska, a project development grant has been made to evaluate the feasibility of introducing a vocational element into a combination nursing home and extended care facility. Client load ranges in age from 23 to 95.

Although State rehabilitation agencies serve older persons during the operation of their regular ongoing program, many special projects are initiated which focus on the aging. The following are presented as representative of this type of specialized service:

Connecticut.—Staff members are cooperating with the Connecticut Commission on Aging in planning a conference for licensed practical nurses to orient them in methods and techniques of working with the geriatric population. Staff members of these agencies are also cooperating in a proposed plan to explore the possibility of obtaining government jobs for the aged population.

Massachusetts.—The agency has been engaged in publicizing the availability of vocational rehabilitation services for "senior citizens" through a series of talks

to various senior citizens groups. The agency has just completed conducting a series of six seminars for all counselors on the medical and social aspects of chronic diseases among the geriatric population.

New York.—The State agency has sponsored two projects which will aid blind public assistance clients residing in long-term nursing homes. Additional staff will be made available to assist in working with these individuals so that they can either return to the community or be moved into foster home settings.

Texas.—An early referral project involving social security beneficiaries was initiated by the State agency in Austin, Tex., this year. The project is modeled after successful projects in other States and is designed to serve social security beneficiaries as soon as possible after disability begins. A large percent of individuals served are over 45.

Three States are engaged in projects which involve other agencies in serving the mentally retarded. Of the estimated 6 million mentally retarded in the United States, approximately 430,000 are aged 65 and over.

Delaware.—A foster grandparents program is in operation at the local hospital for the mentally retarded using older clients from the State rehabilitation agency as foster grandparents. The project has been enthusiastically received.

New Jersey.—A project is being conducted at an institution which aims at developing an intensive social, vocational, and physical rehabilitation program located in a two-unit cottage. Approximately 215 retardates over 50 years of age are served on this project.

Montana.—In cooperation with the Administration on Aging, a project is being conducted by the State agency which employs older persons in an institution to serve elderly, mentally retarded patients.

INTERNATIONAL ACTIVITIES

During calendar year 1968, the Social and Rehabilitation Service under its international research program awarded grants for studies of the conditions of older people in rural areas of Croatia, Yugoslavia, and of a regional sample of the elderly in India. These awards, using local currencies derived primarily from the sale of agricultural products, bring to a total of six SRS-supported projects designed to yield data on living patterns, processes of social adjustment and needs of older people in societies undergoing rapid change. The other ongoing studies are being carried out in Israel, Poland, Yugoslavia, and in Madras, India. A U.S. gerontological research expert provides consultation which assures access to methodology and instruments developed for previous studies in the United States, Britain, and Denmark.

Three cross-national studies are designed to provide comparative and cumulative knowledge on aspects of aging which are of universal concern and to test assumptions and generalizations which have important implications for social policy and for programs to meet the diverse needs of this age group.

The Division of International Activities has, within the limits of available resources, provided liaison for requests from the Network of National (European) Correspondents for Social Welfare Research for information about U.S. research in selected areas. During 1968, these have included a request from Budapest for information about research on "The Social Consequences of Aging" and one from Madrid focusing on various aspects of work by older people.

ITEM 14: SOCIAL SECURITY ADMINISTRATION

EXHIBIT A. REPORT ON THE MEDICARE PROGRAM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Washington, D.C., December 11, 1968.

DEAR SENATOR WILLIAMS: In accordance with my letter dated November 8, 1968, I am sending you a report on the medicare program. A report on overall social security developments during 1968 will be sent to you as soon as it is completed.

I hope that the enclosed report will be useful to your committee in the preparation of its annual report on developments and activities during 1968.

Sincerely yours,

ROBERT M. BALL,
Commissioner of Social Security.

[Enclosure]

Report on the Medicare Program

In fiscal year 1968, medicare paid $5.1 billion for health-care expenses for men and women age 65 and over covered by the program. About $3.7 billion paid for hospital care, extended care facility care, and other services covered by the hospital insurance program. The remaining $1.4 billion paid for physicians' services and various related health and medical items covered by the supplementary medical insurance program.

This broad health insurance coverage, and the actual benefits paid, saved a very great number of senior citizens the pain of exhausting their savings, or looking to others for aid in paying bills for necessary health care. There can be no doubt that many of these would have tried to get by without seeking needed services had they not had medicare coverage. And even for those covered men and women who were fortunate enough to need little if any health-care services, the program served a most valuable purpose. It added to the peace of mind of senior citizens, by providing them assurance that should expensive illness strike, they had extensive protection against the costs.

Medicare has been a highly important force in the upgrading of health care that took place as the result of the quality standards established under the program. A substantial upgrading has already taken place in many institutions and independent laboratories, and further upgrading is underway in many facilities as a condition of continued program participation. Moreover, the requirement of conformity with title VI of the Civil Rights Act of 1964 by participating institutions has resulted, in many communities, in minority group access to high-quality care for the first time.

The operation of the program improved as beneficiaries, physicians, and institution personnel—as well as people employed in the program—became more and more familiar with its coverage and mechanics. Beneficiaries and physicians learned how to make claims properly, hospitals improved their accounting procedures, and intermediaries decreased their processing time.

Valuable information—statistics—accumulated to help show what major health insurance needs remain for study. Under amendments signed into law early in 1968, experiments are underway to find better ways for the program to pay for various health-care costs, while providing an incentive to the suppliers of the services to cut costs without impairing quality.

Other important studies in progress concern the need for and possibility of at least some degree of coverage of prescription drugs, the question of extending medicare coverage to disabled people under age 65, and the matter of whether the services of various nonphysician health care personnel should be covered under the program.

MEDICARE STATISTICAL HIGHLIGHTS, FISCAL YEARS 1967 AND 1968

	Fiscal year 1967	Fiscal year 1968
Enrollment, July 1:		
Hospital insurance (Pt. A)	19,400,000	19,700,000
Supplementary medical insurance (pt. B)	17,900,000	18,800,000
Hospital and extended care facility admissions and home health plans established:		
Inpatient hospital admissions	5,000,000	5,700,000
Extended care facilities admissions	199,000	448,000
Starts of home health plans	228,000	258,000
Medicare bills paid:		
Inpatient hospital	4,800,000	5,800,000
Outpatient hospital	1,400,000	3,000,000
Home health services	500,000	900,000
Extended care facilities	300,000	1,000,000
Physicians' independent laboratories and other medical services	13,700,000	30,800,000
Amounts reimbursed:		
Hospital insurance (pt. A)	$2,500,000,000	$3,700,000,000
Supplementary medical insurance (pt. B)	$664,000,000	$1,400,000,000
Participating providers of services (as of June 30):		
Hospitals:		
Number	6,830	6,900
Beds	1,200,000	1,200,000
Home health agencies	1,810	2,100
Extended care facilities:		
Number	4,090	4,700
Beds	281,000	325,000
Independent laboratories	2,380	2,550

MEDICARE STATISTICS

ENROLLMENT

On July 1, 1968, there were an estimated 19.7 million persons enrolled in the hospital-insurance program and 18.8 million persons enrolled in the supplementary medical insurance program under medicare. About 650,000 persons had enrolled in supplementary medical insurance during the first general enrollment period which lasted from October 1, 1967, to March 31, 1968. Coverage for these persons became effective on July 1, 1968. Only 40,000 persons voluntarily terminated their enrollment during the general enrollment period; many of these were covered by other Government programs.

ADMISSION AND START OF CARE RATES

Inpatient hospital admission rates per thousand persons enrolled increased from 261 in fiscal year 1967 to 291 in fiscal year 1968. Comparable rates for home health starts of care were 12 per thousand in fiscal year 1967 and 13.2 per thousand in fiscal year 1968. Since extended care facility coverage did not start until January 1, 1967, admission rates for nursing homes were annualized for fiscal year 1967 and show 20.8 admissions per thousand enrolled as compared with a rate of 23 for fiscal year 1968. Data on a State basis for fiscal year 1968 are shown on the enclosed table 1.

CLAIMS DATA

Claims approved for payment and processed by the Social Security Administration provide a description of the type and scope of services used. Of the 12.7 million hospital insurance (part A) claims recorded as of August 30, 1968, for the first 2 years of the program (July 1, 1966–June 30, 1968), 78 percent were for inpatient hospital services, 8 percent for outpatient diagnostic services, 9 percent for extended-care services and the remainder were for home health services (table 2). Reimbursements for inpatient hospital care comprised 93 percent of the $5.6 billion in total reimbursements and averaged $525 per claim. Reimbursements averaged $12 per outpatient diagnostic claim, $314 per extended care facility claim, and $67 per home health claim. Table 3 shows that where the type of hospital was known, 98 percent of the recorded inpatient claims, 95 percent of the days of care, and 98 percent of the amount reimbursed were for care of patients in short-stay hospitals.

Under supplementary medical insurance (part B), the 2-year total of bills recorded as of August 30, 1968 amounted to 40.3 million. Of these bills, 82 percent were for physicians' services, 11 percent for outpatient hospital care, and the remaining 6 percent for home health, independent laboratory and other medical services (table 4). Total reasonable charges for these bills amounted to $2.5 billion representing 71 percent of total charges and averaging $61 per bill. For physicians' services, reasonable charges averaged $68 per bill; they averaged $57 per home health bill, $14 per outpatient bill, $23 per independent laboratory bill, and $49 for all other bills.

Of the 33.3 million bills for physicians' services, 14 percent were for surgical and 86 percent were for medical bills (table 5). Reasonable charges for surgical bills amounted to $815 million and averaged $171 per bill; for medical bills, they amounted to nearly $1.5 billion and averaged $51.

CURRENT MEDICARE SURVEY REPORT

Data are available from the current medicare survey for the full calendar year 1967 on the medical care services used and charges incurred by persons enrolled in the supplementary medical insurance program. The current medicare survey is a continuing monthly survey of medical insurance enrollees to obtain current estimates for this part of the program.

Data for the calendar year 1967 show that about 14.8 million persons used covered medical services during the year. This represented almost 80 percent of all medical insurance enrollees exposed to risk. By the end of the year, about 8.6 million persons, or 46 percent of the medical insurance enrollees, had incurred sufficient charges to meet the $50 deductible. The enclosed R. & S. Health Insurance Statistics Report, CMS–5, October 23, 1968, presents highlights from the current medicare survey for the 12 months of 1967.

TABLE 1.—HEALTH INSURANCE PROGRAM: NUMBER OF INPATIENT HOSPITAL ADMISSIONS, EXTENDED CARE FACILITY ADMISSIONS, AND HOME HEALTH, START OF CARE NOTICES AND RATES PER 1,000 ENROLLEES, BY REGION, CENSUS DIVISION, AND STATE, JULY 1, 1967–JUNE 30, 1968

Region, census division and State	Inpatient hospital admissions		Extended care facility admissions		Home health start of care [1]	
	Number [2] (in thousands)	Per 1,000 enrollees	Number [2] (in thousands)	Per 1,000 enrollees	Number [2] (in thousands)	Per 1,000 enrollees
U.S. and territories	5,655.1	291	448.5	23.0	258.1	13.2
U.S. Total [3]	5,621.8	291	448.4	23.2	257.7	13.3
Region: [4]						
Northeastern	1,266.2	247	106.9	20.9	103.3	20.1
North Central	1,696.8	300	104.6	18.5	58.1	10.3
South	1,793.5	320	107.5	19.2	44.6	7.9
West	864.9	297	129.4	44.5	51.7	17.7
New England	335.0	267	35.2	28.0	31.7	25.2
Maine	35.4	301	3.0	25.5	1.6	13.5
New Hampshire	21.8	276	1.1	13.9	1.8	22.7
Vermont	14.7	303	.4	8.2	.8	16.5
Massachusetts	172.4	274	17.3	27.5	16.2	25.7
Rhode Island	22.7	223	1.8	17.7	3.5	34.3
Connecticut	68.0	243	11.6	41.5	7.8	27.9
Middle Atlantic	931.2	241	71.7	18.5	71.6	18.5
New York	462.5	238	32.8	16.8	33.0	16.9
New Jersey	148.8	222	15.7	23.4	17.0	25.3
Pennsylvania	319.9	256	23.2	18.5	21.6	17.2
East North Central	1,046.0	278	72.4	19.3	42.6	11.3
Ohio	257.6	262	18.8	19.1	13.0	13.2
Indiana	127.5	262	7.7	15.8	4.5	9.2
Illinois	309.0	285	22.4	20.7	9.4	8.7
Michigan	208.1	279	13.6	18.3	9.6	12.9
Wisconsin	143.8	310	9.9	21.4	6.1	13.2
West North Central	650.8	343	32.2	16.9	15.5	8.2
Minnesota	145.0	357	9.0	22.2	4.9	12.1
Iowa	119.5	339	6.3	17.9	2.4	6.8
Missouri	174.9	318	7.7	14.0	5.1	9.3
North Dakota	29.4	444	1.0	15.1	.3	4.5
South Dakota	31.8	396	.6	7.5	.4	5.0
Nebraska	60.8	335	2.9	16.0	.9	5.0
Kansas	89.4	339	4.7	17.8	1.5	5.7
South Atlantic	767.8	291	53.5	20.3	24.5	9.3
Delaware	9.6	223	.9	20.9	1.2	27.8
Maryland	57.2	208	5.7	20.8	2.0	7.2
District of Columbia	21.2	312	.7	10.3	1.8	25.7
Virginia	93.4	271	5.6	16.2	2.8	8.1
West Virginia	65.7	337	2.1	10.8	1.6	8.2
North Carolina	118.7	304	4.2	10.8	1.3	3.3
South Carolina	52.5	288	3.2	17.6	1.0	5.5
Georgia	108.9	312	5.8	16.6	2.1	6.0
Florida	240.6	305	25.3	32.1	10.7	13.5
East South Central	397.3	323	20.3	16.5	8.5	6.9
Kentucky	108.5	327	6.8	20.5	2.2	6.6
Tennessee	126.0	341	7.2	19.5	3.1	8.4
Alabama	93.5	300	4.7	15.1	2.5	8.0
Mississippi	69.3	320	1.6	7.4	.7	3.2
West South Central	628.4	362	33.7	19.4	11.6	6.7
Arkansas	81.0	355	2.3	10.1	1.3	5.7
Louisiana	93.7	321	4.1	14.1	2.3	7.9
Oklahoma	104.0	365	4.2	14.7	2.5	8.8
Texas	349.7	375	23.1	24.8	5.5	5.9
Mountain	225.0	349	21.0	32.5	11.4	17.6
Montana	29.0	423	1.7	24.8	.8	11.6
Idaho	21.0	318	2.8	42.4	2.5	37.8
Wyoming	11.2	372	.4	13.3	.3	9.9
Colorado	71.2	391	6.8	37.4	3.1	17.0
New Mexico	20.3	306	1.2	18.1	.8	12.0
Arizona	44.1	330	5.2	39.0	2.7	20.2
Utah	19.6	272	2.0	27.7	.8	11.1
Nevada	8.6	320	.9	33.5	.4	14.9
Pacific	639.9	283	108.4	47.9	40.3	17.8
Washington	96.3	310	16.6	53.4	4.1	13.2
Oregon	63.5	295	9.4	43.7	3.3	15.3
California	466.6	276	81.0	47.9	32.5	19.2
Alaska	1.5	250	.1	16.7	(5)	----------
Hawaii	12.0	298	1.3	32.3	.4	9.9

See footnotes at end of table, p. 170.

TABLE 1.—HEALTH INSURANCE PROGRAM: NUMBER OF INPATIENT HOSPITAL ADMISSIONS, EXTENDED CARE FACILITY ADMISSIONS, AND HOME HEALTH, START OF CARE NOTICES AND RATES PER 1,000 ENROLLEES, BY REGION, CENSUS DIVISION, AND STATE, JULY 1, 1967–JUNE 30, 1968—Continued

Region, census division and State	Inpatient hospital admissions		Extended care facility admissions		Home health start of care [1]	
	Number [2] (in thousands)	Per 1,000 enrollees	Number [2] (in thousands)	Per 1,000 enrollees	Number [2] (in thousands)	Per 1,000 enrollees
Outlying areas	33.3	214	.1	.6	.4	2.6
Unknown	.4					

[1] Includes home health start of care notices under both the hospital insurance (part A) and medical insurance (part B)
[2] Based on notices received in the Social Security Administration from July 1, 1967–June 30, 1968.
[3] Includes unknown place of residence.
[4] Northeastern includes New England and Middle Atlantic States: North Central includes East North Central and West North Central States; South includes South Atlantic, East South Central, and West South Central States: and West includes Mountain and Pacific States.
[5] Less than 50.

Source: Admission notices transmitted to Social Security Administration upon admission to hospital, extended care facility, and start of home health services, as of June 30, 1968.

TABLE 2.—HOSPITAL INSURANCE PROGRAM: NUMBER AND PERCENTAGE DISTRIBUTION OF CLAIMS APPROVED FOR PAYMENT AND AMOUNTS REIMBURSED, BY TYPE OF BENEFIT, JULY 1, 1966–JUNE 30, 1968 [1]

Type of benefit	Approved claims		Amount reimbursed [2]		
	Number	Percent distribution	Total (in thousands)	Percent distribution	Per claim
Total	12,664,892	100.0	$5,631,047	100.0	
Inpatient hospital	9,937,040	78.5	5,212,751	92.6	$525
Outpatient diagnostic	983,311	7.8	11,597	.2	12
Extended care facility	1,174,003	9.3	368,383	6.5	314
Home health	570,538	4.5	38,316	.7	67

[1] Includes only claims approved and recorded in the Social Security Administration central records before Aug. 30, 1968.
[2] Amounts paid to the providers for covered services, based on an interim rate. Payments exclude deductibles, coinsurance amounts, and noncovered services as specified by law. The amounts paid to providers are adjusted at the end of each provider's operating year on the basis of audited reasonable costs of operation.

Source: Claims for payment under the hospital insurance program approved by intermediaries and recorded in the Social Security Administration central records.

TABLE 3.—HOSPITAL INSURANCE PROGRAM: NUMBER AND PERCENTAGE DISTRIBUTION OF CLAIMS FOR INPATIENT HOSPITAL CARE APPROVED FOR PAYMENT, COVERED DAYS, TOTAL CHARGES AND AMOUNTS REIMBURSED, BY TYPE OF HOSPITAL, JULY, 1 1966, TO JUNE 30, 1968 [1]

Item	All hospitals [2]	Short stay	Long stay [3]
Approved inpatient hospital claims:			
Number	9,937,040	9,727,170	170,979
Percent distribution	100	97.9	.17
Covered days of care: [4]			
Total (in thousands)	133,153,891	126,647,923	6,081,466
Percent distribution	100	95.1	4.6
Average per claim	13.4	13	35.6
Charges:			
Total (in thousands)	$6,502,813	$6,360,835	$125,267
Percent distribution	100	97.8	1.9
Per claim	$654	$654	$733
Per day	$49	$50	$21
Amount reimbursed: [5]			
Total (in thousands)	$5,212,751	$5,098,267	$102,439
Percent distribution	100	97.8	2
Percent of total charges	80.2	80.2	81.8

[1] Only claims approved and recorded in the Social Security Administration central records before Aug. 30, 1968.
[2] Includes 38,891 claims with type of hospital unknown.
[3] General and special hospitals reporting average stays of 30 days or more; tuberculosis, psychiatric, and chronic disease hospitals, and Christian Science sanatoriums.
[4] Covered days of care after June 30, 1966 (not including days in excess of 90 in a spell of illness).
[5] Amounts paid to the providers for covered services, based on an interim rate. Payments exclude deductibles, coinsurance amounts and noncovered services as specified by law. The amounts paid to providers are adjusted at the end of each provider's operating year on the basis of audited reasonable costs of operation.

Source: Claims for payment under the hospital insurance program approved by intermediaries and recorded in the Social Security Administration central records.

TABLE 4.—SUPPLEMENTARY MEDICAL INSURANCE PROGRAM: NUMBER OF REIMBURSED BILLS FOR PHYSICIANS' AND RELATED MEDICAL SERVICES, TOTAL CHARGES, AND AMOUNT PER BILL, BY TYPE OF SERVICE, JULY 1, 1966–JUNE 30, 1968 [1]

Type of service	Bills		Charges [2]		
	Number	Percent distribution	Total (in thousands)	Percent distribution	Amount per bill
All services [3]	40,342,719	100.0	$2,467,623	100.0	$61
Physicians	33,302,502	82.5	2,275,723	92.2	68
Home health	592,200	1.5	34,010	1.4	57
Outpatient hospital	4,332,044	10.7	58,646	2.4	14
Independent laboratory	543,485	1.3	12,516	.5	23
All other	1,208,212	3.0	59,526	2.4	49

[1] Only bills for which reimbursements were made by the intermediaries and which were recorded in the Social Security Administration central records before Aug. 30, 1968.
[2] Reasonable charges as determined by the intermediaries on the basis of customary charges for similar service generally made by the physician or suppliertof covered services and on prevailing charges in the locality for similar services. A charge cannot be higher than that applicable for the carrier's own policyholder for comparable services under comparable circumstances.
[3] Includes 364,256 bills and $27,311,000 in total charges for which type of service is unknown.

Source: Payment records submitted by the intermediaries under the Supplementary Medical Insurance Program and recorded in the central records of the Social Security Administration.

TABLE 5.—SUPPLEMENTARY MEDICAL INSURANCE PROGRAM: NUMBER OF REIMBURSED BILLS FOR PHYSICIANS AND RELATED MEDICAL SERVICES, TOTAL CHARGES, AND REIMBURSED AMOUNT, BY TYPE OF BILLS, JULY 1, 1966–JUNE 30, 1968 [1]

Item	All bills [2]	Physicians' services	
		Surgical	Medical
Bills:			
Total number	40,342,719.0	4,760,118.0	28,542,384.0
Percent distribution	100.0	11.8	70.7
Charges: [3]			
Total (in thousands)	$2,467,623.0	$815,219.0	$1,460,504.0
Percent distribution	100.0	33.0	59.2
Per bill	61.0	171.0	51.0
Amount reimbursed: [4]			
Total (in thousands)	$1,760,026.0	$607,827.0	$1,018,805.0
Percent distribution	100.0	34.5	57.9
Percent of total charges	71.3	74.6	69.8

[1] Only bills for which reimbursements were made by the intermediaries and which were recorded in the Social Security Administration central records before Aug. 30, 1968.
[2] Includes 7,040,217 bills for home health, outpatient hospital, independent laboratory, and other services covered under the Medical Insurance Program; as well as bills for which type of service is unknown.
[3] Reasonable charges as determined by the intermediaries on the basis of customary charges for similar services generally made by the physician or supplier of covered services and on prevailing charges in the locality for similar services. A charge cannot be higher than that applicable for the carrier's own policyholder for comparable services under comparable circumstances.
[4] Represents 80 percent of reasonable charges for covered services each year after the beneficiary has paid the first $50 of such charges during the year.

Source: Payment records submitted by the intermediaries under the supplementary medical insurance program and recorded in the central records of the Social Security Administration.

EXHIBIT B. OPERATION OF THE SOCIAL SECURITY PROGRAM IN 1968

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
OFFICE OF THE COMMISSIONER,
Washington, D.C., December 17, 1968.

DEAR SENATOR WILLIAMS: I am glad to send you the second report you requested on the operation of the social security program in 1968.

I hope the enclosed material will serve your needs.

Sincerely yours,

ROBERT M. BALL,
Commissioner of Social Security.

[Enclosure]

SOCIAL SECURITY ADMINISTRATION

The Social Security Administration administers the Federal social security program, which is the Nation's basic method of assuring income to the worker and his family when he retires, becomes disabled, or dies, and of assuring hospital and medical benefits to persons 65 or over. When earnings stop or are reduced because the worker retires, dies, or becomes disabled, monthly cash benefits are paid to replace part of the earnings the family has lost.

Developments in social security

About 89 million people contributed to social security in calendar year 1968. Today, 95 out of 100 mothers and children are protected against the risk of loss of income because of the death of the family breadwinner. The survivorship protection alone, as of July 1, 1968, had a face value of about $950 billion.

About 24.1 million men, women, and children were receiving monthly social security benefits as fiscal year 1968 ended. The beneficiaries include about 15.3 million retired workers and dependents of retired workers, 2.3 million disabled workers and their dependents, and 5.8 million survivors of deceased workers. About 700,000 noninsured persons 72 and over were receiving special payments that are provided to certain aged persons getting no public assistance payments and little or no other governmental pensions. Virtually the entire cost of these special payments is borne by general revenues of the U.S. Treasury.

Ninety percent of those who were 65 or over at the beginning of 1968 were receiving benefits or would be eligible to receive benefits when they or their spouses retire. Of those who reached 65 in 1968, 92 percent were eligible for social security cash benefits. Projections to the year 2000 indicate that 96 percent of all aged persons will then be eligible for cash benefits under the program.

WHAT THE PROGRAM DID IN FISCAL YEAR 1968

Beneficiaries and benefit amounts

During the fiscal year ended June 30, 1968, benefits paid under the old-age, survivors, and disability insurance program totaled $22,825 million—an increase of $2,078 million over the amount paid in the preceding fiscal year. Of this increase, about $1 billion was due to changes in the law provided by the 1967 amendments. Total benefit payments to disabled workers and their dependents were $2,088 million, 12 percent higher than in fiscal year 1967. Old-age and survivors insurance monthly benefits rose 10 percent to $20,481 million. Lump-sum death payments amounted to $256 million, about $10 million higher than in the previous fiscal year.

The number of monthly benefits in current-payment status increased by 900,000 (4 percent) to 24.1 million during the year, and the monthly rate rose $337.2 million (20 percent) to $2 billion. The sharp increase in the monthly rate was due mainly to the higher benefit scale provided in the 1967 amendments and, to a smaller extent, to the normal growth in the beneficiary rolls. Only a relatively small number of the claims which resulted from the legislation enacted in 1968 could be paid in the closing months of the fiscal year. Changes in the law, therefore, had only a minor effect on the growth in the benefit rolls during the year.

In June 1968, the average old-age benefit being paid to a retired worker who had no dependents also receiving benefits was $94 a month. When the worker and his wife were both receiving benefits, the average family benefit was $166. For families composed of a disabled worker and a wife under 65 with one or more entitled children in her care, the average was $245; and for families consisting of a widowed mother and two children, the average benefit was $254. The average monthly benefit for an aged widow was $86.

During the fiscal year, a period of disability was established for about 314,000 workers, 12,000 more than the previous high set in fiscal year 1967. The number of persons determined to have been disabled since childhood totaled 22,000. As a result of the 1967 amendments, about 13,000 persons were found to meet the disability requirements for benefits as disabled widows or widowers, and about 7,000 workers were determined to be disabled under the liberalized insured-status provisions for workers disabled before 31.

The number of disabled workers receiving monthly benefits rose 9 percent in the fiscal year and totaled 1,245,000 at the end of June. Benefits were being paid

to about 1,013,000 wives, husbands, and children of these beneficiaries. By the end of June 1968, child's benefits were being paid at a monthly rate of $14.5 million to 236,000 disabled persons 18 and over—dependent sons or daughters of deceased, disabled, or retired insured workers—whose disabilities began before they reached 18. About 26,000 women were receiving wife's or mother's benefits solely because they were the mothers of persons receiving childhood disability benefits. The number of disabled widows and widowers receiving monthly benefits was about 5,000 at the end of June 1968.

Legislative developments during the year

On January 2, 1968, President Johnson signed into law an important set of amendments to the social security program which had been enacted by the Congress late in 1967. These amendments resulted in the largest total increase in benefit payments since the program began, and included the first major amendments to the medicare program. A summary of the 1967 amendments follows.

CHANGES IN THE CASH BENEFITS PROVISIONS

Increase in monthly cash benefits

Monthly social security cash benefits were increased 13 percent "across-the-board," and the minimum monthly retirement benefit at 65 was increased from $44 to $55. The average monthly benefit paid to retired workers (with or without dependents) already on the rolls was increased from $86 to $98, and the average monthly benefit for a retired worker and his wife was increased from $145 to $164. Monthly benefits range from the new minimum of $55 to a maximum of $168.40 for retired workers on the rolls in January 1968.

Increase in the contribution and benefit base

The increase from $6,600 to $7,800 (effective January 1, 1968) in the amount of annual earnings on which contributions are paid and which can be used in the benefit computation (this amount is known as the contribution and benefit base) results in an ultimate maximum monthly benefit of $218, based on average monthly earnings of $650. The higher earnings base will increase benefit amounts significantly for the large proportion of older current contributors earning above $6,600. For example, a man 50 in 1968 who earns $7,800 a year until he is 65 (about one-third of the group now earning above $6,600 are 50 or older) will get a benefit of $188.80 at 65—21.8 percent higher than under the old law.

Increase in special payments to people 72 and older

The special payments to uninsured people 72 and older were increased from $35 to $40 a month for a single person and from $52.50 to $60 a month for a couple. About 70,000 people who were not entitled to the special payments because they got small local, State, or Federal pensions now qualify for some payments, and over 700,000 people had their payments increased by this provision.

The retirement test

The retirement test was changed so that, beginning with 1968, a beneficiary will get all benefits for the year if his annual earnings are $1,680 or less ($1,500 before the change). If his earnings exceed $1,680, then $1 in benefits will be withheld for each $2 of his earnings in the year between $1,680 and $2,880 (formerly $2,700), and for each $1 of earnings thereafter. He will get benefits, regardless of the amount of his earnings in a year, for any month in which he earns $140 or less ($125 or less before the amendments) in wages and does not perform substantial services in self-employment. About 760,000 people who could not otherwise have collected benefits will start to get them or they will get more benefits than they would have if the law had not been changed.

Improved protection for dependents of women workers

Children's benefits.—The amendments liberalized the conditions under which a child can get benefits based on his mother's earnings record. Now a child can get benefits based on his mother's earnings record under the same conditions as on his father's earnings record—that is, when either parent becomes entitled to retirement or disability benefits or dies.

Husband's and widower's benefits.—The eligibility requirements for husband's and widower's benefits were also liberalized. The requirement that a dependent husband or widower may become entitled to benefits based on his wife's earnings only if his wife had covered work in six out of the last 13 calendar quarters

ending with her disability, retirement, or death was removed. An estimated 5,000 husbands and widowers became eligible for benefits under this provision.

Miscellaneous changes

Underpayments.—The 1967 amendments established an order of priority for the payment of benefits that were unpaid at the time of a beneficiary's death. The provision enables the Administration to pay these benefits when the estate of the deceased was small and would not otherwise require an administrator.

Other improvements in dependents' protection

Definition of "widow," "widower," and "stepchild".—The amendments provide a change in the definition of "widow," "widower," and "stepchild." They will be considered as such for social security purposes now if the worker's marriage existed for 9 months, or, in case of accidental death or death in the line of duty in the uniformed service, if the marriage existed for 3 months, unless it is determined that the deceased individual could not have reasonably been expected to live for 9 months at the time the marriage occurred. Under prior law, the marriage must have existed for 12 months.

CHANGES IN THE DISABILITY PROVISIONS

Definition of disability

The new law clarifies and amplifies the definition of disability for workers and persons disabled in childhood, but does not significantly change the basic meaning of the definition as it has been interpreted by the Social Security Administration in the past.

A person is considered disabled under this definition only if he is unable to engage in any substantial gainful work because of a physical or mental impairment which has lasted (or is expected to last) for 12 months or longer. Vocational factors such as age, education, and previous work experience may be taken into account in deciding whether a worker or a person who has had a severe handicap since childhood is "disabled."

Benefits for disabled widows and widowers

The 1967 amendments provide, for the first time, that disabled widows (including surviving divorced wives) and disabled dependent widowers of insured workers can get benefits as early as age 50. These benefits are reduced, with the amount of the reduction depending on the age at which benefits begin. The widow or widower must have become totally disabled no later than 7 years after the spouse's death, or, in the case of a widowed mother, no later than 7 years after the termination of mother's benefits. The 7-year period protects widows and widowers until there has been reasonable opportunity to work long enough to be insured for disability benefits through their own earnings. About 65,000 disabled widows and widowers became eligible for benefits as a result of this provision.

Liberalized definition of blindness

The law now substitutes, for disability purposes, the less strict definition of blindness (central visual acuity of 20/200 or less, commonly called industrial blindness) for the former statutory definition of blindness (central visual acuity of 5/200 or less). This new definition is the same as the one used in the Internal Revenue Code and by a number of governmental and private agencies.

ITEM 15: VETERANS' ADMINISTRATION

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERAN'S AFFAIRS,
Washington, D.C., December 2, 1968.

DEAR MR. CHAIRMAN: In response to your request of October 23, 1968, I am pleased to forward the enclosed report on Veterans' Administration activities relating to aging during the year 1968.

Because of the increasing number of war veterans and their dependents advancing into the older age groups each year, the VA is particularly interested in finding answers to many of the problems of older people. The studies and investigations by your committee for the purpose of seeking solutions to these problems are invaluable to the VA as well as to the Nation as a whole.

In addition to the required report, I am enclosing two copies of a brochure which we prepared last March, entitled "The Veteran Age 65 and Over—A Profile." * Although the data depicted in the graphs are for periods before 1968, you may find them of some interest. Incidentally, we have a small supply on hand in the event you wish additional copies.

Sincerely,

W. J. DRIVER, *Administrator.*

[Enclosure]

VA ACTIVITIES AFFECTING OLDER VETERANS IN 1968

DEPARTMENT OF MEDICINE AND SURGERY

1. *VA hospitalization.*—Patients in the older age groups continue to represent a major portion of our hospital load. As of November 30, 1967, there were 27,545 patients 65 years and older remaining in VA hospitals (adjusted data). This represents about 28 percent of all patients in VA hospitals on that date. As expected older veterans will be concentrated in our long-term facilities. This means it has been possible for us to devise special programs designed for their particular needs.

2. *Extended care service—*

(*a*) *Inpatients.*—To meet the medical needs of the aging, the VA Department of Medicine and Surgery has created an extended care service which is designed to operate a system of facilities for long-term care. This system includes a wide variety of facilities such as nursing homes, domiciliaries, intermediate care wards (long-term medical wards), and restoration centers. These facilities, within the VA, are paralleled partly by a similar system operated by the States' veterans' bureaus and by individual community enterprises. The total number of patients cared for each day in these facilities exceeds 30,000, of which over 56 percent are veterans age 65 and over. One of the most important tenets of our operation is to require each level of care to attempt rehabilitation of the institutionalized patient. This is carried to the point where he can be either discharged to his own home or moved to another institutional setting of lesser dependency as his ability to care for himself increases. These facilities are arranged in a stepwise fashion of lowered dependence so that movement from one to the other is possible.

The extended care service consists of intermediate care service for patients who are chronically ill but still require more or less daily medical services; nursing home care for patients who do not require daily medical supervision but do require continued or protracted nursing home care; domiciliary care for veterans who are ambulatory and able to perform activities of daily living despite chronic long-term medical or psychiatric disabilities; and restoration center care for veterans who would be expected to be able to return to the community either as self-supporting or to live independently after rehabilitation in the restoration center.

These facilities use the multidisciplinary approach toward the objective that no segment of VA care is ever permitted to regard itself as "the end of the road." The VA is constantly seeking ways of preventing the process of institutionalization such that hospital routines will be altered and modified with a view toward making the patient interact with and take pride in his own contribution to his peer groups.

It is believed that no other nationwide system can offer the variety of care in the great number of communities that the VA's extended care service does. The impact upon community levels of care is being increasingly felt from the standpoint of both example and teaching.

(*b*) *Outpatients.*—Veterans 65 years and over represented a sizable portion of VA's outpatient treatment load. In fiscal year 1968, over 310,000 patients in this age group made almost 900,000 visits to staff and fee basis physicians for outpatient care, representing approximately 15 percent of the total treatment load.

3. *Social Work Service.*—This group has a major role in providing services to the older person in the VA health care system. In providing services to the aging and chronically ill, recognition is given to the special importance of maintaining family life integrity for this age group. A primary responsibility of the social work service is to assist the elderly in their transition from definitive inpatient

*Retained in committee files.

medical care to an appropriate living/care environment that meets his health and social needs and permits him to fully utilize and maintain his capabilities. To this end, the Social Work Service has developed a well-defined foster home and halfway house program which is designed to permit the return of psychiatric patients, many of whom are older and without relatives, into protective homelike settings in the community. For the older person moving into a community nursing home, a full range of social services are provided. During fiscal year 1968, the Social Work Service provided the primary assistance and followup supervision to almost 12,000 patients age 60 or over being cared for in community nursing homes, foster homes, and halfway houses.

The Social Work Service participates with other public and private health and welfare organizations, on both a local and national level, in identifying needs of the older person and developing programs to meet these needs. During 1968, representatives of the VA Chief Attorney's Office and the Social Work Service were active participants in planning a National Institute on Protective Services for the Aged.

4. *Voluntary service.*—Each year the VA sees more and more older and retired persons join the ranks of those volunteering their services to aid in the care and treatment of patients in the hospital, and those patients returning to their homes and communities. This year, senior citizens proved more valuable and effective in their voluntary service assignments than in previous years.

Maturity of mind, depth of knowledge, and understanding of human relationships on the part of the retired or older volunteer offered a wealth and range of volunteer service limited only by physical abilities and extent of these citizens to become a part of the hospital team. Acceptance of these services was limited only by flexibility and vision to broaden the opportunities for voluntary service offered by these men and women on the part of the members of the VA staff charged with the care and treatment of our patients and members.

The volunteer services of these persons are gradually being expanded in, and extended to, new and changing care and treatment programs, such as alcoholism, day treatment, restoration, nursing home care, outpatient, and community care which includes community nursing homes, foster homes, and halfway houses.

The mature and experienced retirees are a prime source of volunteers for leadership roles within the hospital program and within their organization programs of service to veteran-patients.

5. *Psychology service.*—The resources of this service has been increasingly involved in the care, treatment, and rehabilitation of patients in the older age groups. Psychologists are now assigned part time to the intra-VA nursing home care units where they provide direct patient services in the area of psychological therapy and counseling to both individuals and groups of patients to assist them with their emotional and behavioral problems. Special programs to "behavior modification" have been developed, as well as structured programs of "reality orientation," which help geriatric patients to maintain their orientation in time and place and to retain other types of reality contacts. In addition, they provide consulation to the nursing home care unit supervisors and staff to assist in the development and maintenance of psychologically healthful environments which are especially adapted to the problems of the aging patients. Psychologists also serve as special resource personnel to the newly implemented hospital based home care programs where they deal with specific behaviors which might otherwise predicate against home based living.

Special efforts are being made to involve the psychology trainees in programs geared to the aging so that there will be trained professional psychology personnel available to meet the rising expected future needs in the area of gerontology.

Using the latest in automated testing equipment and techniques, efforts are currently underway to develop normative levels of such things as sensing, perceiving, thinking, and problem solving so that precise measures can be made of levels of deficit associated with the aging process. This is a collaborative psychology study of age with the overall aim of obtaining more reliable and valid measures through an automated system.

6. *The research program on aging.*—To meet its responsibilities to our increasing number of aging citizens and older patients, the Veterans' Administration sponsors basic and clinical research programs on a broad front attacking the problem of the mechanisms of aging. This is being studied from the standpoint of current concepts of biology, heredity, biochemistry, disease processes, and the environment, with emphasis placed on the changes that occur with age. Thus,

just as fundamental research was important to broadening and strengthening our knowledge of disease processes, fundamental research is believed to be of vital importance for advancing our understanding of aging or of mechanisms bearing on the aging process. The following are a few examples of such investigations sponsored by the VA.

It should be possible to understand why connective tissue changes with age and time, relationships between age, and the incidence of cardiovascular disease, osteoarthritis, glomerular sclerosis, and malignancy. Characteristic of the aging process is the replacement of parenchymal cells (the essential elements of an organ as distinguished from its framework) by nonfunctional connective tissue elements. Some investigators claim that such changes in elastic fibers are responsible for loss of resiliency of tissues and this is considered to be the first stage in the development of arteriosclerosis, pulmonary emphysema, and wrinkling of skin. It has been contended by some investigators that the skin may serve as a mirror of systemic metabolic events. Dr. Harry Sobel at the VA hospital in Sepulveda, Calif., has been particularly concerned with the response of the skin to nitrogen-losing states. His laboratory is developing techniques for estimating degree of nitrogen loss in debilitating conditions such as following surgery, chronic disease, in aging and explaining reduction of mucopolysaccharides in skin which occurs with age. The studies in his laboratory are consistent with the concept that the "ground substance" of tissues in a limited sense may serve as a protein storage site. The findings suggest the existence of a very sensitive feedback system which operates to conserve protein in more vital organs. In this regard, Dr. Sobel is investigating the question whether an explanation of the reduction in the mucopolysaccharide content of skin with age may not lie in the changes which take place in these constituents during nitrogen loss.

At the VA hospital at Jefferson Barracks, Mo., Dr. Shui Yes Yu is conducting a comprehensive investigation concerned with the histochemical and biochemical alterations in various connective tissues and their related structures with aging. By a technique called enzymatic digestion, Dr. Yu isolated elastic fibers from young and arteiosclerotic aortas. From comparative studies of the outer core of elastin and the intact elastin he observed characteristic age differences with respect to chemical composition, amino acid composition and fluoresence substances primarily in the outer core of the elastic fibers. Furthermore, from the amino acid composition, the characteristic change of aging of elastin was found in the primary structure of the protein. Based on this finding, a hypothesis is proposed that a specific protein in one life-span alters its primary structure by aging or arteriosclerosis. This could be attributed to somatic mutation or a metabolic alteration of the young and old fibroblasts which are the cell units responsible for synthesis of elastin.

The loss of bone tissue as a consequence of aging is a well-documented occurrence. Just why this negative calcium balance occurs, has not been explained satisfactorily; but it seems probable that a change in bone cellular regulation is involved. Dr. Paul Thornton, at the VA hospital, Lexington, Ky., hypothesized that adrenal cortex hormone secretions are implicated in the subtle loss of bone tissue during the aging process since an excess of these particular hormones (glucocorticoids) is associated with net loss of bone tissue in individuals afflicted with Cushing's Syndrome. Dr. Thornton's study of bone metabolism as influenced by aging factors showed that young rats and guinea pigs respond to excess glucocorticoid hormone with an increase in serum calcium which is mobilized from bone while old animals do not exhibit an increase in serum calcium.

A projected by Dr. A. F. Abt, at the VA hospital in Martinsburg, W. Va., also bears on this problem of bone metabolism in aging. In this study, the data indicate that in bone healing following fractures in guinea pigs the pattern of calcium turnover varies with age; that aging has a retarding effect on bone union; and that the amount of bone matrix produced is influenced by the nutritional level of vitamin C. It is apparent that of various mechanisms affecting bone metabolism, hormonal and nutritional are only two factors influencing calcium mobilization and are associated with aging.

Since it is almost axiomatic that aging is a process involving the complex changes in cells after a period of time, the corollary follows that pertinent cellular changes related to aging involves protein metabolism. At the VA hospital in Long Beach, Calif., Dr. Harry Walter is conducting research on red blood cells which have been separated by special techniques as a function of the time elapsed since their biosynthesis of certain soluble proteins. The thesis is that such separation would allow the differentiation of an older protein molecule from a younger

one of the same species—and enable study of the nature of chemical and structural changes of macromolecules as a function of their biological age. Evidence was obtained with hemoglobin (the oxygen-carrying protein of red blood cells) that certain of its biochemical characteristics such as oxygen dissociation, its electrophoretic mobility and chromium-51 uptake, behave differently as a function of the biological age of this protein molecule. Experimental study utilizing this special separations technique of a given type of cell could possibly also be applied to determine the molecular basis of biochemical events that lead to diminished enzyme activities in older red blood cells. At the Buffalo, N.Y., VA hospital, Dr. Tuang-Mei Wang is examining the distribution of enzymatic activities in different cellular components of tissues at various ages of a given animal. He found that incorporation of C–14 leucine into various organ proteins during the development of the chick embryo is highest in the earliest stages of development. Following upon these results, he is studying the isotopic incorporation of labeled leucine *in vivo* in conjunction with assaying some enzymatic activities in an attempt to correlate changes in enzymatic activities with protein synthesis as a function of aging.

At the VA hospital in Jackson, Miss., Dr. Joseph Haining is conducting research on the rate of turnover or removal of enzymes as a function of aging. His thesis is that fundamental understanding is lacking of the capabilities and limitations of aging cells for autorenewal with respect to protein-enzymes and the efficiency with which they function as a dependent of aging. Dr. Haining observed that the kinetics of accumulation in rat liver of an enzyme-tryptophan pyrrolase, in response to administration of the amino acid tryptophan undergoes age-related alteration which is not the result of changes in the pattern of tryptophan uptake with age. He is pursuing these observations with studies on enzyme induction as a function of age by examining the response of several inducible enzymes to administration of hydrocortisone, a secretion of the adrenal gland. The objective of this research project is an attempt to separate and contrast the anabolic and catabolic components (tissue building and tissue breakdown, respectively) of the dynamic equilibrium of proteins which theoretically plays a role in growth and in aging.

DEPARTMENT OF VETERANS BENEFITS

1. *Guardianship Program.*—The Department of Veterans Benefits, through its guardianship program, provides a protective service for our aged beneficiaries who are legally incompetent and are incapable of prudently managing benefits payable through VA programs. There is ready identification of these individuals needing assistance. A problem which has caused this Department considerable concern is that of persons who are legally competent but who are unable to manage their affairs because of afflictions of aging. This problem is general through all sectors of the aged and not limited to this class of VA beneficiaries. Difficulty arises in identifying these aged individuals in need of assistance and providing assistance without infringing on their legal rights.

The entire area of protective service was the subject of exploration and discussion at the National Institute on Protective Service for Older People held in Houston, Tex., January 16 to 18, 1968. This department was represented by the Director, Guardianship Service. Attention was focused on the medico-socio-legal aspects of the problem. The results of this institute are incorporated in a report prepared by the National Council on Aging, "Overcoming Barriers to Protective Services for the Aged."

2. *Compensation and pension programs.*—The Veterans' Administration, through the various programs administered by the Department of Veterans Benefits (Compensation, Pension and Dependency and Indemnity Compensation), provides all or part of the income for almost 2 million persons age 65 or older. This total is broken down to: 1,024,641 veterans, 695,637 widows, 148,331 mothers and 61,182 fathers of veterans.

3. *Educational assistance.*—Public Law 90–631, enacted October 23, 1968, and effective December 1, 1968, extends eligibility for a maximum of 36 months entitlement to educational benefits under the provisions and at the rates of chapter 35 of title 38, United States Code, to widows of veterans who died of service-connected causes or wives of veterans who are permanently and totally disabled from service-connected disabilities. Counseling under this law is optional but not mandatory. This portion of the law is primarily intended to assist the wives and widows of the younger veterans of the Vietnam era. However, the law contains no age limit so that the benefit would be equally available to wives and

widows over age 65 who are otherwise qualified. It is not presently possible to determine whether many in this older category will choose to take advantage of the benefit.

ITEM 16: DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT: REPORT ON HOUSING FOR SENIOR CITIZENS IN 1968 [1]

INTRODUCTION

The Department of Housing and Urban Development administers a wide and varied array of programs which provide financial assistance to public and private sponsors for the development of rental housing specially designed for senior citizens and the physically handicapped. These programs vary primarily on the basis of the type of financing, sponsorship, and the income group which will occupy the housing. The low-rent public housing program provides housing for the lowest income group; the direct loan program is utilized by various sponsors to build housing for those with lower-middle incomes; and for the elderly and handicapped in a wider income range, the FHA section 231 mortgage insurance program is available to both nonprofit and profit-motivated sponsors.

The Housing and Urban Development Act of 1965 also permits housing for the elderly and handicapped developed under the FHA section 221(d)(3) market interest rate program to be eligible for rent supplements on behalf of low-income occupants. Eligible sponsors include private nonprofit corporations, cooperatives, and limited dividend mortgagors.

Another new financing method for the development of housing for lower income senior citizens is the new FHA section 236 program included in the 1968 Housing and Urban Development Act. This program, available to nonprofit groups, cooperatives, and limited dividend entities, will provide interest-reduction payments on market rate mortgages. These payments, which can reduce effective interest rates on mortgages down to as low as 1 percent, will help many lower income families to afford good housing.

While these are the HUD programs which provide assistance for rental housing for the elderly, the Department also administers a number of other programs of significant benefit to senior citizens. For example, FHA's section 232 mortgage insurance program provides mortgage insurance for profit-motivated and nonprofit sponsored nursing homes. While nursing homes provide care for all age groups, the elderly are the largest group by far to use such facilities. An amendment in the 1968 Housing Act which permits the cost of major equipment used in the operation of nursing homes to be included in an FHA-insured nursing home mortgage will facilitate their financing.

The new act also includes a program which authorizes HUD to make 80 percent interest-free loans to nonprofit sponsors of low- and moderate-income housing, including housing developed under section 202 and section 236. These loans will be available to cover costs such as those incurred for preliminary surveys, market analyses, site acquisition, mortgage commitment fees, and the like.

For older people who want to and are able to afford their own homes, the FHA offers mortgage insurance for the purchase of homes under its section 203 and section 221 sales housing programs. The 1968 act also includes an interest-reduction payment for homeowners under a new section 235 program which also will be available to the elderly.

Two other new provisions of the 1968 act relating to relocation payments are of particular interest to the elderly. One broadens HUD's authority to make "additional" payments over a 2-year period, in an amount not in excess of $500 per year, to assist displaced families of all ages and elderly single persons in obtaining suitable replacement housing. Previously, the maximum payment was $500, payable over a 5-month period. Eligibility for these payments was extended to handicapped individuals.

In addition, HUD was authorized to make a "replacement housing" payment to an owner-occupant (regardless of age) of residential property which is acquired for a HUD-assisted project to enable him to purchase a replacement home. The payment could be up to $5,000, but would be paid only if the displaced owner buys and occupies a dwelling within 1 year after the date on which he is required to move, and he elects not to receive an "additional" payment. This "replacement housing" payment program may be particularly helpful to older people dispossessed by public action from modest homes which they own, often free of debt,

[1] Submitted by the Department of HUD at the request of Sen. Harrison A. Williams, committee chairman.

but without sufficient compensation otherwise to enable them to purchase other homes suited to their needs. For many older people, these payments will permit those who wish to do so to remain homeowners for the rest of their lives.

In 1966, the Demonstration Cities and Metropolitan Development Act included a new program authorizing the FHA to insure mortgage loans to private nonprofit corporations to finance the construction or rehabilitation of, and the purchase of equipment for, facilities for the group practice of medicine, dentistry, or optometry. All age groups will benefit through the use of facilities developed under this program, but the elderly can be expected to benefit particularly.

The 1968 Housing Act added still another important dimension to FHA's participation in the financing of health-related institutions, by authorizing FHA to insure mortgages covering new or rehabilitated hospitals.

HUD's Renewal Assistance Administration is responsible for administering the neighborhood facilities grant program under which grants for neighborhood facilities such as multipurpose centers are available. The RAA also administers the direct loan and grant programs which assist homeowners to rehabilitate their homes in urban renewal and concentrated code enforcement areas. Both programs can be very helpful to the many elderly people who reside, often in disproportionate numbers, in those areas subject to renewal and code enforcement.

The low income housing demonstration program, administered by the Office of Urban Technology and Research, provides grants to assist in the development of improved means of providing housing for the low-income population. A number of grants have been made which relate specifically to older people under this program.

The model cities program also is expected to make real contributions to the elderly and HUD's senior citizens housing programs will be available for the development of better housing for the older residents of those areas. President Johnson has directed that HUD give special attention to the needs of older people in poor housing and decaying neighborhoods included in the model cities areas. (See p. 188 for list of cities selected for planning grants.)

Progress and Activity in 1968

Through September 1968, HUD's low-rent public housing program, together with the section 202 direct loan program and FHA's section 231 program, had made net commitments for nearly 260,000 specially designed units for the elderly. During the first 9 months of calendar 1968 alone, nearly 27,000 units were started under these three programs, bringing the cumulative total of units placed under construction in these programs to nearly 194,000. As of the end of September, the cumulative total of completed units amounted to nearly 148,000, of which over 25,000 were completed during the first three-quarters of the year.

Rent supplements under the section 202 and section 231 programs

Five percent of the rent supplement funds may be used to assist low-income elderly or handicapped occupants of section 202 and section 231 senior citizens housing projects under the experimental provisions of the rent supplement program. As of the end of September, nearly $2.2 million of the approximate $2.4 million avaiable for these two programs had been allocated. These allocations had been made for 140 projects in 113 cities in 37 States and Puerto Rico, estimated to provide assistance for occupants of about 3,400 of the approximate 17,700 units included in these projects.

By the end of September 1968, just over 100 of the section 202 projects were receiving rent supplement payments. Another 30 had rent supplement contracts or formal reservations for rent supplements. Six of the eight section 231 projects participating in the program also were receiving payments under this program.

Overall activity in the rent supplement program

Through November 1968, the FHA had made formal reservations or contracts for over $55 million of the total $72 million in contract authority which the Congress had approved for the rent supplement program, including the $30 million approved October 4, 1968. Well over 700 projects—planned, under construction, or completed—thus already were, or will be participants in the rent supplement program. Many elderly people will be among the residents and beneficiaries of rent supplements in housing intended for families of all ages developed under the 221(d)(3) market and below market rate programs, and in the future, from the

new section 236 program. These, of course, will be in addition to those elderly who receive this important assistance while occupants of housing specially designed for them in HUD's several senior citizens housing programs.

RENT SUPPLEMENT ACTIVITY UNDER THE FHA SECTION 221(d)(3) MARKET RATE PROGRAM

In addition to the above, as of the end of September 1968, a total of 35 rent supplement projects were being planned for occupancy by the elderly and handicapped under FHA's section 221(d)(3) market interest rate mortgage insurance program. These 35 projects involve formal reservations or contracts for annual rent supplements totaling over $2.5 million and will contain about 2,600 dwelling units, practically all of which will be available for occupancy by families benefiting from assistance.

Fourteen of these projects will be sponsored by nonprofit organizations and will include about 1,500 units with formal reservations or contracts for annual rent supplements of up to about $1.4 million. The 21 projects sponsored by limited dividend corporations will have over 1,100 dwelling units with formal reservations or contracts for up to about $1.2 million annually in supplementary assistance.

These 14 nonprofit projects will be developed in nine States, while the 21 limited dividend projects will be distributed among five States, with 11 in the State of Washington.

As of September 30, 1968, formal applications for mortgage insurance had been received for 29 of the projects, in contrast with only 13 at the end of 1967. During the first 9 months of 1968, FHA commitments were issued for 19 projects with a total of over 900 units, bringing the total number of units in the 26 projects with commitments to approximately 1,700.

During the first 9 months of 1968, a total of 17 projects with 1,400 units were placed under construction (initial endorsements), bringing the cumulative total up to 20. At the end of September, rent supplement payments already were being made in two of these projects.

ACTION BY CONGRESS ON THE RENT SUPPLEMENT PROGRAM IN 1968

The 1968 Housing Act broadened sponsor eligibility provisions of the rent supplement program by including sponsors of rental or cooperative housing projects financed under a State or local program providing assistance through loans, loan insurance, or tax abatement, and which prior to completion of construction or rehabilitation, are approved for receiving rent supplement benefits.

The 1968 act also provided that rent supplement funds may be used to supplement 20 percent of the units in a project constructed under the new 236 rental and cooperative housing program.

THE INSURANCE INDUSTRY'S $1 BILLION INVESTMENT FUND

In 1967, the insurance industry created a $1 billion investment program for low-income housing purposes to purchase mortgages in section 221(d)(3) rent supplement projects when the mortgage was at the market rate of 6¾ percent. This fund was not pooled, but each participating company selected the mortgages it wished to purchase from among mortgages referred by the FHA to a central committee established by the various insurance companies. In addition to mortgages on multifamily housing, the fund also was used to purchase mortgages on single family homes in older or blighted neighborhoods, providing significant assistance to families seeking to purchase homes in inner city areas.

The first criterion for purchases under the program is that the mortgage be insured by FHA. Secondly, the projects are to provide low-income housing in or near slum areas. However, projects located outside the city core areas offering relocation housing for present slum dwellers also qualify. Finally, the program is designed to provide financing for projects intended to serve families currently living in substandard urban housing or those displaced by urban renewal projects.

As of September 13, 1968, after 1 full year of operation, the participating insurance companies have committed themselves to purchase $484.7 million in mortgages. They have issued firm commitments to purchase $194.7 million of multifamily mortgages involving 16,493 units and $290 million of home mortgages involving 25,117 units.

FHA is negotiating with the insurance industry with the hope of obtaining company pledges of an additional billion dollars to purchase mortgages on FHA insured loans for low-income housing projects.

ACTIVITY IN LOW-RENT PUBLIC HOUSING

With the greatest need for more suitable housing among the low-income elderly, the low-rent public housing program continues as the single largest program providing good housing for senior citizens. During the first 9 months of 1968, over 18,000 dwelling units were approved for annual contributions contracts, bringing the cumulative total to nearly 174,000. Cumulative construction starts through September 1968 rose to over 118,000 units, of which over 21,000 were started during the January-September period. By the end of September, almost 88,000 units had been completed, of which almost 20,000 were completed during the first 9 months of the year. It is important to note that older people also live in nonspecially designed low-rent units, and as of June 1968, it is estimated that 350,000 elderly persons were living in public housing, both in regular and specially designed units. In fact, HAA is concerned that insufficient housing is being supplied for large families, and is considering policies which would create a better balance between housing for senior citizens and large families. While the percentage of units designed for the elderly under such policies might decrease, the number of units to be produced each year for occupancy by senior citizens would continue to increase with the growth of the program. (A table is attached which summarizes projects approved in each State under this program, from its inception through September 1968, and another table lists projects approved during the first 9 months of the year.)

During the year, interest continued at a high level in providing good housing for the handicapped. In April, the Seattle, Wash., Housing Authority's 150-unit project, specially designed for occupancy by both the elderly and handicapped, was placed under construction and is expected to be completed around August 1969. This development will include covered parking for occupants. Adjacent to the project is the new Seattle-King County chapter of the American Red Cross Building, where some physically impaired persons will be employed. The Seattle Handicapped Club, a very active organization, will construct a multiservice center nearby, which will include a restaurant, facilities for recreation, social, therapeutic and rehabilitation services, and research and training conducted under the direction of the School of Medicine of the University of Washington.

In Fall River, Mass., the Housing Authority placed its 209-unit development, designed specifically for the elderly and handicapped, under construction in June 1968. The project is located on land adjacent to the Hussey City Hospital and the two will be connected by an underground passage. The basement of the housing development will be equipped with facilities for occupational therapy, hydrotherapy, exercise, a nurse's station, and a barber and beauty shop. All of these facilities will be operated by hospital staff, and their development will be financed with funds from the city. An important consideration in the design of the quasi-medical facilities in the basement is that they are physically and visually separated from the first floor entrance of the dwelling portion of the project so that it retains its residential atmosphere. The project is expected to be completed around December 1969.

Another project of special interest placed under construction during the year is located in Charlotte Amalie, St. Thomas, located in the Virgin Islands. This will be an 85-unit elevator project, equipped for full housekeeping. However, in addition, the Virgin Islands government, through an agreement with HUD, also is financing a central kitchen and dining facility for use by the residents when they wish to do so. Construction on the project started in October 1968, and when completed, around March 1970, occupants will be living in a lovely setting facing the beautiful Bay of St. Thomas.

During 1967, in order to react more rapidly to the urgent housing needs of low-income Americans, the Housing Assistance Administration was reorganized to give regional administrators new responsibility and authority aimed at speeding and increasing actual dwelling unit production. This reorganization included the centralization of production staff in the regional offices which provides a one-step processing unit, the elimination of many processing procedures, and the development of streamlined, simplified forms. In the central office, a production division was organized to set production goals, allocate resources, monitor progress, and to break bottlenecks.

In September 1967, President Johnson announced that HAA would make 70,000 dwelling units ready for occupancy in the period from October 1, 1967, to September 30, 1968. HAA met the "production goal", and a very substantial proportion of the 70,000 units were designed for the elderly and handicapped.

THE DIRECT LOAN PROGRAM

Section 202 of the Housing Act of 1959, as amended, authorizes HUD to make long-term, low-interest loans to nonprofit organizations, and consumer cooperatives, and certain public agencies to build rental housing for the elderly and physically handicapped. These groups are eligible for loans covering up to 100 percent of total development cost. The 1968 Housing Act added limited profit sponsors to those eligible under the program, but limits the loans to not more than 90 percent of development cost.

The maximum rate of interest is 3 percent and loans may be made for periods of up to 50 years. The program is intended to provide assistance for housing for lower middle income elderly, and is administered by HUD's Housing Assistance Administration.

Sponsors continued to be very interested in this program in 1968. During the first 9 months of the year, net applications were received for 67 projects and about 10,600 units for loans of about $136.7 million. This volume of applications was higher than the volume for the entire 1967 calendar year.

During these first 9 months of 1968, 55 projects with 8,600 units and loans of $112.6 million were approved, bringing the cumulative total up to 306 projects with 41,600 units and $509 million. As of the end of September, the "pipeline" of applications on hand not yet approved amounted to about 80 projects, with requests to fund about 11,500 units with loans of $146.6 million. In addition, it was estimated that sponsors were developing applications for loans amounting to about $350 million.

Construction starts during the first three quarters of 1968 amounted to nearly 5,000 units in 34 projects, with loans of $63.6 million, bringing the cumulative totals up to 238 projects, with 31,500 units, and loans of $382.9 million.

During this 9-month period, 34 projects with nearly 4,800 units were completed, involving loans of $61.2 million. These brought the cumulative totals up to 184 projects with over 22,000 dwelling units and loans of $267.8 million. A table is attached which summarizes projects approved in each State under this program from its inception through September 1968, and another table lists projects approved during the year.

DIRECT LOAN HIGHLIGHTS

The first three-quarters of the year were marked by a number of significant events with regard to the direct loan program. For example, in May, the first "202" project to be developed in the Nation's Capital was approved. This will be the Episcopal Church Home and will contain 200 dwelling units. The sponsoring group is itself providing $350,000 in funds for the development, in addition to the Federal loan.

In June, a 112-unit project in Los Angeles, sponsored by the Pilgrim Lutheran Church for the Deaf, was completed. This is the first "202" project specifically intended for the elderly and handicapped, and project occupancy already is at a high level, with most of the residents older deaf persons, as originally anticipated. The first "202" conversion project also was completed during the year in San Antonio, as the rehabilitation of the Granada Hotel was completed under the sponsorship of the San Antonio Building & Construction Trades Council, Housing Authority, and Senior Community Services, Inc.

Northern New England's first direct loan development was completed in October when the Sunset Manor project in Bangor, Maine, opened its doors to occupancy. This is the first "202" in Maine, New Hampshire, or Vermont.

In 1967, two projects were approved in Massachusetts and California involving housing for senior citizens on scattered sites. In 1968, both projects were placed under construction. Each sponsoring group will provide the advantages of centralized management to its satellites. In Massachusetts, the housing is being built in Beverly, Danvers, Peabody, and Salem by the Episcopal Housing Corp. and Episcopal Diocese of Massachusetts. In California, the housing is being developed in Oakland and Berkeley by a group of five churches which have formed a nonprofit corporation together with the Social Service Bureau of the Oakland Council of Churches. As part of its original plan, this sponsor also applied for two additional loans during the year to help meet the need for decent housing for the elderly in the Oakland area.

During the year, occupants and sponsors of direct loan projects in California, New York, and Connecticut benefited from the enactment of legislation providing local real estate tax exemption to all "202's." In Florida, existing law was amended to permit licensing of direct loan projects under special provisions which provide total local real estate tax exemption. These actions mean that rents in the projects

in these States can be significantly lower than they would have to be if these lower middle income housing developments were subject to these taxes.

FHA MORTGAGE INSURANCE FOR RENTAL HOUSING FOR THE ELDERLY

The Federal Housing Administration is authorized to insure lenders against losses on mortgages for construction or rehabilitation of rental housing for the elderly. This authority is contained in section 231 which was added to the National Housing Act in 1959. The program provides mortgage insurance for 90 percent of replacement cost in the case of profit-motivated sponsors and 100 percent of replacement cost for nonprofit sponsors. Mortgage terms may be for as much as 40 years and the allowable interest rate is currently 6¾ percent, plus one-half of 1 percent mortgage insurance premium. Prior to the enactment of section 231, FHA mortgage insurance assistance for housing for the elderly was available under the section 207 program, pursuant to legislation enacted in 1956.

This program serves a higher income group than that served by public housing or the direct loan program. Activity during the year was at a relatively low level, with only six projects receiving commitments for a total of around 500 dwelling units, involving mortgage insurance of about $7.3 million.

As of the end of September 1968, cumulative commitments (net) under this program had been issued for 286 projects, with nearly 43,500 units and mortgage insurance amounting to over $534 million. During the year, projects with nearly 900 units were placed under construction and about 800 were completed. As of the end of September, there were 251 projects with 37,600 units completed, with mortgage insurance of $455.5 million and another 6,100 units under construction. A table is attached which summarizes projects for which commitments were issued for housing for the elderly under section 207 and section 231 from the inception of the program through September 1968, and another table lists section 231 commitments during the first 9 months of the year.

Tight money and associated high-interest rates which continue to prevail account in large measure for the comparative inactivity in this program. Another factor was the continuing unfavorable experience which resulted in the acquisition of an additional seven projects by foreclosure, making a total of 37 since the inception of the program. In 23 additional cases, mortgagees assigned the mortgages to HUD. Since these represent about one-fifth of all FHA-insured senior citizens projects, this experience no doubt has prompted the FHA insuring offices to adopt a cautious approach in making feasibility determinations.

HOUSING FOR SENIOR CITIZENS UNDER SECTION 236

The 1968 Housing and Urban Development Act includes the new section 236 program which may be used to assist in financing housing for all age groups as well as housing specially designed for the elderly and handicapped. This program provides assistance in the form of periodic payments to the mortgagee financing the housing to reduce the mortgagor's interest costs on a market rate FHA-insured project mortgage.

The interest-reduction payments will reduce payments on the project mortgage from that required for principal, interest, and mortgage insurance premium on a market rate mortgage to that required for principal and interest on a mortgage bearing an interest rate of 1 percent.

These payments will reduce rentals to a basic charge, and a tenant will either pay the basic charge or such greater amount as represents 25 percent of his income, but not in excess of the charges which would be necessary without any interest-reduction payments.

Tenants who pay less than the fair market rental charge for their units generally will have to have incomes, at the time of the initial rent-up of the projects, not in excess of 135 percent of the maximum income limits that can be established in the area for initial occupancy in public housing. However, up to 20 percent of the contract funds authorized in appropriation acts may be made available for projects in which some or all of the units will be occupied, at the time of the initial rent-up, by tenants whose incomes exceed the above limit, but do not exceed 90 percent of the income limits for occupancy of section 221(d)(3) below-market rate rental housing.

To qualify for mortgage insurance under this new program, a mortgagor must be a nonprofit organization, a cooperative, or a limited dividend entity. Mortgage limitations are the same as for mortgages insured under the 221(d)(3) program.

Interest-reduction payments also can be made with respect to State-aided rental housing projects approved for receiving the benefits of the program prior to completion of construction or rehabilitation of the projects.

Contracts for assistance payments are authorized, subject to approval in appropriation acts, in the amount of $75 million annually prior to July 1, 1969. This amount is increased by $100 million on July 1, 1969, and by $125 million on July 1, 1970. A reasonable portion of this authority is to be transferred to the Secretary of Agriculture for use in rural areas and small towns.

A project financed under the new program can include nondwelling facilities to serve the occupants of the project and the surrounding neighborhood, as long as the project is predominantly residential and any nondwelling facilities contribute to the economic feasibility of the project. Where a project is designed primarily for occupancy by the elderly or handicapped, it can include related facilities for their use, such as dining, work, recreation, and health facilities.

Projects for the elderly or handicapped approved for direct loans can be refinanced under this new interest-reduction program at any time up to, or a reasonable time after, project completion.

The current appropriation for this program through fiscal 1969 is $25 million in authority to contract for assistance payments and $3.5 million for actual payments.

FHA MORTGAGE INSURANCE NURSING HOME PROGRAM

Section 232 of the National Housing Act authorizes the FHA to provide mortgage insurance for proprietary nursing homes and those sponsored by private nonprofit corporations or associations. The Housing and Urban Development Act of 1968 authorized payment of major nonrealty equipment from mortgage proceeds. There is a statutory limit of $12.5 million per project under this program. Within this limit, the maximum insurable mortgage amount is 90 percent of the FHA-estimated value of the project and equipment at completion, but on rehabilitation projects, not over five times the cost of new improvements. The maximum mortgage maturity period is 20 years and the current maximum interest rate is 6¾ percent plus one-half of 1 percent mortgage insurance premium. Each project covered by mortgage insurance under this program must consist of not less than 20 nursing beds.

Joint financing through a combination of FHA mortgage insurance and a Federal grant or loan made by the Department of Health, Education, and Welfare under the Hill-Burton Act is permissible for nonprofit nursing homes.

As of November 1968, there were seven nursing home projects which involve this joint financing. Two (in Atlanta, Ga., and Phoenix, Ariz.) were in operation. Another two (in Denver, Colo., and Fairlea, W. Va.) were under construction. One project in Beaumont, Tex., has been approved and applications are in process for homes in Horse Cave, Ky., and Columbus, Ohio.

During the first three quarters of 1968, the FHA approved applications for 77 nursing homes planned to contain about 9,100 beds and for mortgage insurance of about $82 million. This brought the cumulative total up to 615 nursing home commitments (net), with over 58,000 beds and mortgage insurance of $402.2 million. During the year, nursing homes with about 6,200 beds were placed under construction, and in the 9-month period over 3,400 beds in 35 nursing homes were completed. The cumulative total of nursing homes completed through September 1968 since the program's inception rose to 423, containing about 38,600 beds and insured for about $252.3 million. In addition, at the end of September nursing homes with 12,300 beds were under construction. A table is attached which summarizes commitments issued through September 1968, and another lists projects for which commitments were issued during the first 9 months of the year.

NEIGHBORHOOD FACILITIES

A program of grants to local public bodies or agencies to finance neighborhood facilities projects was established by section 703 of the Housing and Urban Development Act of 1965. The program provides grants, normally two-thirds of the development cost of such facilities, except in areas designated under the Area Redevelopment Act which may receive grants of up to three-fourths of the development cost.

A center must be multiservice in character by offering a wide range of health, welfare, education, social, recreational, and other similar community services. Priority is given to those projects which are designed primarily to benefit low-income families or otherwise substantially further the objectives of a local com-

munity action program approved under title II of the Economic Opportunity Act of 1964.

The types of services offered to senior citizens in a neighborhood facility are varied and include health services, recreational and social activities, employment programs, welfare and social security services and legal aid. A substantial number of neighborhood facilities plan to have senior citizens components and services. Approximately 40 percent of approved projects will offer senior citizen programs.

HOME REHABILITATION LOANS AND GRANTS

Section 312 of the Housing Act of 1964, as amended, authorizes HUD to make direct Federal loans to finance the cost of rehabilitating property in federally aided urban renewal areas or concentrated code enforcement projects. In 1965 legislation also was enacted to permit HUD to make direct Federal grants under the new section 115 of title I of the Housing Act of 1949, as amended, to finance the rehabilitation of structures located in federally aided urban renewal areas or concentrated code enforcement projects. Both of these programs are administered by HUD's Renewal Assistance Administration. A significant difference between these two programs and most programs administered by HUD is that these loans and grants are made to individuals directly rather than through local public agencies or other private profit-motivated or nonprofit groups.

Prior to the enactment of these direct loan and grant programs, low-income homeowners in blighted areas were severely limited in their ability to secure financing to rehabilitate their properties. As a result, their properties would continue to run down and eventually be subject to clearance. As a result of the rehabilitation loan and grant programs, families in federally aided urban renewal and concentrated code enforcement areas may receive direct Federal financial assistance. A substantial number of these families are elderly, and the availability of this direct assistance is of particular importance to such families since the other deterrents which the conventional money market places on them are aggravated and compounded by their age.

Any families owning and occupying the one- to four-family dwellings in federally aided urban renewal or concentrated code enforcement areas whose incomes are $3,000 or less are eligible for a grant of $3,000 or the cost of rehabilitation, whichever is less. Families with incomes of more than $3,000 also are eligible if their housing expense exceeds 25 percent of income. These families also are eligible for the direct 3 percent 20-year loans. These loans, not to exceed $10,000, or up to $14,500 in high-cost areas, are available basically for rehabilitation. However, in special cases where the sum of the monthly payments on existing debt related to the property and the proposed rehabilitation loans would exceed 20 percent of the family's income, the rehabilitation loan also could be used to refinance the family's existing debt. This combination often serves not only to make the rehabilitation possible, but at the same time to substantially reduce the monthly payments which the family has to make on its property. In many cases, the owner-occupant family is able to qualify for a combination loan and grant, and this assistance is particularly meaningful to the elderly.

As of September 30, 1968, more than 5,400 direct loans covering 9,000 dwelling units for over $31 million had been approved, compared to 2,700 loans covering 4,000 dwelling units for about $14.1 million approved at the end of 1967. With regard to the grant program, by September 30, 1968, over 7,300 grants for more than $10.5 million had been approved, compared to about 4,500 for $6.2 million at the end of 1967. Data are not yet available with regard to the participation of the elderly in these programs, but it is estimated that a substantial number of these loans and grants have been made to senior citizen homeowners.

The rehabilitation workload in urban renewal and concentrated code enforcement areas continues to be very large. As indicated by the rapid expansion of grants and loans approved under these programs since their enactment, they are helping to meet the need and are expected to continue expanding their roles as a major force in the rehabilitation of blighted areas.

GROUP PRACTICE FACILITIES PROGRAM

The Demonstration Cities and Metropolitan Development Act of 1966 authorizes HUD, under title XI of the National Housing Act, to insure mortgage loans financing the construction or rehabilitation of, and the purchase of equipment for, facilities for the group practice of medicine, dentistry, or optometry. The program is administered by the FHA which receives technical guidance and assistance

covering medical and health aspects of the program from the Public Health Service of the Department of Health, Education, and Welfare.

Group practice makes possible more efficient use of scarce manpower and costly health care facilities and equipment. It can be particularly beneficial to small communities and low-income urban areas where adequate health facilities of a comprehensive nature may not otherwise be available. In addition, costly hospitalization can be significantly reduced where the group practice is combined with a comprehensive prepayment plan. This new FHA program was conceived in recognition of the potential of group practice in delivering efficient, comprehensive health services of high quality. It is intended to assure the availability of credit on reasonable terms to finance construction and equipment of medical, dental, and optometric group practice facilities.

Under the law, a group practice project may be sponsored by a group or organization which will either own and operate the proposed facility as a nonprofit unit, or will create a separate nonprofit entity to own the facility. Payment for health services provided by the group may be on either a prepayment or a fee-for-service basis.

The maximum mortgage is $5 million and a loan-to-value limitation of 90 percent of the FHA estimate of the value of the property, including equipment, covered by the mortgage. The term of the mortgage may be up to 25 years and the maximum interest rate is 6¾ percent, plus one-half of 1 percent mortgage insurance premium.

As of November 1968, two group practice facilities, in Lynch, Ky., and Nashville, Tenn., were under construction, The Nashville facility is receiving financial assistance from OEO in addition to the FHA-insured mortgage. Fifteen other group practice facilities are in the "pipeline" and a number of these also are planned for FHA–OEO financing. The group practice program is another which will serve all age groups, but which should be of particular benefit to senior citizens, whose needs for health care are so great.

NONPROFIT HOSPITALS

A new program included in the 1968 Housing Act authorizes the FHA to insure mortgage loans on nonprofit hospitals. The maximum individual mortgage is $25 million. Loans under this program will be based on a maximum of 90 percent of the estimated replacement cost of the property or project, including equipment to be used in the operation of the hospital. The maximum interest rate is 6¾ percent, plus one-half of 1 percent mortgage insurance premium.

This new program, which will be known as the section 242 program, is not operational, but policies and procedures which are being developed with HEW's assistance will be released at the earliest possible time.

MODEL CITIES

The Senate Special Committee on Aging held hearings on "The Usefulness of the Model Cities Program to the Elderly" on July 23, 1968. Included among those testifying were H. Ralph Taylor, assistant secretary for model cities and governmental relations and Mrs. Marie C. McGuire, assistant for problems of the elderly and handicapped.

Assistant Secretary Taylor indicated that of the 75 communities awarded model cities planning grants by March 1968, six listed an aged population in the model neighborhood of 20 percent or above; 35 cities indicated an aged model neighborhood population of 10.1 to 20 percent; and 29 cited a model neighborhood aged population of 1 to 10 percent. No information regarding the aged population was available for five of the 75 communities.

Comprehensive program plans are now beginning to come in from some of these 75 cities. The plans include problem identification and analysis, statement of goals, and program approaches including a 5-year forecast as well as a 1-year action plan.

With these plans already being submitted, the Model Cities Administration expects to be able to make supplemental grant awards to those cities early in 1969. In addition, the Model Cities Administration hopes to announce program support to model neighborhoods from other departments when the supplemental grants are awarded. It is anticipated that programs for the elderly residents in model neighborhoods will focus primarily on housing, health, social services, employment, and recreation.

The latest announcement of planning grants for model cities was made on November 21, 1968, completing the second round of cities selected for participation

in the program. A list is attached that contains all announced model cities planning grants, including an estimate of the population of each of the cities in 1965.

Summary

HUD's contributions to the development of housing specially designed for the elderly and handicapped during 1968 continued at a high level. By the end of September 1968 and since the programs first began, the cumulative number of units for which commitments had been issued under HUD's several senior citizens programs had risen to over 260,000 dwelling units. These commitments involve a total public and private investment of over $3 billion. In terms of people, when all of these dwellings are completed, they will house around 325,000 senior citizens. In addition, other hundreds of thousands of elderly people live in HUD-assisted housing where families of all ages live.

Cumulatively, by the end of September, nearly 200,000 units for the elderly had been placed under construction, and the number of units completed already was around 150,000.

Many of the trends which had their beginnings in the last several years continued in 1968. More and more sponsors are interested in helping to house the handicapped. More groups also are indicating interest in the development of housing in the community for elderly nonpsychotic citizens who are in mental hospitals primarily because of the lack of suitable alternatives. HUD, together with local housing authorities in Ohio, already has helped finance senior citizens housing where older people released from State mental institutions are living with other elderly residents, instead of being held in the demoralizing environment of those institutions. Further efforts also are being directed at the development of housing for those frailer elderly who, with limited personal care, could find their ability to live independently extended significantly.

The new and massive housing legislation enacted in 1968 will provide further assistance in the effort to provide more and better housing and living arrangements for the Nation's elderly. The year also witnessed the important enactment of legislation to assure accessibility to the physically handicapped in public buildings and public housing.

Thus, substantial progress has and is being made. However, far more needs to be accomplished to reach the goal of decent housing for all our senior citizens.

Cities Selected for Model City Planning Grants

[Population based on 1965 estimates]

Alabama:
- Huntsville (127,000)
- Tuskegee (12,000)

Alaska: Juneau (7,000)

Arizona:
- Gila River (6,000)
- Tucson (245,000)

Arkansas: Texarkana (21,000)

California:
- Berkeley (116,000)
- Compton (77,000)
- Fresno (156,000)
- Los Angeles City (2,695,000)
- Los Angeles County (1,099,000)
- Oakland (387,000)
- Pittsburg (21,000)
- Richmond (83,000)
- SanDiego (636,000)
- San Francisco (745,000)
- San Jose (308,000)

Colorado:
- Denver (520,000)
- Trinidad (10,000)

Connecticut:
- Bridgeport (156,000)
- Hartford (158,000)
- New Haven (151,000)
- New London (35,000)
- Waterbury (106,000)

Delaware: Wilmington (93,000)

District of Columbia: Washington, D.C. (802,000)

Florida:
- Dade County (1,064,000)
- Tampa (305,000)

Georgia:
- Alma (4,000)
- Athens (43,000)
- Atlanta (535,000)
- Gainesville (18,000)
- Savannah (141,000)

Hawaii: Honolulu (611,000)

Idaho: Boise (55,000)

Illinois:
- Carbondale (19,000)
- Chicago (3,520,000)
- East St. Louis (82,000)
- Rock Island (53,000)

Indiana:
- Gary (179,000)
- Indianapolis (530,000)
- South Bend (135,000)

Iowa: Des Moines (216,000)

Kansas:
- Kansas City (121,000)
- Wichita (275,000)

Kentucky:
- Bowling Green (33,000)

CITIES SELECTED FOR MODEL CITY PLANNING GRANTS—Continued

[Population based on 1965 estimates]

Kentucky—Continued
- Covington (57,000)
- Danville (13,000)
- Pikeville (5,000)

Louisiana: New Orleans (655,000)

Maine:
- Lewiston (43,000)
- Portland (72,000)

Maryland:
- Baltimore (925,000)
- Prince Georges County (583,000)

Massachusetts:
- Boston (616,000)
- Cambridge (104,000)
- Fall River (94,000)
- Holyoke (52,000)
- Lowell (87,000)
- Lynn (92,000)
- New Bedford (99,000)
- Springfield (166,000)
- Worcester (187,000)

Michigan:
- Ann Arbor (80,000)
- Benton Harbor-Benton Township (39,000)
- Detroit (1,660,000)
- Flint (Genesee County) (375,000)
- Grand Rapids (203,000)
- Highland Park (36,000)
- Lansing (121,000)
- Saginaw (99,000)

Minnesota:
- Duluth (104,000)
- Minneapolis (465,000)
- St. Paul (308,000)

Missouri:
- Kansas City (530,000)
- St. Louis (710,000)

Montana:
- Butte (27,000)
- Helena (22,000)

New Hampshire: Manchester (90,000)

New Jersey:
- Atlantic City (59,000)
- East Orange (77,000)
- Hoboken (47,000)
- Jersey City (270,000)
- Newark (395,000)
- Paterson (144,000)
- Perth Amboy (37,000)
- Plainfield (47,000)
- Trenton (107,000)

New Mexico:
- Albuquerque (242,000)
- Santa Fe (40,000)

New York:
- Binghamton (75,000)
- Buffalo (505,000)
- Cohoes (20,000)
- Mount Vernon (75,000)
- New York City (8,080,000)
  - Central and East Harlem
  - South Bronx
  - Central Brooklyn
- Poughkeepsie (37,000)

New York—Continued
- Rochester (305,000)
- Syracuse (216,000)

North Carolina:
- Asheville (62,000)
- Charlotte (230,000)
- High Point (65,000)
- Winston-Salem (139,000)

North Dakota: Fargo (50,000)

Ohio:
- Akron (298,000)
- Cincinnati (495,000)
- Cleveland (855,000)
- Columbus (540,000)
- Dayton (260,000)
- Martins Ferry (11,000)
- Toledo (354,000)
- Youngstown (162,000)

Oklahoma:
- Lawton (71,000)
- McAlester (17,000)
- Tulsa (280,000)

Oregon: Portland (380,000)

Pennsylvania:
- Allegheny County (600,000)
- Bradford (14,000)
- Erie (136,000)
- Lancaster (60,000)
- Philadelphia (2,030,000)
- Pittsburgh (560,000)
- Reading-Berks County (95,000)
- Wilkes-Barre (59,000)

Puerto Rico: San Juan (580,000)

Rhode Island:
- Pawtucket (81,000)
- Providence (190,000)

South Carolina:
- Rock Hill (32,000)
- Spartanburg (47,000)

Tennessee:
- Chattanooga (128,000)
- Cookeville (14,000)
- Nashville-Davidson County (261,000)
- Smithville-DeKalb County (11,000)

Texas:
- Austin (220,000)
- Eagle Pass (14,000)
- Edenburg (20,000)
- Laredo (64,000)
- San Antonio (645,000)
- Texarkana (32,000)
- Waco (105,000)

Utah: Salt Lake County (261,000)

Vermont: Winooski (8,000)

Virginia:
- Norfolk (322,000)
- Richmond (223,000)

Washington:
- Seattle (565,000)
- Tacoma (152,000)

Wisconsin: Milwaukee (765,000)

Wyoming: Cheyenne (50,000)

LOW-RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED JAN. 1, 1968, THROUGH SEPT. 30, 1968 (SOME OR ALL UNITS DESIGNED FOR ELDERLY)

Location	Number of housing units		Total development cost (in thousands of dollars)
	Total	For elderly	
Alabama:			
Bay Minette [1]	24	24	415
Birmingham	136	136	1,231
Decatur	1	1	16
Enterprise	100	30	1,503
Foley	90	10	1,451
Haleyville	88	42	1,271
Lanete	128	48	1,834
Livingston	60	15	973
Montgomery [1]	200	200	1,215
Piedmont	75	25	1,299
Selma	80	30	1,046
Scottsboro	130	50	2,152
Sumiton	40	15	709
Troy	350	90	5,348
Total, Alabama	1,502	716	20,463
Arizona:			
Maricopa County [1]	100	10	1,548
Tucson	96	96	1,603
Total, Arizona	196	106	3,151
Arkansas: Russellville	61	61	847
California:			
Berkeley [1]	500	200	9,215
Crescent City [1]	100	45	2,022
Los Angeles [1]	1,000	850	15,237
Marin County [1]	200	100	4,014
Monterey County [1]	300	75	6,390
Northgate Area	40	40	599
Oxnard [1]	150	20	3,142
Port Hueneme [1]	50	6	1,047
Richmond [1]	300	125	4,878
Sacramento City [1]	500	150	10,271
Sacramento County [1]	500	150	10,448
San Bernardino [1]	350	150	7,065
San Mateo [1]	150	30	3,436
Santa Clara County [1]	350	125	7,093
Stockton [1]	500	245	9,744
Yolo County [1]	100	25	2,112
Total, California	5,090	2,336	96,713
Connecticut:			
Ansonia	74	74	1,256
Hartford [1]	75	75	1,193
New Haven [1]	180	60	4,165
Total, Connecticut	329	209	6,614
Delaware: Wilmington	234	234	3,895
District of Columbia: Washington	271	271	4,163
Florida:			
Fort Myers	101	101	1,703
Fort Pierce	150	46	2,450
Jacksonville	201	201	3,143
Jacksonville [1]	198	124	1,562
Miami	60	60	493
Merritt Island	190	190	1,937
New Smyrna Beach [1]	100	100	1,552
Orlando	104	104	1,455
Tampa	400	400	4,519
Tampa [1]	100	20	1,656
Total, Florida	1,604	1,346	20,470

[1] Leased housing.

LOW-RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED JAN. 1, 1968, THROUGH SEPT. 30, 1968 (SOME OR ALL UNITS DESIGNED FOR ELDERLY)—Continued

Location	Number of housing units		Total development cost (in thousands of dollars)
	Total	For elderly	
Georgia:			
Calhoun	84	50	1,266
Conyers	70	70	953
Columbus [1]	80	25	849
Eastman	40	40	577
East Point [1]	225	50	3,465
McDonough	60	10	983
Royston	42	15	677
Total, Georgia	601	260	8,770
Hawaii: Honolulu [1]	300	30	6,876
Illinois:			
Elgin [1]	50	20	877
Jersey County	70	20	1,150
Moline	303	303	4,486
Total, Illinois	423	343	6,513
Indiana:			
East Chicago [1]	150	27	9,237
Evansville	56	8	854
South Bend [1]	75	5	1,944
Total, Indiana	281	40	12,035
Iowa: Burlington	201	201	2,915
Kansas:			
Atwood	24	24	385
Kinsley	40	40	601
Total, Kansas	64	64	986
Kentucky:			
Bowling Green	200	50	3,320
Calvert City	20	10	309
Campbellsville	120	44	2,137
Lebanon	100	24	1,800
Middlesborough	100	30	1,720
Mount Vernon	30	10	555
Springfield [1]	25	25	307
Versailles	54	10	1,021
Total, Kentucky	649	203	11,169
Louisiana:			
Jonesboro	70	40	1,102
Lake Providence	114	34	1,826
New Orleans [1]	500	100	8,182
Opelousas	220	40	4,022
Slidell [1]	76	10	1,311
Total, Louisiana	980	224	16,443
Maryland:			
Baltimore	161	161	2,743
Glenarden	62	12	1,101
Wicomico	75	75	1,192
Total, Maryland	298	248	5,036
Massachusetts:			
Boston [1]	2,000	350	28,710
Fall River	301	301	5,424
Fall River [1]	200	75	4,581
Malden [1]	50	25	1,048
Medford [1]	50	50	861
New Bedford [1]	125	30	2,965
Newton [1]	100	100	1,631
Quincy [1]	40	25	840
Taunton	40	40	731
Worcester	65	65	1,019
Total, Massachusetts	2,971	1,061	47,810

[1] Leased housing.

LOW-RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED JAN. 1, 1968, THROUGH SEPT. 30, 1968 (SOME OR ALL UNITS DESIGNED FOR ELDERLY)—Continued

Location	Number of housing units		Total development cost (in thousands of dollars)
	Total	For elderly	
Michigan:			
Bay City	381	381	6,257
Detroit	525	525	6,111
Flint	19	19	197
Gladstone	50	50	785
Grand Rapids	228	188	3,514
Ironwood	82	82	1,230
Manistique	35	35	528
Reed City	60	40	965
Rockwood [1]	50	34	946
Wakefield	30	30	450
Total, Michigan	1,460	1,384	20,983
Minnesota:			
Brainerd	162	162	2,429
Hibbing	60	60	949
Le Sueur	51	51	741
Madison	42	42	625
Minneapolis	350	350	5,864
Morris	60	60	899
Red Lake	10	10	84
Redwood Falls	60	60	900
St. James	73	73	1,083
St. Paul	372	332	5,664
Total, Minnesota	1,240	1,200	19,238
Missouri:			
Glasgow	30	14	479
Independence	250	250	3,474
St. Louis	230	70	4,319
St Joseph [1]	250	130	3,253
Springfield [1]	60	40	887
Total, Missouri	820	504	12,412
Nebraska:			
Benkelman	14	14	210
Blue Hill	16	16	240
Cozad	40	40	600
Geona	20	20	302
Nelson	20	20	300
Omaha [1]	100	70	1,954
Red Cloud	20	20	295
Total, Nebraska	230	200	3,901
Nevada:			
Clark County [1]	200	53	4,658
North Las Vegas [1]	100	10	2,332
Total, Nevada	300	63	6,990
New Hampshire:			
Lebanon	56	56	953
Manchester	4	4	76
Portsmouth	40	40	703
Portsmouth [1]	125	110	2,276
Somersworth [1]	40	40	672
Total, New Hampshire	265	250	4,680
New Jersey:			
Cliffside Park [1]	350	350	5,922
Edison Twp [1]	35	4	664
Fort Lee [1]	100	100	1,696
Glassboro	40	40	649
Long Branch [1]	30	20	615
Total, New Jersey	555	514	9,546
New Mexico:			
Albuquerque [1]	300	30	4,400
Bayard	40	14	687
Central Village	50	14	777
Total, New Mexico	390	58	5,874

[1] Leased housing.

LOW-RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED JAN. 1, 1968, THROUGH SEPT. 30, 1968 (SOME OR ALL UNITS DESIGNED FOR ELDERLY)—Continued

Location	Number of housing units		Total development cost (in thousands of dollars)
	Total	For elderly	
New York:			
Albany [1]	250	175	4,766
Hempstead	4	4	71
Mechanicville [1]	50	30	826
New York City	233	95	4,650
Do [1]	500	198	9,150
Rochester	151	129	2,075
Sodus [1]	10	2	221
Whitehall [1]	30	15	607
White Plains [1]	75	10	1,458
Total, New York	1,303	658	23,824
North Carolina:			
Ashville	100	100	1,413
Burlington	250	50	4,278
Charlotte [1]	100	22	1,727
Durham	224	92	2,974
Kings Mountain	150	30	2,485
Kinston [1]	156	50	2,539
Laurinburg [1]	100	25	1,537
Monroe	160	40	2,464
Do [1]	50	10	811
Winston-Salem	402	402	6,287
Do [1]	200	200	2,473
Total, North Carolina	1,892	1,021	28,988
North Dakota:			
Cando	30	24	453
Grand Forks [1]	64	64	997
Jamestown [1]	100	100	1,475
Mandan [1]	32	32	453
Rolette	20	20	295
Total, North Dakota	246	240	3,673
Ohio:			
Akron	385	313	5,614
Cleveland	232	232	3,874
Columbus	512	512	7,404
Dayton	24	24	306
Lorain	210	210	3,149
Mansfield [1]	100	50	1,878
New Boston	59	59	872
Painesville	100	100	1,515
Sandusky	158	158	2,368
Toledo	186	186	2,658
Total, Ohio	1,966	1,844	29,638
Oklahoma:			
Chickasaw Nation [1]	300	130	4,501
Colgate	50	30	782
Oklahoma City	345	345	4,957
Terral	12	12	177
Tuttle	18	14	272
Total, Oklahoma	725	531	10,689
Oregon:			
Cottage Grove [1]	50	50	1,111
Eugene [1]	300	70	6,664
Salem [1]	250	85	5,299
Veneta	50	30	773
Total, Oregon	650	235	13,847
Pennsylvania:			
Beaver	98	98	1,422
Carnegie	15	12	276
Pittsburgh	274	274	5,032
Reading	156	156	2,412
Total, Pennsylvania	543	540	9,142

[1] Leased housing.

LOW-RENT PUBLIC HOUSING PROGRAM ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED JAN. 1, 1968, THROUGH SEPT. 30, 1968 (SOME OR ALL UNITS DESIGNED FOR ELDERLY)—Continued

Location	Number of housing units		Total development cost (in thousands of dollars)
	Total	For elderly	
Rhode Island:			
Central Falls	154	154	2,829
Cranston	200	200	3,496
Warwick	42	42	677
Total, Rhode Island	396	396	7,002
South Carolina:			
Denmark	80	18	1,344
Rock Hill [1]	100	30	1,335
Total, South Carolina	180	48	2,679
Tennessee:			
Erin	30	7	492
Etowah	32	32	423
Hohenwald	40	14	685
Knoxville	551	551	8,053
La Follette	50	50	627
Lenoir City [1]	60	17	952
Lewisburg [1]	40	11	563
Livingston	20	6	329
Livingston [1]	20	6	300
Murfreesboro [1]	125	100	1,654
Sneedville	25	10	406
Winchester [1]	50	10	819
Woodbury	30	10	490
Total, Tennessee	1,073	824	15,793
Texas:			
Gorman	20	20	316
Granbury	32	28	499
San Antonio	89	89	1,242
Total, Texas	141	137	2,057
Virginia: Richmond	100	24	1,488
Washington:			
Bremerton [1]	150	60	1,948
Seattle	200	200	3,470
Seattle [1]	100	40	2,047
Tacoma	58	58	682
Tacoma [1]	150	75	3,212
Total, Washington	658	433	11,359
West Virginia: Spencer	70	30	1,264
Wisconsin:			
Fond Du Lac	156	156	2,335
Hurley	54	54	746
Kaukauna	74	74	1,051
Lake Mills	63	63	936
Oconto	82	82	1,227
Richland Center	65	65	973
Shawano	80	80	1,183
Wittenberg [1]	14	14	227
Total, Wisconsin	588	588	8,678
Grand total	31,846	19,675	528,614

[1] Leased housing.

ELDERLY HOUSING LOANS PROGRAM SEC. 202, SUMMARY OF APPROVED PROJECTS FROM INCEPTION OF PROGRAM THROUGH SEPT. 30, 1968

State	Number of projects	Number of units	Aggregate project cost
Total	306	41,486	$513,291,204
Alabama	1	151	1,870,000
Alaska			
Arizona	2	273	3,284,550
Arkansas	1	136	1,608,000
California	38	4,743	59,113,684
Colorado	9	796	8,887,476
Connecticut	6	764	9,364,974
Delaware	1	204	2,730,000
District of Columbia	1	200	3,140,000
Florida	28	5,308	64,886,476
Georgia	7	1,274	15,501,538
Hawaii	1	111	1,455,000
Idaho			
Illinois	7	499	6,358,466
Indiana	4	290	3,640,744
Iowa	10	750	8,645,706
Kansas	3	256	3,462,000
Kentucky	1	143	1,969,000
Louisiana	3	417	5,277,220
Maine	3	123	1,574,000
Maryland	10	1,880	24,445,006
Massachusetts	10	1,569	20,147,000
Michigan	21	3,063	37,759,812
Minnesota	17	1,447	18,179,465
Mississippi	1	101	967,000
Missouri	7	1,188	14,415,000
Montana	6	484	5,697,659
Nebraska	2	176	2,160,000
Nevada			
New Hampshire			
New Jersey	11	2,068	25,358,100
New Mexico	3	274	3,281,000
New York	6	948	11,677,000
North Carolina	1	142	1,790,000
North Dakota	3	158	1,643,289
Ohio	21	3,223	39,989,500
Oklahoma	4	402	4,328,144
Oregon	3	610	7,294,000
Pennsylvania	17	3,204	41,095,000
Rhode Island	1	117	1,469,000
South Carolina			
South Dakota	4	154	1,773,976
Tennessee	4	619	7,364,657
Texas	6	843	8,937,634
Utah	2	334	4,358,000
Vermont			
Virginia			
Washington	8	1,157	14,241,328
West Virginia	2	105	1,881,000
Wisconsin	2	145	2,136,000
Wyoming	4	276	3,332,300
Puerto Rico	4	361	4,801,500
Virgin Islands			

ELDERLY HOUSING LOANS PROGRAM, SEC. 202, APPROVED PROJECTS 9 MONTHS (JANUARY–SEPTEMBER) 1968

State and city	Name of project applicant	Aggregate project cost	Number of units
January–September 1968 program total		$109,127,400	8,570
Alabama: Montgomery	John Knox Manor Inc	1,870,000	151
California:			
Los Angeles	Progressive Home for the Elderly	1,742,000	141
Los Angeles	Wilnor Corp	3,797,000	287
Oakland	Printing Specialties Union Retirement Center, Inc	2,775,000	201
Pleasanton	Pleasanton Gardens, Inc	475,100	40
San Diego	Green Manor	1,962,000	151
San Luis Obispo	Judson Terrace Homes	915,000	75
Seaside	Seaside Civic League, Inc	984,300	80
Connecticut: Hamden	Davenport Residence, Inc	2,610,000	217
Delaware: Wilmington	Lutheran Senior Services, Inc	2,730,000	204
District of Columbia	Episcopal Church Home	3,140,000	200
Florida:			
Deland	Bert Fish Trustees, Inc	1,500,000	131
Fort Myers	Fort Myers Presbyterian Community, Inc	2,440,000	180
Miami Beach	Young Israel 202, Inc	2,460,000	199
Orlando	First Baptist Housing, Inc	2,400,000	197
South Pasadena	Lutheran Residences, Inc	2,390,000	180
Sunny Isles (Miami)	Sunny Isles Tower, Inc	2,660,000	224
West Palm Beach	St. Andrews Residence of Palm Beach	2,320,000	182
Georgia:			
Atlanta	Campbell Stone Apartments, Inc	2,300,000	196
Macon	Vineville Christian Towers, Inc	2,480,000	196
Hawaii: Kahului	Hale Mahaolu	1,455,000	111
Indiana: Evansville	Luther Village, Inc	1,850,000	148
Iowa: Mason City	Good Shepherd Retirement Apartments	1,188,000	93
Kansas: Kansas City	Cross-Lines Retirement Center, Inc	1,173,000	105
Louisiana: New Orleans	Christopher Homes, Inc	2,000,000	154
Maine: Madawaska	Elderly Home, Inc	534,000	48
Massachusetts:			
Falmouth	Cape Cod United Church Homes, Inc	1,117,000	85
Fitchburg	First Parish Housing Fitchburg, Inc	2,291,000	168
Quincy	Quincy Point Congregational Church Homes, Inc., No. 2	2,725,000	218
Michigan:			
Clawson	New Life, Inc	3,275,000	252
Detroit	Cathedral Terrace, Inc	2,859,000	238
Detroit	St. Paul's Housing, Inc	1,800,000	141
Flint	Flint Retirement Homes, Inc	1,394,000	110
Flint (vicinity)	Flint Heights Senior Citizens Apartments Association	2,325,000	196
Haslett (vicinity)	Capital Grange Senior Citizens Housing Corp	1,196,000	100
Inkster	Chateau Cherry Hill, Inc	2,541,000	192
Owosso	Kiwanis Village of Owosso, Inc	779,000	60
Saginaw	Saginaw Westchester Village, Inc	2,230,000	176
Saginaw	Essex Manor, Inc	1,238,000	96
Troy	Bethany Villa Housing Association, Inc	1,549,000	119
Minnesota:			
Litchfield	Augustana Lutheran Homes, Inc	611,000	47
Minneapolis	Ebenezer Towers, Inc	2,800,000	200
Thief River Falls	Valley Home Society	367,000	31
Missouri: St. Louis	Little Sisters of Poor, NS Home for Aged	2,041,000	161
Nebraska: North Platte	North Platte Odd Fellows Housing Corp	1,524,000	120
New Jersey:			
Keyport	Bethany Manor, Inc	2,770,000	210
Wildwood	Lions Center	1,490,000	112
New Mexico: Albuquerque	The Community Association for Senior Housing, Inc	1,384,000	121
Ohio:			
Cleveland	Villa St. Rose, Inc	2,525,000	202
Dayton	Dayton-Miami Valley AFL–CIO Senior Housing Foundation.	2,059,000	159
East Cleveland	Teamsters Housing, Inc	3,030,000	231
Mayfield Heights	Schnurmann House	2,752,000	198
Pennsylvania: Philadelphia	Unico Village, Inc	2,308,000	221
Rhode Island: East Providence	Trustees of Methodist Health and Welfare Services	1,469,000	117
Washington: Tacoma	Harborview Property, Inc	2,528,000	198

NEW COMMITMENTS ISSUED ON ELDERLY HOUSING PROJECTS UNDER SECS. 207 AND 231 THROUGH SEPTEMBER 1968

State	Projects	Units	Mortgage amount
Alabama	1	80	$800,000
Alaska			
Arizona	18	4,504	51,064,629
Arkansas	2	139	1,446,000
California	51	9,420	123,826,668
Colorado	22	2,146	24,529,387
Connecticut	5	535	8,654,600
Delaware	1	234	3,540,300
District of Columbia	2	659	8,666,704
Florida	15	4,097	50,290,859
Georgia	1	48	436,800
Hawaii			
Idaho	1	32	311,000
Illinois	7	1,067	12,525,334
Indiana	3	407	5,900,000
Iowa	5	474	4,926,100
Kansas	5	603	8,082,000
Kentucky	8	788	9,169,050
Louisiana	5	324	3,761,400
Maine			
Maryland			
Massachusetts	1	25	225,000
Michigan	6	1,080	11,612,006
Minnesota	14	864	10,465,400
Mississippi	2	331	3,855,100
Missouri	5	944	12,928,769
Montana	2	158	2,115,000
Nebraska	9	1,115	14,106,205
Nevada	2	394	4,480,200
New Hampshire	1	170	1,379,100
New Jersey	3	621	7,459,200
New Mexico	1	60	787,000
New York	4	301	3,641,009
North Carolina	2	264	1,350,000
North Dakota	2	95	1,127,330
Ohio	10	1,553	18,981,900
Oklahoma	3	261	3,479,800
Oregon	10	1,598	18,204,500
Pennsylvania	2	442	5,902,300
Rhode Island			
South Carolina			
South Dakota	3	122	1,030,300
Tennessee	5	573	7,261,500
Texas	24	3,703	44,941,784
Utah	2	402	5,326,600
Vermont			
Virginia	2	384	6,358,400
Washington	9	1,685	20,653,200
West Virginia			
Wisconsin	8	524	5,424,507
Wyoming			
Puerto Rico	2	258	3,243,400
Virgin Islands			
U.S. total	286	43,484	534,270,341

COMMITMENTS ISSUED JANUARY THROUGH SEPTEMBER 1968 ON SEC. 231 PROJECTS FOR THE ELDERLY

State and city	Name of project	Number of units for senior citizens	Mortgage amount
California:			
Riverside	Plymouth Towers	110	$1,748,700
Stockton	Plymouth Square	106	1,762,400
Connecticut: Greenwich	Merry Go Round MEWS	66	1,168,000
Kentucky: Lancaster	Garrard County Home for Aged and Infirm	24	300,000
Minnesota: Blue Earth	St. Lukes Lutheran Home	76	1,094,700
Texas: Midland	Midland Presbyterian Home	94	1,274,600
Total		476	7,348,400

FEDERALLY AIDED PUBLIC HOUSING PROJECTS WITH ALL OR SOME UNITS DESIGNED SPECIFICALLY FOR THE ELDERLY, WITH ANNUAL CONTRIBUTIONS CONTRACTS EXECUTED, CUMULATIVE THROUGH SEPT. 30, 1968

State or territory	Total public housing units for the elderly	Projects with all units for the elderly		Projects with some but not all units for the elderly	
		Number of projects	Number of units	Number of projects	Number of units
Total	175,210	1,101	103,998	1,506	71,212
Alabama	3,235	21	1,339	103	1,896
Alaska	25			1	25
Arizona	187	1	96	4	91
Arkansas	3,081	23	1,317	79	1,764
California	6,903	21	1,519	38	5,384
Colorado	903	9	803	7	100
Connecticut	3,556	41	3,169	7	387
Delaware	503	2	383	3	120
District of Columbia	1,649	4	804	7	845
Florida	5,281	25	3,196	29	2,085
Georgia	3,844	21	1,798	97	2,046
Hawaii	564	4	422	5	142
Idaho	170	4	170		
Illinois	14,751	102	10,686	108	4,065
Indiana	3,680	21	2,599	17	1,081
Iowa	788	10	717	4	71
Kansas	1,796	8	682	14	1,114
Kentucky	3,673	17	2,023	82	1,650
Louisiana	2,782	11	402	59	2,380
Maine	482	4	482		
Maryland	1,660	7	586	8	1,074
Massachusetts	8,755	70	6,429	17	2,326
Michigan	6,357	58	5,265	25	1,092
Minnesota	7,893	52	5,624	15	2,269
Mississippi	155	1	30	9	125
Missouri	3,066	9	1,038	34	2,028
Montana	16			2	16
Nebraska	4,082	64	3,391	18	691
Nevada	559	2	275	4	284
New Hampshire	1,504	13	1,064	6	440
New Jersey	12,737	81	10,821	34	1,916
New Mexico	527	4	192	16	335
New York	17,858	41	5,185	111	12,673
North Carolina	3,009	12	1,229	64	1,780
North Dakota	343	7	268	6	75
Ohio	9,649	44	5,630	33	4,019
Oklahoma	2,383	9	916	46	1,467
Oregon	2,419	11	871	9	1,548
Pennsylvania	9,233	62	5,276	75	3,957
Puerto Rico	120			12	120
Rhode Island	3,886	30	3,568	2	318
South Carolina	714	5	377	8	337
South Dakota	147	2	73	9	74
Tennessee	4,301	25	2,945	80	1,356
Texas	6,963	63	3,505	149	3,458
Utah					
Vermont	155	2	130	1	25
Virginia	421	1	50	7	371
Virgin Islands	158	1	84	7	74
Washington	3,546	36	3,047	11	499
West Virginia	960	5	450	14	510
Wisconsin	3,781	35	3,072	10	709
Wyoming					

NET COMMITMENTS ISSUED ON NURSING HOME PROJECTS UNDER SEC. 232 THROUGH SEPT. 30, 1968

State	Projects	Beds	Mortgage amount
Alabama	9	819	$5,054,259
Alaska			
Arizona	5	350	1,825,300
Arkansas	3	318	1,825,800
California	44	3,747	26,569,034
Colorado	8	1,015	6,132,600
Connecticut	16	1,557	9,725,968
Delaware	5	502	4,632,900
District of Columbia	1	199	1,450,000
Florida	35	3,158	19,184,151
Georgia	15	1,484	9,154,600
Hawaii	2	224	1,774,200
Idaho	6	430	1,915,543
Illinois	28	3,026	18,405,202
Indiana	10	816	5,045,200
Iowa	6	443	2,372,700
Kansas	6	420	2,525,529
Kentucky	16	1,328	7,327,449
Louisiana	7	768	4,750,400
Maine	4	252	1,384,000
Maryland	10	1,291	10,218,931
Massachusetts	13	1,029	8,461,262
Michigan	43	3,546	23,711,712
Minnesota	5	423	2,277,000
Mississippi	13	768	4,620,800
Missouri	16	1,795	14,602,900
Montana	4	320	2,025,500
Nebraska	13	830	4,830,031
Nevada	3	214	1,971,900
New Hampshire	3	200	1,561,700
New Jersey	46	4,931	44,521,070
New Mexico	2	100	678,500
New York	31	4,365	40,604,198
North Carolina	2	193	1,310,800
North Dakota	1	71	653,500
Ohio	24	2,249	15,482,663
Oklahoma	10	694	3,521,400
Oregon	16	1,312	7,521,000
Pennsylvania	16	1,735	12,368,243
Rhode Island	1	135	1,184,700
South Carolina	12	806	5,290,600
South Dakota	3	199	1,554,600
Tennessee	15	1,187	7,267,700
Texas	38	4,186	24,345,800
Utah	8	679	3,988,800
Vermont	3	238	1,633,300
Virginia	8	823	5,874,000
Washington	15	1,484	8,858,656
West Virginia	4	343	2,584,200
Wisconsin	10	979	5,943,719
Wyoming			
Puerto Rico	1	160	1,726,400
Virgin Islands			
U.S. total	615	58,141	402,250,402

COMMITMENTS ISSUED JANUARY THROUGH SEPTEMBER 1968 ON SEC. 232 NURSING HOME PROJECTS

State	City	Name of project	Number of beds	Mortgage amount
Arkansas	North Little Rock	Oak Hills Manor	168	$860,300
California	Chico	Crestwood of Chico	92	683,300
	Concord	Valley Manor Geriatrics Center	107	840,400
	Fresno	Northside Hospital	117	864,800
	do	Quad Nursing Home	99	604,600
	Los Altos	Los Altos Convalescent Hospital	154	1,094,700
	Woodland	Woodland Center Convalescent Hospital	100	757,000
Colorado	Denver	City Park Manor Nursing Home	120	995,500
	do	Davis Nursing Home	237	1,696,100
Delaware	Dover	Courtland Manor Nursing Home	100	955,000
	Wilmington	Mercy Village Nursing Home	100	994,400
	do	Hillside House, Inc	86	973,200

COMMITMENTS ISSUED JANUARY THROUGH SEPTEMBER 1968 ON SEC. 232 NURSING HOME PROJECTS—Continued

State	City	Name of project	Number of beds	Mortgage amount
Florida	Crestview	Crestview Nursing Home	60	293,100
	Dania	Dania Nursing Home	84	345,000
	Fernandina Beach	Nassau Hall, Inc	60	338,400
	Jacksonville	St. Jude Manor, Inc	137	729,200
	Melbourne	Binz Nursing Home	101	746,100
	Miami	Miami Convalescent Home, Inc	150	780,300
	Ocala	New Horizons Convalescent Home, Inc	82	510,000
	South Miami	South Miami Convalescent Home	120	1,020,600
	Tallahassee	Florida State Primitive Baptist Convention	60	369,900
Georgia	Douglas	Shady Acres, Inc	62	374,400
	Rossville	Rossville Nursing Home	100	667,800
Illinois	Dixon	Windsor Estates No. 7	82	513,000
	Posen	Posen Nursing Home	70	447,800
	Sterling	Windsor Estates No. 7	60	396,400
Indiana	Gary	Simmons Miller Nursing Home	46	313,500
	Winchester	Randolph Nursing Home, Inc	60	430,000
Kentucky	Glasgow	Homewood Nursing Home	94	480,000
	Louisville	Georgetown Manor Home	100	631,600
	Do	The Christopher East	150	988,600
	Pikeville	Mountain Manor Pike	100	796,600
	Tompkinsville	Monroe Nursing Home	60	324,100
Louisiana	New Orleans	Villa St. Charles, Inc	220	1,714,500
Maine	Rockland	Rockland Nursing Home	60	330,000
Maryland	Takoma Park	Sligo Gardens Nursing Home	100	905,700
Massachusetts	Melrose	Elmhurst Nursing Home	44	625,500
	South Dartmouth	Hillcrest Nursing Home	100	1,152,000
Michigan	Cadillac	Lakeview Manor	112	696,100
	Chelsea	Chelsea Medical Center	110	960,800
	Flint	Extend Care, Inc	92	853,200
	Holland	Birchwood Manor	107	592,800
	Marshall	Marshall Manor, Inc	66	571,300
	Trenton	Crestmont Nursing Home	72	670,000
Mississippi	Jackson	Fountain Blue Nursing Center	50	350,000
	Do	Lakeland Nursing Center	105	671,500
	Meridian	Meridian Nursing Center	75	379,400
Missouri	California	Windsor Estates of California, Inc	60	330,000
	Camdenton	Windsor Estates of Camdenton	60	330,000
	Independence	Windsor Estates of Independence	81	475,000
	Malden	Sunshine Nursing Home	50	260,000
Nebraska	N. Platte	Valleyview of North Platte	83	553,500
New Jersey	Hamilton Township	Mercer Care Center	100	971,500
	Neptune	Medicenter	100	990,000
	Princeton	Princeton House	128	1,476,000
	Union	Union Nursing Home	100	1,012,700
New York	Rockville Center	Lakeside Nursing Home	152	1,571,400
	Whitestone	Whitestone Nursing Home	200	2,142,000
North Dakota	Garrison	Garrison Nursing Home	71	653,500
Ohio	Findlay	Winebrenner Extensive Care Facility	106	985,000
	London	Madison Nursing Extensive Care Facility	100	846,000
	Newark	Newark Nursing and Convelascent Inn	200	1,494,000
Oklahoma	Blanchard	Senior Village	50	276,800
	Lawton	The Orlando	96	432,500
Oregon	Gearhart	Edgewater Nursing Home	42	249,300
South Carolina	Columbia	Capital Convalescent Center	120	941,800
South Dakota	Sioux Falls	Luther Manor	84	910,200
Tennessee	Murfreesboro	Boulevard Terrace	60	370,000
Texas	Beaumont	Schlesingers Home Care	208	1,250,000
	El Paso	Logan Heights Nursing Home	60	331,300
	Goldthwaite	Hickman Nursing Home	60	225,000
	Houston	Winter Haven	150	859,800
	Monohans	Monohans Convalescent Center	54	125,000
	San Antonio	American Nursing Convalescent Center, Inc	120	947,200
	Waco	Fireside Manor Nursing Home	120	777,200
Utah	Murray	Midgley Manor	120	673,200
Vermont	Rutland	Eden Park Nursing Home	120	1,094,600
Virginia	Richmond	Forest Hills Nursing Home	150	1,200,200
Washington	Seattle	Pinehurst Park Royal Convalescent Center	200	1,183,300
	Do	West Crest Convalescent Center	100	684,900
West Virginia	Fairlea	Greenbriar County Nursing Home	100	$850,000
	South Charleston	Riverside Convalescent Nursing Center	98	960,000
Wisconsin	Milwaukee	Milway Nursing Home	89	599,100
	West Allis	Methodist Manor Health Center	168	1,200,000
Puerto Rico	Rio Piedras	Valle Alto Nursing Home	160	1,726,400
Total, 85 projects			8,751	65,219,900

ITEM 17: OFFICE OF ECONOMIC OPPORTUNITY

OFFICE OF ECONOMIC OPPORTUNITY,
EXECUTIVE OFFICE OF THE PRESIDENT,
Washington, D.C., December 31, 1968.

DEAR SENATOR WILLIAMS: I am pleased to enclose a statement for your committee's report regarding what OEO considers significant progress in meeting some of the needs of the elderly poor.

As our report states, the EOA Amendments of 1967 resulted in the restructuring of many program emphases. Our attempts to carry out these amendments have brought about a determined effort to do even more in the future in providing worthwhile programs affecting this age group. Our efforts have been limited only by insufficient funds, which have prevented the fullest realization of program plans for elderly people in need of help.

Sincerely,

BERTRAND M. HARDING,
Acting Director.

[Enclosure]

THE 1967 AMENDMENTS TO THE ECONOMIC OPPORTUNITY ACT

By far the most significant change in the work of the Office of Older Persons programs during this calendar year of 1968 was brought about by the amendments made to the Economic Opportunity Act, which became effective December 23, 1967. These amendments, numerous and obvious in their intent to increase OEO aid for the older poor, have had far-reaching effects, limited only by the fact that funds were not available for their full implementation.

Every title and many individual sections of the act were amended by the insertion of words or phrases to make it clear that the programs covered therein were intended to include older people as participants or as beneficiaries, and general language was also inserted to emphasize that the older poor are to be involved, employed, and served in all antipoverty programs to the greatest extent possible. A special subsection was added to the list of community action programs to be given national emphasis, and this provided for a new category to be designated as senior opportunities and services programs. And, finally, not only was the OEO Director required to report to Congress at the end of each fiscal year as to how much improvement there has been in the involvement, employment or service of the older poor in all antipoverty programs, but the earmarks for the old special emphasis programs were removed in the appropriations legislation. Thus eliminated was one of the former obstacles to the funding of older persons programs by community action agencies, for, when legislatively mandated to spend earmarked sums in certain youth-oriented programs, needed and wanted or not, they had no funds available for older persons programs even when urgently desired.

The assistant director for older persons programs reminded all program and regional directors of these amendments and of their implications as soon as they took effect. She explained them in detail at many meetings and in countless individual conferences, and she prepared and distributed copies of the amendments and a written analysis of their effects. All program and regional directors were requested to advise their respective staff subordinates of the information furnished to them, and the assistant director also notified the individual community action agencies. Throughout the year, reminders have several times been issued when it seemed to the assistant director that the intent of the Congress as indicated in the 1967 amendments, was being forgotten. And, while, there are still occasions when such reminders are required, they are happily becoming fewer.

NEW FUNDING OF OLDER PERSONS PROGRAMS

Close behind the 1967 Economic Opportunity Act amendments in significance for older persons programs in 1968, was the allocation of reclaimed funds to such programs just before the close of the fiscal year on June 30, 1968. While it had been very disappointing that the OEO could not allocate funds immediately for the new senior opportunities and services special emphasis programs, when the 1968 fiscal year budget was finally approved early in 1968, the promise had been made

then by the director that an effort would be made to remedy the situation later if at all possible. A similar commitment was made as to the allocation of funds for older persons programs proposed as demonstrations by community action agencies. Then, when it was found that some funds previously allocated for other purposes would likely not be used during the fiscal year, these were in part reclaimed for older persons programs. The total amount so reallocated was approximately $2,900,000, of which roughly $2,500,000 was used to fund CAA programs in the various regions, and about $400,000 was reserved to fund a national demonstration program which will be described later. A summary of the new CAA programs will also be given later.

For fiscal year 1969, the OEO has allocated sufficient funds to annualize the programs funded at the end of fiscal year 1968, both as senior opportunities and services programs and under other headings, and it is again hoped that additional funds can be reclaimed from other allocations in fiscal year 1969 to fund more older persons programs before the fiscal year ends. If, of course, new funds should be appropriated by the Congress to the OEO, the amount of this allocation could be further increased.

The availability of funds for many older persons programs, which had long awaited approval, was an encouraging sign to those community action agencies which had been asking for such programs, usually unsuccessfully, for a long time. As a result, many more programs were submitted, and many are now pending, awaiting availability of funds.

Attempted Legislative Earmark of Funds for Older Persons Programs

When the OEO appropriations bill was under consideration in the Senate, language was inserted directing the earmark of $50 million for older persons programs above and beyond any amount previously funded under the senior opportunities and services subsection of the community action program's special emphasis programs. Similar language also directed the earmark of an additional $10 million in funds delegated to the Department of Labor under title I. There being no such language in the House version of the bill, this conflict was referred along with others to a conference committee. When the conference committee report was filed, it did not refer either affirmatively or negatively to the Senate earmarks, and conferees were questioned in both the House and Senate as to the meaning of this omission. Congressman Mahon, leader of the House conferees, said that the conferees rejected all earmarks. Senator Hill, leader of the Senate conferees, took the opposite point of view. The Congress adjourned without any further clarification of its position, and, inasmuch as the total OEO appropriation was felt to be needed by the agency and by the Bureau of the Budget to continue current programs, nothing was left for new programs. The agency has indicated, however, in response to several congressional inquiries, that it will do its best to meet the intended or unintended earmarks to the fullest extent possible as fast as reclaimed funds may permit.

While the proposed legislative earmark was legally ineffective as a practical matter, it did much to increase OEO awareness of the need to do more in aid of the older poor. News of it spread among the CAA directors and CAA board members and among regional staff members, all of whom, while worrying that, if the earmarks applied, they would have to cut back other programs drastically, were also impressed by the concern of the Congress that the older poor get more OEO attention. Psychologically at least, the proposed legislative earmarks actually had a considerable impact.

Regional Older Persons Programs Specialists

During 1968 each of the seven OEO regions finally acquired an older persons program specialist, appointed by the regional director but assigned to work under the coordination of the assistant director for older persons programs. To have these staff members on duty in each region, with their services supplemented by those of the regional representatives of the National Council on the Aging, who are made available under the continuing OEO/CAP contract with the NCOA, has been of great importance in advancing the interests of the older poor in all OEO programs.

Principally, these regional specialists have worked to develop community action programs, both general and special. They have also, however, kept in contact with Job Corps and VISTA programs to insure that the interests of the older poor are met wherever possible. They have assisted in the staging of regional training

institutes, where older persons programs have been studied in depth by hundreds of OEO personnel, and they have also set up many State and local training sessions. A special national training session was held for them in July 1968.

More will be said of these training efforts later, but enough cannot be said of the significance of having a "voice" for older persons programs now "speaking up" in each OEO region. When a similar voice can be provided in each community action agency, results will really begin to show, for it seems sadly true that the older poor are not automatically remembered, even by dedicated antipoverty workers. If today's poor are properly described as the "invisible poor," the older poor are certainly the most invisible, and they are least given to "speaking up" for themselves. Nationally, they were given a spokesman when Congress in a 1966 EOA amendment provided for an Assistant OEO Director to represent them and when the OEO designated such an official in 1967. Regionally, they now have spokesmen in the regional representatives, but locally they still need someone to see that they are not forgotten. More will be said of this later, too.

Regional Conference and Training Institutes

As 1968 began, only two of the four regional conferences which the OEO had contracted with the National Council on the Aging to conduct within a 12-month period had been held. The final two, one in Berkeley, Calif., and the other in Arlington, Va., were held in January and March, respectively. Both were very successful, and the latter was climaxed by a visit from President Johnson, who reviewed recent developments in the fulfillment of his commitments to aid the older poor. It was also addressed by the Acting Director of the OEO, who pledged increasing OEO attention to older persons programs. The assistant director for older persons programs, of course, spoke at both meetings, as did many nationally known experts in the field. Features of both meetings were descriptions of their work given by several older people, who have been employed as foster grandparents, in operation green thumb, in Project FIND, etc.

Under the new NCOA contract, executed in March 1968, a series of seven regional training institutes was provided for, one in each OEO region, and each to explore one or two special types of older persons programs in depth. The 1967–68 regional conferences had been concerned with general problems and solutions, and it was thought wise now to begin with more detailed studies of special programs. Four of these institutes have been held during 1968, and, the remaining three are scheduled for January and February 1969, with a national conference in March.

At the first regional training institute in Chicago in September 1968, senior centers and housing were given principal attention. At Kansas City in October, emphasis was given to health and employment. The Atlanta meeting in November was focused on providing health services in the home, while the Charleston, W. Va., meeting, also in November, dealt mainly with senior centers and planning community services. The upcoming institute in Boston in January 1969 will emphasize employment and senior centers; the Austin meeting, also in January, health services and planning community services; and the Seattle sessions in February, senior centers and planning community service. The March conference in Washington will be for general discussion of all types of problems and programs.

The assistant director for older persons programs and the community action programs older persons programs planner have taken active parts in all of these 1968 regional training institutes, as have many other prominent OEO and other Federal agency personnel. In addition, speakers and workshop faculty members have included well-known experts in State, local and private older persons programs, as well as many legislative and academic experts. Mr. William Oriol, Staff Director of the Senate Special Committee on Aging has been one of these experts, and has addressed several of the institutes. His help is most gratefully acknowledged.

Each institute lasted 4 days and included at least seven intensive workshop sessions, with all participants meeting in small groups of about 10 members each for several hours at a time. While not limited to OEO personnel, and many representatives of other Federal, State, local and private agencies attended, the value of the sessions for the hundreds of OEO personnel who did attend has been immeasurable. Evaluation comments, which were solicited on an anonymous basis from all participants, were unanimously enthusiastic. Many indicated that they had not previously understood the magnitude of the poverty problems among the older people nor how the OEO could do anything to help, but that they were now both better motivated and better prepared to do what should have been long before.

Current Older Persons Programs

FOSTER GRANDPARENTS

The most popular older persons program in 1968 was still the foster grandparents program, but the number of projects (68) and the number of employees (4,000) remained about the same, as did the number of children served at any one time (8,000). $10 million was allocated for this program in fiscal year 1968, and $9 million was allocated in fiscal year 1969. This project is jointly administered by the community action program (OEO) and the Administration on Aging (HEW), with economic opportunity funds originally delegated under operation: Mainstream to the Department of Labor and redelegated to the community action program (OEO) and the Administration on Aging (HEW) for joint administration. Many applications for new projects have been filed, and many present projects would like to expand, but limited funds have kept this fine program almost static.

An exceptionally interesting program has just been instituted in Atlanta, in which older women are being trained to serve as aides in day-care centers for children. In a sense, they act as foster grandparents in a new setting, and they have functioned very successfully.

Similarly, in St. Louis, older people are being trained and employed to work with emotionally disturbed children in a combined resident and commuter-student institution for educating these children. In what amounts to another adaptation of the foster grandparent idea, these senior psychiatric aides provide just the kind of relaxed and loving care which disturbed children need between the training sessions which often must be abruptly terminated or interrupted because of their unpredictable reactions. The project director reports that the older men and women in this setting are "miracle workers," something already often said of the original foster grandparents who have been working for 3 years in long-term-care children's institutions and hospitals.

It was proposed during 1968 that the foster grandparents program be transferred to the exclusive jurisdiction of the Administration on Aging (HEW) which has previously administered the program jointly with the community action program (OEO). This was one of the provisions in the amendments offered for the Older Americans Act by the Administration on Aging, and these amendments also provided for the establishment of an AOA program to be known as senior service roles in retirement. Foster grandparents were to be the principal part of this effort for the present, but other related retirement roles were contemplated. These included serving as companions and visitors to other older people, or people of all ages, in hospitals of all kinds, as well as serving in other community service roles. While these amendments seemed uncontroversial when introduced, and the OEO was prepared to transfer the foster grandparents programs, with certain protections in the interest of the older poor and the CAA's in the program, question was raised about the wisdom of the amendments at a Senate hearing, and the ultimate result was that the legislation died. Negotiations are now underway to effectuate the transfer without further authorizing legislation, if the legal experts can agree that this is possible.

OPERATION: GREEN THUMB

Operation Green Thumb has been mentioned previously. It also should be expanded as soon as funds permit. The 2,100 older men whom it employs in 14 States are but a fraction of the number who would like this work and whom many other States would gladly employ. This program was allocated $3,500,000 in fiscal year 1968, and the same amount in fiscal year 1969, all consisting of economic opportunity funds delegated to the Department of Labor for administration, and the program was actually operated by Green Thumb, Inc., an organization established for the project by the National Farmers Union.

PROJECT FIND

Project FIND, as a national demonstration, has been in the phaseout period during 1968 and the report of its operation in its 12 demonstration areas is now being completed. Preliminary reports indicate that this will certainly be a significant study, both in what it reveals as to the number and needs of the older poor and in what it indicates regarding present community ability to meet these needs. Project FIND has contacted 115,149 households for the purpose of interviewing; completed 44,401 interviews; and 50,261 individuals have been reached and given assistance, since it began its surveying of older poor persons needs in July 1967.

As has been noted previously, Project FIND is now being copied in many CAA's throughout the country, and it is proving an excellent and basic beginning for many communities which want to aid their older poor as effectively as they can.

Jobs Corps and VISTA

No significant advances can be reported as to the involvement of more older people in either Job Corps or VISTA programs. While each had a staff member assigned to older persons programs early in the year, who made many substantial efforts to induce the hiring of older staff members, and the acceptance of more projects in aid of the older poor, both representatives resigned during the year. One has not been replaced, and the other has been replaced only recently. The Job Corps has 2,162 staff members, including counsellors, instructors, et cetera, who are over 50 years of age, and, while many centers do occasionally provide outside programs that aid the older poor, this effort is poorly documented and only sporadic.

VISTA has 590 volunteers who are over 55 years of age, plus several thousand associates in that age category. It has 40 projects especially designed to serve the older poor.

It should be noted, however, that there are two programs pending which would involve these two agencies much more in aid of the older poor.

JAC's coordinators

One is a proposal that older men of low income be hired to coordinate the volunteers who help recruit and place men Job Corps trainees. The organization known as JAC's, which now provides these services, has been having trouble finding volunteers with the time sufficient to serve as coordinators in the larger communities, and it is felt that older men could do this job very well on a part-time basis. It is proposed that the OEO fund a demonstration program for this purpose.

It may well be, too, that some older women could be employed part time to coordinate the women volunteers who work with WICS to recruit and place women Job Corps trainees.

VISTA volunteers as older persons programs specialists in CAA's

VISTA Volunteers, of all ages, will be trained to serve as older persons programs specialists for community action agencies and to develop and mobilize community resources for the older poor under a new CAP-VISTA program. Most CAA's realize the need of someone to handle this job, but have no staff member available or well enough skilled. If a VISTA Volunteer could supply this need, even for a year, enough interest could probably be generated in the community either to provide volunteer continuance of the service thereafter or even to find a way to finance a paid staff member for the purpose. A minimum of $400,000 of CAP funds has been earmarked to fund over 100 VISTA Volunteers who will be working in three or more OEO regions in the coming year.

There are presently thousands of golden age clubs, senior citizens groups, retiree organizations, church, business, labor and fraternal-sponsored activities—all concerned about aiding older people. But their efforts are often duplicated, wasted, and conflicting. The CAA ought to get them together in each community, and might give them the wanted leadership which would start the community toward real assistance for its older poor. It needs a way to get this effort underway though, and some specially trained VISTA Volunteers will fill this need.

In this connection it is felt especially urgent that teenage volunteers in each community be organized to serve some of the needs of the older poor. Successful programs using teenagers for this purpose have been launched by some private organizations (Boy Scouts, Girl Scouts, Marian Visitors, Adopt a Grandparent Plan, etc.) and many more would do the same if given some encouragement and direction. A trained VISTA Volunteer could easily do this work.

Senior Opportunities and Services Programs and (221) Versatile CAP Older Persons Programs

During the calender year of 1968, program activities of community action agencies on behalf of older persons showed a marked increase. In sum, a total of 184 title II, community action programs for older poor persons were being adminis-

tered in 42 States at a total cost of $5,813,000. Of this total, programs funded under section 222,a,8 (Senior Opportunities and Services) account for 101 projects involving some $2,733,000 in title II funds. Most of these programs were funded during the month of June 1968 utilizing title II balance funds which became available at the end of the fiscal year. These programs involve a wide variety of program formats but show a very concentration on the development of "senior opportunity centers" as the focal point on community activity on behalf of the elderly.

In addition to these programs, a number of CAA's utilized their own free program funds for 83 older persons projects at a total of $3,080,000. In general, these programs follow the same formats as do the section 222 programs mentioned above.

The most important factor in 1968 community action programs in behalf of older poor persons is the growing recognition that older persons constitute a legitimate and viable social interest group around which to develop specialized programs. In addition, the 1968 activities reflect a mounting demand by older persons for specific program attention by CAA's. Increasingly, older persons groups, composed of low-income persons, are making requests to CAA's for a role in the administration of older persons programs in OEO and give evidence of reaching the status of a full-fledged program area.

A supplement is provided at the conclusion of this general report which lists the regional and national totals of OEO fundings of older persons projects during fiscal year 1968 and the first 5 months (July 1 through November 30 of fiscal year 1969).

New Programs for Older Persons

LABOR DEPARTMENT CONTRACTS: SENIOR AIDES, ETC.

In March 1968 the Department of Labor announced three contracts in aid of the older poor, funded in large part with Economic Opportunity funds. One was with the Farmers Union, Inc., for the expansion of Operation Green Thumb to seven more States, or a total of 14. One was with the National Council of Senior Citizens, and the third was one with the National Council on the Aging, both of these latter being for the training and employment of older people of low income to provide needed community services. The total committed in these three 1-year contracts was approximately $5,500,000 and this was intended to provide for the employment of nearly 3,000 older men and women. All contracts are now operative, and all show evidence of success. Operation Green Thumb, of course, has already demonstrated its value in the seven States, and counties would like to have it if funds were available. The other two projects, whose participants are known as senior community service aides by the NCOA and as senior aides by the NCSC, show every promise of equal or greater success. There are 21 programs now functioning in these two projects, providing a wide variety of community services, including social services, employment referral, job development, surplus food distribution, library and hospital service, etc.

STUDY OF ELDERLY USE OF NEIGHBORHOOD HEALTH FACILITIES

Through the Gerontological Society, Inc., a number of specialists in public health services for the elderly have initiated an evaluation of the effectiveness of the Office of Economic Opportunity Neighborhood Comprehensive Health Service Centers in meeting the needs of the older poor in the target areas. The results of these evaluations will be available in 1969.

OMBUDSMAN-TYPE LEGAL SERVICES FOR OLDER PERSONS

The community action program contracted with the National Council of Senior Citizens in June 1968 to conduct a national demonstration of a $500,000 ombudsman-type legal services program for the older poor. On the assumption that many of the low-income elderly do not take advantage of, and are frequently in need of competent legal service, this program will set up several different possible ways to get adequate legal services to them, and then analyze the relative effectiveness of these programs. Sites and local sponsors for this program are now being selected, and this project gives much promise of future significance.

OPERATION: LATE START

Another national demonstration contract is being negotiated at present with the American Association of Retired Persons to set up a program to be known

as "Operation: Late Start". Based in both name and concept on the successful "Headstart" program for disadvantaged preschool children, "Late start" would apply "Headstart" methods and techniques in aiding disadvantaged older people as they begin the period of their old age. It is designed for men and women who are recently retired, or about to retire, and who are faced with the necessity for living on incomes so reduced as to be at or below the poverty level. They usually have little or no ideas as to how to cope with the problems of reduced income and its accompanying problems of poor housing, poor health, etc. So "Late start" would: (1) organize them into small homogeneous neighborhood groups, (2) arrange daily meetings in a convenient neighborhood church, school, or club facility, (3) schedule full physical examinations and needed medical or health services, (4) arrange continuing health care and referral to community agencies for other needed services, (5) provide one daily nutritious meal for all participants, (6) schedule daily information sessions in any of several fields of concern for older people, such as health and nutrition, budget buying and money management, home, furniture or clothes repair, job skill development, music and art, literary appreciation, handcrafts, etc., (7) provide part-time employment for those older people competent to serve as instructors, group leaders, aides, cooks, etc., in the program; and (8) provide a small stipend to all participants to cover the cost of their daily meal, for which they will pay, and transportation, if such is required, plus a token additional amount for their personal needs, so that attendance would not work a financial hardship on anyone.

"Late start" groups would meet for a 3-month period, and contact would be maintained with all who complete one of the sessions. Eventually, arrangements might be made for an individual to "repeat" if openings occurred. Just as "Headstart" tries to prepare the disadvantaged youngster for his or more school years, so "Late start" will try to prepare the disadvantaged oldster for his probably many more than 12 "old-age years." It will show him how he can either live in good health and in decency by better management of a reduced income or find ways to augment his income by useful employment.

It is planned that four "Late start" sites will be selected within the next few weeks, each to operate four 3-month sessions for groups of about 25 to 30 older people each, or a year's total of 400 to 480 people in the first year. An effort will be made, of course, to make the sites as varied as possible and to extend the number if funds should later permit.

Meanwhile, at least one private organization and several community action agencies on their own are planning to fund experiments of a "Late start" variety, some even using the exact pattern, others using an existing senior center to provide similar services. All of these developments will of course, be encouraged, closely watched, and coordinated as much as possible.

CAMBRIDGE (MASS.) HOUSING ASSISTANCE PROJECT

Among the more significant research and demonstration programs affecting the elderly funded this year by OEO, in the amount of $186,000, is the housing assistance project being conducted by the Cambridge (Mass.) economic opportunity committee. During this year, in the first phase of the program, the elderly residents of Cambridge, Mass., have organized themselves into effective and militant neighborhood and citywide housing action groups. The program is designed to utilize the rental housing program of section 232 of the Housing Act.

The housing assistance program is providing a model of realistic cooperation between a community action agency, public housing authority officials, and the elderly poor as a housing interest group. In its first 18 months the program has mobilized the elderly poor of Cambridge into eight neighborhood housing caucuses that have bridged ethnic and racial barriers.

Leadership has developed from within elderly communities. Older poor persons were hired as housing and social service aides and helped survey 2,000 elderly poor to establish priority needs.

A major community housing convention drew 900 older Cambridge residents and resulted in a permanent coordinating committee to deal with public and private housing authorities in Cambridge. Community pressure was brought to bear on the agencies that control land use—the public housing authority, the urban renewal agency, the city council, Harvard, and MIT. All are responding with new policies that will consider housing needs for low-income persons in current and future land development.

The 12-month refunding grant will provide for two distinct but coordinated tasks and staffs. The housing section will continue to search for housing units

through the Cambridge housing authority. Three hundred units will be located, to add to the 100 located in the first 18 months. Coordination with urban renewal and model cities will be expanded.

A rental clearinghouse, a rehabilitation program, and continued study with the Harvard-MIT joint center for urban studies are included.

The elderly services section of the program will concentrate on the health, legal, income, and public service problems facing the elderly poor. Several storefront older persons service centers, in target areas will be outreach centers and meeting places for community groups.

Legal services will assist the elderly in social security, medicare, and consumer fraud problems. Coordination with existing older persons groups and the creation of a community "task force" will work for better services and involvement of the elderly in meeting Cambridge's housing needs.

MISCELLANEOUS COMMUNITY ACTION PROGRAMS

Stimulated by the regional conferences and training institutes and by the recent funding of some older persons programs, many community action agencies throughout the country have funded a wide variety of new programs which aid the older poor.

Many of these are modeled on Project FIND, and are frequently known by that name. They employ older people as canvassers to seek out and identify the older poor, ascertain their needs, refer them to existing services where possible, or attempt to secure the inauguration of needed new services if such are not yet existing.

Many, too, are senior centers, either separately maintained or part of a multipurpose neighborhood center. These range from facilities open once a week to 7-day-a-week, many-hour-a-day organizations. Some provide nothing but meeting rooms, others have highly professionalized programs with full-time staff. Some provide food service; others do not. The President's Council on Aging is now attempting to compile a complete list of all senior centers, which will include those funded by the OEO as well as those sponsored by local CAA's but funded by the AOA for some other governmental or private agency or by a combination of agencies.

There are many programs to provide some sort of home service. Home health aids perform minor health services under the directions of a doctor or nurse. Home help aids perform household chores. Home repair aids make minor building or furniture repairs. Friendly visitors or telephone contacts aids make periodic checks and obtain services as needed. Transportation aids escort or transport older people to clinics, markets, hospitals, etc. Meals-on-wheels programs provide one or more nutritious meals to shut-ins on a regular basis, etc.

A few programs seek to mobilize community resources for the older poor. Some attempt to secure lower rates or more adequate service on public transportation facilities; some, to get reductions in the price of drugs, theater and sports event admissions, etc.; some, to provide relocation services for older people forced out of their homes by renewal projects; and some, to establish retail outlets for handcrafted objects.

There seems almost literally no limit to the number and variety of the programs daily being proposed by CAA's in an effort to meet what are seen to be the problems of their people who are both old and poor. Their interest is inspiring, and our only regret is that they still lack the expertise to make the best use of their limited funds so as to help the most people possible. It will take years, of course, before there are enough people trained and experienced in older persons programs to have any real impact on the formulation on new projects in our hundreds of city and rural CAA's. Meanwhile, those who are being forced by circumstance to develop some know-how in this field are finding that their time, talents, and resourcefulness are being severely tested in the fact of the severely limited funds.

STIMULATION OF PRIVATE, STATE AND LOCAL OLDER PERSONS PROGRAMS

Realizing the improbability of much OEO funding for older persons programs during 1968, and believing moreover that private funding should be encouraged in any event, the assistant director for older persons programs made a special effort during the year to encourage interest on the part of many different private organizations in meeting the needs of the older poor. And she encouraged all regional and local OEO personnel to do the same.

Not many measurable results can be reported yet, nor can all of the recent signs of awakening concern in the private sector be attributed to these very limited efforts, but it is encouraging to note some significant developments.

Early in the year the assistant director met with a newly formed committee on the aging organized by the National Conference of Catholic Charities, and outlined for its members some of the facts regarding the situation of the older Americans who live in poverty. The committee decided to urge all Catholic dioceses to set up committees to cooperate with community action agencies and any other organizations aiding the older poor. It was also decided to ask all national Catholic lay organizations to consider the problem. Subsequent conferences were held with representatives of the National Council of Catholic Women, the National Catholic Youth Organization, the Pennsylvania Catholic Daughters of America, and the National Association of Ladies of Charity of the United States. The first two requested and received signed articles for their magazines, and the last two had the assistant director as the featured speaker of their last State and National conventions, respectively.

Invitations to speak in the early part of the year before several different Protestant church groups resulted in a later invitation to the assistant director to participate in a November interfaith conference called by the National Presbyterian Church. Its purpose was to consider what the major religious organizations could do to help the older poor. The interest demonstrated at this meeting was so great and the impatience to get moving with concrete programs was so noticeable, that major action can certainly be predicted in the very near future. It was unanimously agreed that the churches ought to play a leading role in finding solutions for the multiple problems facing the older poor. A later 3-day seminar dealing with some of the things the churches might do was also well attended and very encouraging.

In July, the assistant director was requested to give the keynote address at the Annual Convention of the International Fraternal Order of Eagles Auxiliary. Later in the convention, a resolution was unanimously adopted making aid for the older poor a new program emphasis for this organization, and letters were sent to all chapters throughout the country directing them to initiate appropriate local activity.

In May the assistant director was invited to take part in the speaking program of the National Conference on Public Welfare and specifically to describe Project FIND. She was also asked to become a member of the Committee on Aging of the American Social Welfare Association. She has taken advantage of both opportunities to make hundreds of welfare workers more aware than they have previously been on the needs of the "invisible" older poor, and she has been assured that subsequent programs will be designed to give greater emphasis to this particular field of concern. As one of the welfare workers said, "You make us realize that programs for the disadvantaged elderly are today just about where programs for the disadvantaged children were 30 years ago. And we can't afford to let problems like this get ahead of us again."

Many speaking opportunities were afforded by women's clubs in various parts of the country, and the assistant director made a special effort to enlist the support of their national leadership. The National Federation of Business and Professional Women's Clubs ran a special article in their magazine, which attracted much interest and comment. The Pennsylvania and Long Island Federations of Women's Clubs both had the assistant director speak at their annual conventions.

Another group, whose interest the assistant director has tried particularly to enlist, is that made up of State and local government officials. She solicited and was granted opportunities to address the national meetings of Directors of State Offices of Economic Opportunity and State commissions on aging. She also addressed other groups of State and local officials in several different States and regions. She conferred with leading national representatives of such organizations as the National Conference of Mayors, the American Municipal Association, the National Municipal League, and the National Association of Counties.

The city of New York has recently established a commission on aging, the mayor of San Francisco has just appointed a special consultant on aging, the city of Philadelphia has set up a mayor's commission on aging, and the city of Cleveland has proposed a comprehensive city program in aid of the older poor.

Meanwhile, many other municipalities have expanded programs established earlier by giving more attention to the special needs of the aging who are poor.

Santa Clara County, Calif., for example, recently hosted an all-day conference on aging for its senior citizens sponsored by the county commission on aging. Congressman Richard White of Texas held a similar 1-day conference in El Paso, similar to one held last year in the Bronx by Congressman James Scheuer.

The assistant director has made many visits to individual officials and State and local civic leaders, and has not yet encountered one who did not indicate an intention to do something soon in aid of the older poor, once he was made aware of their plight.

Coordination of Other Federal Programs

Although the Economic Opportunity Act seems to direct the OEO to coordinate all antipoverty programs in all Federal agencies, its actual power to coordinate seems never to have been successfully exercised. And, inasmuch as Federal programs in aid of the older poor have been very limited, the need for coordination in this particular field has not been very obvious and, of course, has not even been attempted.

The assistant director has, however, tried to bring about as much cooperation and mutual exchange of information as possible. She has met personally with the executive committee of the President's Council on Aging on a regular monthly basis, and intermittently with the Economic Opportunity Committee of the Department of Agriculture. She has also maintained regular contact with model cities and housing officials handling their several programs relating to the elderly.

Similarly, she has encouraged the regional representatives for older persons programs to establish and maintain frequent and regular contacts with the regional representatives of other Federal agencies as well as with representatives of State, local, and private agencies concerned with the older poor.

Stimulation of Business and Labor Interest

Believing that former employers and employee organizations should be more concerned about their ex-employees and fellow workers who are living in an impoverished retirement, the assistant director has made an effort to enlist support for older persons programs from both business and labor leaders.

Many organizations of both businessmen and organized labor already have limited programs underway, but every such group contacted has indicated an interest and desire to do more.

The Bell Telephone Co., for example, already has an extensive program for its own retirees in the Bell Pioneers, but it has agreed to urge them to become more involved with aiding the older poor in the communities where they live. The assistant director has spoken and written to the Pioneers, and she believes they will soon be engaged in a number of useful activities. United Steelworker retirees have already done some organizing work among their fellow members, and are now supporting training programs to give their members the information they need to go out into the community and provide referral service but frequently not aware of its existence or of how to get it.

Much more can be done in this field, and good results would certainly be forthcoming if more time could be spent in making the necessary contacts.

One very interesting development has been the promise by the Polaroid Co. to publish a beau tiful photographic essay regarding Project FIND. It happened that the famous photographer, Beaument Newhall, was conducting a class at San Jose State College in California during the 1968 summer session, and a faculty friend recommended the Santa Cruz Project FIND to him as a possible theme for his students photographic assignments. When he looked into the project, which dealt mainly with the many elderly onetime migrant workers now settled around San Jose, he was enthusiastic about demonstrating how their stories and the story of Project FIND could be told in pictures, and he assigned his students to the task. The results were so spectacular that, when Poloraid people saw the photographs, they asked permission to publish them in their annual report. It was later decided to publish them in a special book supplement to the annual report, and the book will be ready for distribution in early 1969. If it can be given wide enough distribution, it should direct much favorable public attention to what Project FIND is finding out about the needs of the older poor and to the importance of taking positive action soon to meet those needs.

Preparation for 1971 White House Conference on Aging

With a White House Conference on Aging now scheduled for 1971, the assistant director for older persons programs has asked each regional specialist and Community Action Agency director to take part in local and State preparation for this meeting and to make sure that the special needs of the aging who are poor are not forgotten as agendas and resolutions are prepared. She has also taken every occasion possible to register similar reminders with the Commissioner on Aging, who will serve as executive officer of the Conference. Of course, with 40 percent of the elderly living on incomes at or below the poverty line, and most of the rest living in constant fear of being pushed over that line by the first unexpected emergency that requires any substantial outlay of funds, it is hardly likely that anyone will need persuading that inadequate income is a major problem for almost all older Americans.

Conclusion

The progress during 1968 has been significant, but there is still a long way to go in meeting the needs of the older poor to the extent to where the Office of Economic Opportunity could meet them if sufficient funds were available. The interest exists, the program designs are available, the success of many programs have been amply demonstrated, and the possibility of developing viable new programs is practically unlimited. Until the agency receives sufficient funds, however, to carry on the youth-oriented programs it has already undertaken plus the general programs which are also underway, and have some left over to apply in this new direction, not much can be really accomplished for the older poor without "taking back" some of the admittedly inadequate help now extended to the poor in other age categories. It is hoped that the President and the Congress will see fit to make enough money available to the OEO to carry out its mandate effectively in relating to our nation's poor in every respect, including its mandate in relation to the older poor.

ITEM 18: REPORT FROM THE DEPARTMENT OF AGRICULTURE[1]

(Including the Farmers Home Administration)

Insured Rental and Cooperative Housing

Insured rural rental and cooperative housing loans are made to build, improve, repair, or buy rental or cooperatively owned housing for rural residents with low or moderate incomes and for senior citizens. Urban residents with a low or moderate income who are employed in a rural area may also occupy the housing. Through this program, the Department has insured loans for 1,048 units as of June 30, 1968. This will provide housing for an estimated 2,100 persons, most of whom are elderly.

As of June 30, 1968, we had on hand about 404 applications for insured rental housing loans and 2 applications for cooperative housing loans for both elderly and younger families. We estimate that these applications will result in housing for about 3,000 elderly persons.

Recent changes in this phase of our housing program include the broadening of the authority to include urban residents employed in rural areas as eligible occupants and the granting of authority to give interest supplements to certain nonprofit borrower organizations who provide rental housing for families of low and moderate incomes. Interest credits are also available to housing cooperatives composed of families with low or moderate incomes. These changes were authorized by the Housing and Urban Development Act of 1968. This Act permits the delegation of authority, by the Department of Housing and Urban Development (HUD), to the Department of Agricuture to assist in the development of HWD rental and cooperative housing loans in rural areas.

Direct Rental and Cooperative Housing

Direct rural rental and cooperative housing loans are made to provide loans to eligible nonprofit corporations to build, repair, or buy rental and cooperative housing for rural residents with low incomes and senior citizens with low to moderate incomes. Units may be houses or apartments for independent living.

[1] Submitted at the request of the Committee on Aging.

As of June 30, 1968, direct loans have been made to provide 1,353 living units. We have on hand about 200 applications from organizations to provide rental housing. These are initial loan applications and because of recent legislative changes, will be processed as insured loans. The Housing and Urban Development Act of 1968 changed our direct rural rental and cooperative housing loan program to an insured loan program. Direct loans are now available only to currently indebted borrowers.

Loans to Individuals

Direct and insured loans are made to senior citizens to build, buy or improve homes and when necessary to buy building sites. As of June 30, 1968, the Department had made loans to 10,908 senior citizen families and had an additional 1,384 applications on hand.

A recent legislative change in the program permits loans to be made to urban residents employed in rural areas and gives the authority for providing interest supplements to certain low- and moderate-income families. The Department of Agriculture, under authority delegated by the Department of Housing and Urban Development (HUD) will make HUD insured loans with interest supplements in rural areas.

Research Activities in the Economic Research Service Pertaining to Older Americans

The Economic Research Service in the Department of Agriculture has several studies underway which include the problems of the aging. Preliminary results of the studies in rural parts of the Coastal Plain, the Mississippi Delta, and the Ozarks are available. Approximately 7 percent of the rural population in the Southeast Coastal Plain were 65 or older and 55 percent of the aged were poor in 1966. In the Mississippi Delta 11 percent of the rural population were aged and 61 percent of those 65 or older were poor. About 18 percent of the rural Ozarks population were 65 or older and 37 percent of the aged were poor. One out of three household heads in the Ozarks were aged and one out of five of the houses occupied by these aged heads had no plumbing. In the Ozarks half the housing occupied by aged heads was considered inadequate. These studies include data on the health, financial situation, work experience, housing conditions, and use of community services for some 1,500 aged rural persons who reside in sample households representing all rural households in the 316 counties comprising these regions.

Studies of men over 50 years of age have been made in Midwest towns of 2,500 to 10,000 population to examine their labor force participation, occupations, health and financial situation, social activities, and attitudes. Nearly a fifth of the older workers studied were still working after reaching 65.

The assessment of the social psychological aspects of human aging is continuing in Kentucky with a study planned for the Appalachian area of Eastern Kentucky. The study will compare rural/urban differences, generational differences, differences associated with socio-economic status, and race differences as they affect human aging.

Food Assistance Programs and the Elderly

Low-income senior citizens are eligible to participate in the food assistance programs that supplement existing food purchasing power either through the donated foods program or the food stamp program. Under the donated foods program, participating families receive a variety of foods each month so that their limited food purchasing power may be used for other foods to improve their nutrition. Under the food stamp program, families purchase food coupons in amounts that reflect their normal level of food expenditures, based on family size and income. They receive food coupons worth more and spend the coupons, like cash in food stores authorized to redeem the coupons.

Although specific data are not available as to the number of older Americans participating in these programs, the U.S. Department of Agriculture estimates that there are probably at least one and a quarter million elderly persons benefiting from one or the other of these programs. All but some 500 counties and independent cities out of the national total of 3,126 counties and independent cities have either a food stamp or a donated foods program.

Many communities, churches, and civic groups make special efforts to see to it that those elderly persons who have difficulty getting to a certification or distribution center or out to do their shopping are helped to do so by volunteers. These and other groups are also working to encourage participation by the elderly and to hold workshops and provide basic materials on nutrition. Good nutrition is a serious problem among the elderly—particularly in one and two person households where they have lost interest in preparing a good meal.

In addition to the family food assistance programs, donated foods are made available to charitable institutions to help them in providing meals for residents of these institutions. An estimated 600,000 older Americans benefit from these foods donated to institutions.

Donated foods are also provided to social centers for the aging that operate a non-profit food service. Once again, these foods can be of great help in holding the price line to those who come to enjoy a good meal and the activities of the center.

Housing and design for safety, convenience, and energy saving—within the economic limits of the persons concerned.

Financial planning and management, including supplementary income-producing and income-conserving possibilities.

Transfer of property, inheritance laws, wills, and farm partnership arrangements with younger members of the family.

Family relationships and personal deyelopment.

Home gardening and use of home produced food supplies.

Recreation and community activities suitable for older persons' participation, which promote their physical and mental well-being.

Information regarding Social Security, Medicare, Medicaid, and other sources of assistance.

LEADERSHIP OPPORTUNITIES AND TRAINING

Many older men and women who remain active and alert are currently serving as volunteer leaders and paid subprofessional aides to help all audiences, adult and youth, to receive the benefits of various Extension programs. This makes it possible to reach many more people than could be reached by a relatively limited professional staff. Leadership training programs currently being developed aim toward a much greater use of the potential in the older population.

SERVICES OF PROFESSIONALLY TRAINED PERSONNEL

The Cooperative Extension Service maintains professionally staffed offices in all rural counties and in many urban centers throughout the Nation. Extension agents and specialists trained in agriculture, home economics, human resource development, and related subject areas are available through these offices to individuals and groups to provide information, educational leadership, and program help. Several State Extension Services in cooperation with State Commissions on Aging employ specialists in aging who provide consultant help to State and local groups. This assistance may be either in organization or program development, or in formulating research and/or program proposals for older people under governmental or private funding. The more than 3,000 county Extension offices are, with very few exceptions, located in county seat towns or cities. Their specific addresses can be obtained from local telephone directories.

PROGRAMS AND RESOURCES OF THE COOPERATIVE EXTENSION SERVICE RELATED TO AGING*

The Cooperative Extension Service of the United States Department of Agriculture and the land-grant colleges and universities provides the following programs and resources of benefit to older persons (each is described more fully below):

Informal educational programs in a variety of subjects.

Leadership training.

The services of professionally trained personnel at municipal, county, State and national levels.

The resources of the United States Department of Agriculture and the land-grant colleges and universities.

*Prepared by Federal Extension Service for D. R. Matthews for inclusion in the summary of the Department's activities during 1968 pertaining to housing for older Americans. 11/27/68.

INFORMAL EDUCATIONAL PROGRAMS

Continuing educational programs of an informal nature are made available in local communities across the Nation.

These programs are developed in cooperation with local people and are centered on important problems locally recognized as reflecting interests and needs of people of all ages. Increasingly, programs are being planned to meet specific needs of older people, especially those hampered by low incomes, isolation, handicaps and other forms of disadvantage.

Among the more frequently noted program offerings of significance to older people are those dealing with:

Good nutrition in the interest of maintaining optimum health.

Appendix 2

TABLES SHOWING POPULATION CHANGES AND PROVIDING DEMOGRAPHIC DATA ABOUT OLDER AMERICANS

ITEM 1: RESIDENT POPULATION OF ALL AGES AND 65-PLUS, BY STATE, JULY 1, 1967 [1]

[Numbers of persons in thousands]

State	Numbers					State rank [2]				
	Total, all ages		65-plus			Total, all ages		65-plus		
	Number	Percent change from Apr. 1, 1960	Number	Percent change from Apr. 1, 1960	Percent of total, all ages	Number	Percent change from Apr. 1, 1960	Number	Percent change from Apr. 1, 1960	Percent of total, all ages
Total, 51 "States"	197,863	+10.3	18,793	+13.5	9.5	(3)	(3)	(3)	(3)	(3)
Alabama	3,533	+8.1	302	+15.7	8.5	21	25	22	19	35
Alaska	271	+19.9	6	+20.0	2.2	51	6	51	8	51
Arizona	1,637	+25.7	129	+43.3	7.9	34	2	35	2	40
Arkansas	1,972	+10.4	222	+14.4	11.2	32	22	28	20	9
California	18,992	+20.8	1,644	+19.5	8.6	1	4	2	9	34
Colorado	2,012	+14.7	177	+12.0	8.8	30	11	32	26	33
Connecticut	2,918	+15.1	272	+11.9	9.3	24	9	25	27	27
Delaware	524	+17.5	42	+16.7	8.0	47	8	47	11	39
District of Columbia	808	+5.8	69	0	8.5	40	36	41	51	36
Florida	6,035	+21.9	767	+38.7	12.7	9	3	7	3	1
Georgia	4,490	+13.9	338	+16.2	7.5	15	14	18	17	42
Hawaii	760	+20.1	39	+34.5	5.1	41	5	48	4	50
Idaho	701	+5.1	64	+10.3	9.1	42	40	43	33	28
Illinois	10,887	+8.0	1,060	+8.7	9.7	4	27	4	36	22
Indiana	5,012	+7.5	474	+6.3	9.4	12	31	12	48	24
Iowa	2,772	+.5	344	+4.9	12.4	25	47	17	49	2
Kansas	2,281	+4.7	258	+7.5	11.3	29	42	27	43	7
Kentucky	3,201	+5.4	324	+11.0	10.1	23	38	20	31	20
Louisiana	3,663	+12.5	282	+16.5	7.7	19	17	23	15	41
Maine	982	+1.3	115	+7.5	11.7	38	46	36	44	4
Maryland	3,680	+18.7	267	+17.6	7.2	18	7	26	10	45
Massachusetts	5,434	+5.5	616	+7.7	11.3	10	37	10	42	8
Michigan	8,608	+10.0	726	+13.8	8.4	7	24	8	21	37
Minnesota	3,625	+6.2	395	+11.6	10.9	20	33	14	28	14

See footnotes at end of table, p. 216.

ITEM 1: RESIDENT POPULATION OF ALL AGES AND 65-PLUS, BY STATE, JULY 1, 1967 [1]—Continued

[Numbers of persons in thousands]

State	Numbers					State rank [2]				
	Total, all ages		65-plus			Total, all ages		65-plus		
	Number	Percent change from Apr. 1, 1960	Number	Percent change from Apr. 1, 1960	Percent of total, all ages	Number	Percent change from Apr. 1, 1960	Number	Percent change from Apr. 1, 1960	Percent of total, all ages
Mississippi	2,344	+7.6	211	+11.0	9.0	28	30	29	32	32
Missouri	4,587	+6.2	537	+6.8	11.7	13	34	11	46	5
Montana	699	+3.6	67	+3.1	9.6	43	43	42	50	23
Nebraska	1,443	+2.3	177	+7.9	12.3	35	45	33	41	3
Nevada	436	+53.0	26	+44.4	6.0	48	1	50	1	49
New Hampshire	691	+13.8	77	+13.2	11.1	44	15	39	23	11
New Jersey	6,981	+15.1	653	+16.6	9.4	8	10	9	13	25
New Mexico	1,002	+5.4	64	+25.5	6.4	37	39	44	5	38
New York	18,023	+7.4	1,900	+12.6	10.5	2	32	1	24	17
North Carolina	5,059	+11.0	379	+21.5	7.5	11	20	15	6	43
North Dakota	632	0.0	64	+8.5	10.1	46	48	45	38	21
Ohio	10,488	+8.0	959	+6.9	9.1	6	28	25	45	29
Oklahoma	2,516	+8.1	278	+11.6	11.0	27	26	24	29	12
Oregon	1,981	+12.0	209	+13.6	10.6	31	19	30	22	16
Pennsylvania	11,672	+3.1	1,222	+8.2	10.5	3	44	3	40	18
Rhode Island	901	+4.9	99	+10.0	11.0	39	41	37	34	13
South Carolina	2,638	+10.7	176	+16.6	6.7	26	21	34	14	47
South Dakota	668	−1.9	78	+8.3	11.7	45	49	38	39	6
Tennessee	3,936	+10.3	358	+15.8	9.1	17	23	16	18	30
Texas	10,858	+13.3	900	+20.8	8.3	5	16	6	7	38
Utah	1,022	+14.7	70	+16.7	6.8	36	12	40	12	46
Vermont	420	+7.7	47	+6.8	11.2	49	29	46	47	10
Virginia	4,541	+14.5	336	+16.3	7.4	14	13	19	16	44
Washington	3,208	+12.4	303	+8.6	9.4	22	18	21	37	26
West Virginia	1,807	−2.8	190	+9.8	10.5	33	50	31	35	19
Wisconsin	4,194	+6.1	452	+12.2	10.8	16	35	13	25	15
Wyoming	319	−3.3	29	+11.5	9.1	50	51	49	30	31

[1] Unpublished estimates prepared by the Bureau of the Census; not adjusted for net census errors of coverage and of age misreporting.

[2] States ranked in decreasing order; State with largest quantity ranked "1"; State with lowest quantity ranked "51". In order to avoid fractional rankings, States with identical quantities are ranked consecutively in alphabetic order.

[3] Not applicable.

Source: Administration on Aging, Social and Rehabilitation Service, Department of Health, Education, and Welfare, February 1969.

ITEM 2: THE OLDER POPULATION, BY SEX, AGE, AND COLOR, 1900, 1930, 1960, AND 1990

TABLE 1[1]

[Total: Numbers in thousands]

Sex and age	1900	1930	1960	1990
Both sexes:				
65-plus	3,084	6,644	16,560	27,006
75-plus	895	1,916	5,563	10,405
85-plus			929	1,969
65 to 69	1,304	2,776	6,258	9,299
70 to 74	885	1,953	4,739	7,302
75 to 79			3,054	5,297
80 to 84			1,580	3,139
85-plus			929	1,969
Males:				
65-plus	1,558	3,333	7,503	10,904
75-plus	439	917	2,387	3,849
85-plus			362	660
65 to 69	669	1,422	2,931	4,043
70 to 74	450	994	2,185	3,011
75 to 79			1,359	2,054
80 to 84			665	1,135
85-plus			362	660
Females:				
65-plus	1,526	3,311	9,056	16,102
75-plus	456	998	3,176	6,554
85-plus			567	1,308
65 to 69	636	1,354	3,327	5,256
70 to 74	435	959	2,554	4,292
75 to 79			1,694	3,242
80 to 84			915	2,004
85-plus			567	1,308
Females per 100 males:				
65-plus	98.0	99.4	120.7	147.7
75-plus	103.9	108.8	133.1	170.3
85-plus			156.5	198.2
65 to 69	95.1	95.2	113.5	130.0
70 to 74	96.5	96.5	116.9	142.5
75 to 79			124.6	157.8
80 to 84			137.5	176.6
85-plus			156.5	198.2

[1] From "Useful Facts No. 42," Administration on Aging, Social and Rehabilitation Service, Department of Health, Education, and Welfare, May 1968.

Source: Basic data, Bureau of the Census.

TABLE 2[1]

[Total: Percent distribution]

Sex and age	1900	1930	1960	1990
Both sexes:				
65-plus	100.0	100.0	100.0	100.0
75-plus	29.0	28.8	33.6	38.5
85-plus			5.6	7.3
65 to 69	42.3	41.8	37.8	34.4
70 to 74	28.7	29.4	28.6	27.0
75 to 79			18.4	19.6
80 to 84			9.5	11.6
85-plus			5.6	7.3
Males:				
65-plus	100.0	100.0	100.0	100.0
75-plus	28.2	27.5	31.8	35.3
85-plus			4.8	6.1
65 to 69	42.9	42.7	39.1	37.1
70 to 74	28.9	29.8	29.1	27.6
75 to 79			18.1	18.8
80 to 84			8.9	10.4
85-plus			4.8	6.1
Females:				
65-plus	100.0	100.0	100.0	100.0
75-plus	29.9	30.1	35.1	40.7
85-plus			6.3	8.1
65 to 69	41.6	40.9	36.7	32.6
70 to 74	28.5	29.0	28.2	26.6
75 to 79			18.7	20.1
80 to 84			10.1	12.4
85-plus			6.3	8.1

[1] From "Useful Facts No. 42," Administration on Aging, Social and Rehabilitation Service, Department of Health, Education, and Welfare.

Source: Basic data, Bureau of the Census.

TABLE 3[1]

[White: Numbers in thousands]

Sex and age	1900	1930	1960	1990
Both sexes:				
65 plus	2,807	6,244	15,304	24,722
75 plus		1,789	5,174	9,540
85 plus			858	1,771
65 to 69		2,609	5,739	8,469
70 to 74		1,847	4,391	6,713
75 to 79			2,835	4,879
80 to 84			1,481	2,890
85 plus			858	1,771
Males:				
65 plus	1,416	3,126	6,908	9,979
75 plus		857	2,206	3,516
85 plus			331	588
65 to 69		1,331	2,684	3,690
70 to 74		938	2,018	2,771
75 to 79			1,255	1,889
80 to 84			619	1,039
85 plus			331	588
Females:				
65 plus	1,391	3,118	8,396	14,743
75 plus		932	2,968	6,022
85 plus			527	1,182
65 to 69		1,278	3,055	4,779
70 to 74		908	2,373	3,943
75 to 79			1,580	2,989
80 to 84			861	1,851
85 plus			527	1,182
Females per 100 males:				
65 plus	98.2	99.8	121.5	147.7
75 plus		108.8	134.6	171.3
85 plus			159.2	201.0
65 to 69		96.0	113.8	129.5
70 to 74		96.8	117.6	142.3
75 to 79			125.9	158.2
80 to 84			139.1	178.2
85 plus			159.2	201.0

[1] From "Useful Facts No. 42," Administration on Aging, Social and Rehabilitation Service, Department of Health, Education, and Welfare.

Source: Basic data, Bureau of the Census.

TABLE 4[1]

[White: Percent distribution]

Sex and age	1900	1930	1960	1990
Both sexes:				
65 plus	100.0	100.0	100.0	100.0
75 plus		28.6	33.8	38.6
85 plus			5.6	7.2
65 to 69		41.8	37.5	34.2
70 to 74		29.6	28.7	27.2
75 to 79			18.5	19.7
80 to 84			9.7	11.7
85 plus			5.6	7.2
Males:				
65 plus	100.0	100.0	100.0	100.0
75 plus		27.4	31.9	35.2
85 plus			4.8	5.9
65 to 69		42.6	38.8	37.0
70 to 74		30.0	29.2	27.8
75 to 79			18.2	18.9
80 to 84			9.0	10.4
85 plus			4.8	5.9
Females:				
65 plus	100.0	100.0	100.0	100.0
75 plus		29.9	35.4	40.8
85 plus			6.3	8.0
65 to 69		41.0	36.4	32.4
70 to 74		29.1	28.3	26.7
75 to 79			18.8	20.3
80 to 84			10.3	12.6
85 plus			6.3	8.0

[1] From "Useful Facts No. 42," Administration on Aging, Social and Rehabilitation Service, Department of Health, Education, and Welfare.

Source: Basic data, Bureau of the Census.

TABLE 5 [1]

[Nonwhite: Numbers in thousands]

Sex and age	1900	1930	1960	1990
Both sexes:				
65 plus	276	400	1,256	2,284
75 plus		127	389	865
85 plus			72	198
65 to 69		167	519	830
70 to 74		106	348	589
75 to 79			218	418
80 to 84			99	249
85 plus			72	198
Males:				
65 plus	141	207	595	925
75 plus		61	181	333
85 plus			31	72
65 to 69		91	247	353
70 to 74		56	169	240
75 to 79			104	165
80 to 84			46	96
85 plus			31	72
Females:				
65 plus	135	193	660	1,359
75 plus		66	208	532
85 plus			40	126
65 to 69		76	272	477
70 to 74		51	181	349
75 to 79			114	253
80 to 84			53	153
85 plus			40	126
Females per 100 males:				
65 plus	95.9	93.3	111.0	146.9
75 plus		109.4	114.7	159.8
85 plus			128.4	175.0
65 to 69		83.7	110.0	135.1
70 to 74		91.3	108.5	145.4
75 to 79			109.6	153.3
80 to 84			116.9	159.4
85 plus			128.4	175.0

[1] From "Useful Facts No. 42," Administration on Aging, Social and Rehabilitation Service, Department of Health, Education, and Welfare.

Source: Basic data, Bureau of the Census.

TABLE 6 [1]

[Nonwhite: Percent distribution]

Sex and age	1900	1930	1960	1990
Both sexes:				
65 plus	100.0	100.0	100.0	100.0
75 plus		31.7	31.0	37.9
85 plus			5.7	8.7
65 to 69		41.7	41.3	36.3
70 to 74		26.6	27.7	25.8
75 to 79			17.4	18.3
80 to 84			7.9	10.9
85 plus			5.7	8.7
Males:				
65 plus	100.0	100.0	100.0	100.0
75 plus		29.3	30.5	36.0
85 plus			5.3	7.8
65 to 69		43.9	41.5	38.2
70 to 74		26.8	28.0	25.9
75 to 79			17.5	17.8
80 to 84			7.7	10.4
85 plus			5.3	7.8
Females:				
65 plus	100.0	100.0	100.0	100.0
75 plus		34.4	31.5	39.1
85 plus			6.1	9.3
65 to 69		39.4	41.1	35.1
70 to 74		26.3	27.4	25.7
75 to 79			17.3	18.6
80 to 84			8.1	11.3
85 plus			6.1	9.3

[1] From "Useful Facts No. 42," Administration on Aging, Social and Rehabilitation Service, Department of Health, Education, and Welfare.

Source: Basic data, Bureau of the Census.

ITEM 3: LIFE EXPECTANCY, 1966

Age	Average number of years of life remaining		
	Total	Male	Female
At birth	70.1	66.7	73.8
At age:			
65	14.6	12.8	16.2
70	11.6	10.3	12.8
75	9.0	8.2	9.7
80	6.7	6.2	7.1
85	4.7	4.5	4.8

Source: Public Health Service.

ITEM 4: THE OLDER POPULATION: MARITAL STATUS BY SEX AND AGE, 1967 [1]

[Numbers in thousands]

Marital status	Male			Female		
	65+	65 to 74	75+	65+	65 to 74	75+
Total	8,069	5,178	2,891	10,619	6,453	4,166
Single	508	340	168	776	480	296
Married	5,849	4,146	1,703	3,824	2,997	827
Spouse present	5,570	3,959	1,611	3,631	2,845	786
Spouse absent	279	187	92	193	152	41
Widowed	1,513	561	952	5,827	2,828	2,999
Divorced	199	132	67	192	147	45
PERCENT DISTRIBUTION						
Total	100.0	100.0	100.0	100.0	100.0	100.0
Single	6.3	6.6	5.8	7.3	7.4	7.1
Married	72.5	80.1	58.9	36.0	46.4	19.9
Spouse present	69.0	76.5	55.7	34.2	44.1	18.9
Spouse absent	3.5	3.6	3.2	1.8	2.4	1.0
Widowed	18.8	10.8	32.9	54.9	43.8	72.0
Divorced	2.5	2.5	2.3	1.8	2.3	1.1

[1] From "Useful Facts No. 42," Administration on Aging, Social and Rehabilitation Service, Department of Health, Education, and Welfare, July 1968.

Source: Basic data, Bureau of the Census.

ITEM 5: THE OLDER POPULATION: LIVING ARRANGEMENTS BY SEX AND AGE, 1967 [1]

Sex and living arrangement	Number (in thousands)			Percent distribution [2]		
	65+	65 to 74	75+	65+	65 to 74	75+
Males	8,069	5,178	2,891	100.0	100.0	100.0
Living in families	6,502	4,370	2,132	80.6	84.4	73.7
Family head, wife present	5,466	3,908	1,558	67.7	75.5	53.9
Family head, no wife	341	179	162	4.2	3.4	5.6
Relative of family head [3]	695	283	412	8.6	5.5	14.2
Living alone or with nonrelatives	1,282	694	588	15.9	13.4	20.3
Alone	1,010	547	463	12.5	10.6	16.0
Widowed	609	262	347	7.5	5.0	12.0
With nonrelatives	272	147	125	3.4	2.8	4.3
Living in an institution	285	114	171	3.5	2.2	5.9
Females	10,619	6,453	4,166	100.0	100.0	100.0
Living in families	6,559	4,225	2,334	61.8	65.5	56.0
Wife of family head	3,550	2,806	744	33.4	43.5	17.8
Family head, no husband	1,121	635	486	10.6	9.8	11.7
Relative of family head [3]	1,888	784	1,104	17.8	12.1	26.5
Living alone or with nonrelatives	3,593	2,100	1,493	33.8	32.5	35.8
Alone	3,201	1,879	1,322	30.1	29.1	31.7
Widowed	2,739	1,542	1,197	25.8	23.9	28.7
With nonrelatives	392	221	171	3.7	3.4	4.1
Living in an institution	467	128	339	4.4	2.0	8.1

[1] From "Useful Facts No. 42," Administration on Aging Social and Rehabilitation Service, Department of Health, Education, and Welfare, July 1968.
[2] Computed from rounded figures; details may not add to 100 percent.
[3] Other than spouse.

ITEM 6: THE OLDER POPULATION: FAMILY EXPENDITURES FOR CURRENT CONSUMPTION, 1960–61 [1]

Category	Amount			Percent distribution	
	65 to 74	75+			
		Amount	Percent of 65 to 74	65 to 74	75+
Total	$3,220	$2,347	72.9	100.0	100.0
Food	822	644	78.3	25.5	27.4
Prepared at home	694	560	80.7	21.5	23.9
Away from home	128	84	65.6	4.0	3.6
Tobacco	46	26	56.5	1.4	1.1
Alcoholic beverages	43	19	44.2	1.3	0.8
Housing	1,034	820	79.3	32.1	34.9
Shelter	469	379	80.8	14.6	16.1
Rented dwelling	200	184	92.0	6.2	7.8
Owned dwelling	243	182	74.9	7.5	7.8
Other shelter	26	13	50.0	.8	0.6
Fuel, light, refrigeration, water	219	189	86.3	6.8	8.1
Household operation	208	168	80.8	6.5	7.2
Housefurnishings and equipment	138	84	60.9	4.3	3.6
Clothing, materials, services	243	144	59.2	7.5	6.1
Personal care	88	61	69.3	2.7	2.6
Medical care	311	283	91.0	9.7	12.1
Recreation	87	42	48.3	2.7	1.8
Reading	34	27	79.4	1.1	1.2
Education	11	4	36.4	0.3	0.2
Transportation	420	210	50.0	13.0	8.9
Automobile	344	179	52.0	10.7	7.6
Other travel and transportation	76	31	40.8	2.4	1.3
All other	81	67	82.7	2.5	2.9

[1] From "Useful Facts No. 42," Administration on Aging, Social and Rehabilitation Service, Department of Health, Education, and Welfare, July 1968.

Source: Bureau of Labor Statistics.

Appendix 3

STEPS TOWARD A WHITE HOUSE CONFERENCE ON AGING IN 1971

On September 28, 1968, the President signed into law (Public Law 90–526) House Joint Resolution 1371, providing that it is the sense of Congress that a White House Conference on Aging be called by the President in 1971, to be planned and conducted by the Secretary of Health, Education, and Welfare.

Congressional action toward a White House Conference on Aging began with the introduction on October 18, 1967, of Senate Joint Resolution 117 by Senator Williams of New Jersey, with the cosponsorship of 15 other Senators. On March 5 and 6, 1968, hearings on this resolution were held by the Special Subcommittee on Aging of the Senate Committee on Labor and Public Welfare. The resolution was reported from the Senate Committee on Labor and Public Welfare on May 2 and passed the Senate on May 6.

In the House, a White House Conference on Aging resolution, House Joint Resolution 1271, was introduced by Congressman Dominick Daniels, of New Jersey, and others on May 14, 1968. Hearings on this and related proposals were held on June 18 before the Select Subcommittee on Education (Congressman Daniels, chairman) of the House Committee on Education and Labor. As a result of these hearings, Congressman Daniels and others introduced a "clean resolution" (slightly different from H.J. Res. 1271) on June 27. This resolution was reported from the House Committee on Education and Labor on July 25, and passed the House on July 30.

Since a resolution similar in many respects to House Joint Resolution 1371 had previously been considered and reported by the Senate Committee on Labor and Public Welfare and passed by the Senate, it was possible to place House Joint Resolution 1371 on the calendar in the Senate and to take action on the Senate floor on it without its being referred to committee. Accordingly, it was passed, with amendments, by the Senate on September 9. The House agreed to the Senate amendments on September 12, clearing the proposal for the President's signature.

THE TEXT OF P.L. 90–526

90th Congress, H.J. Res. 1371, September 28, 1968

JOINT RESOLUTION

To provide that it be the sense of Congress that a White House Conference on Aging be called by the President of the United States in 1971, to be planned and conducted by the Secretary of Health, Education, and Welfare, and for related purposes.

Whereas the primary responsibility for meeting the challenge and problems of aging is that of the States and communities, all levels of government are involved and must necessarily share responsibility; and it is therefore the policy of the Congress that the Federal Government shall work jointly with the States and their citizens, to develop recommendations and plans for action, consistent with the objectives of this joint resolution, which will serve the purposes of—

(1) assuring middle-aged and older persons equal opportunity with others to engage in gainful employment which they are capable of performing; and

(2) enabling retired persons to enjoy incomes sufficient for health and for participation in family and community life as self-respecting citizens; and

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(3) providing housing suited to the needs of older persons and at prices they can afford to pay; and

(4) assisting middle-aged and older persons to make the preparation, develop skills and interests, and find social contacts which will make the gift of added years of life a period of reward and satisfaction; and

(5) stepping up research designed to relieve old age of its burdens of sickness, mental breakdown, and social ostracism; and

(6) evaluating progress made since the last White House Conference on Aging, and examining the changes which the next decade will bring in the character of the problems confronting older persons; and

Whereas it is essential that in all programs developed for the aging, emphasis should be upon the right and obligation of older persons to free choice and self-help in planning their own futures: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) the President of the United States is authorized to call a White House Conference on Aging in 1971 in order to develop recommendations for further research and action in the field of aging, which will further the policies set forth in the preamble of this joint resolution, shall be planned and conducted under the direction of the Secretary who shall have the cooperation and assistance of such other Federal departments and agencies, including the assignment of personnel, as may be appropriate.

(b) For the purpose of arriving at facts and recommendations concerning the utilization of skills, experience, and energies and the improvement of the conditions of our older people, the conference shall bring together representatives of Federal, State, and local governments, professional and lay people who are working in the field of aging, and of the general public, including older persons themselves.

(c) A final report of the White House Conference on Aging shall be submitted to the President not later than one hundred and twenty days following the date on which the Conference is called and the findings and recommendations included therein shall be immediately made available to the public. The Secretary of Health, Education, and Welfare shall, within ninety days after the submission of such final report, transmit to the President and the Congress his recommendations for the administrative action and the legislation necessary to implement the recommendations contained in such report.

ADMINISTRATION

SEC. 2. In administering this joint resolution, the Secretary shall—

(a) request the cooperation and assistance of such other Federal departments and agencies as may be appropriate in carrying out the provisions of this joint resolution;

(b) render all reasonable assistance, including financial assistance, to the States in enabling them to organize and conduct conferences on aging prior to the White House Conference on Aging;

(c) prepare and make available background materials for the use of delegates to the White House Conference as he may deem necessary and shall prepare and distribute such report or reports of the Conference as may be indicated; and

(d) in carrying out the provisions of this joint resolution, engage such additional personnel as may be necessary without regard to the provisions of title 5, United States Code, governing appointments in the competitive civil service, and without regard to chapter 57 and subchapter 111 of chapter 53 of such title relating to classification and General Schedule pay rates.

ADVISORY COMMITTEES

SEC. 3. The Secretary is authorized and directed to establish an Advisory Committee to the White House Conference on Aging composed of not more than twenty-eight professional and public members, a substantial number of whom shall be fifty-five years of age or older, and, as necessary, to establish technical advisory committees to advise and assist in planning and conducting the Conference. The Secretary shall designate one of the appointed members as Chairman. Members of any committee appointed pursuant to this section, who are not officers or employees of the United States, while attending conferences or meetings of their committees or otherwise serving at the request of the Secretary, shall be entitled to receive compensation at a rate to be fixed by the Secretary but not exceeding

$75 per diem, including traveltime, and while away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized under section 5703 of title 5 of the United States Code for persons in the Government service employed intermittently. The Commissioner on Aging shall act as Executive Secretary of the Committee.

DEFINITIONS

SEC. 4. For the purposes of this joint resolution—

(1) the term "Secretary" means the Secretary of Health, Education, and Welfare; and

(2) the term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, Guam, American Samoa, the Virgin Islands, and the Trust Territory of the Pacific Islands.

SEC. 5. There is authorized to be appropriated to carry out this joint resolution the sum of $1,900,000.

Appendix 4

MATERIAL RELATED TO RETIREMENT INCOME*

ITEM 1: EXCERPT FROM SECRETARY'S INTRODUCTION TO THE ANNUAL REPORT OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, FISCAL YEAR 1968, SUBMITTED BY SECRETARY WILBUR J. COHEN, JANUARY 17, 1969

Social Security

For the first time since the world began, we, as a nation, have the capacity to end poverty. The most formidable weapon in our arsenal is one most Americans have not usually thought of as an antipoverty program—social security. The social security and unemployment insurance systems moderate the loss in earnings due to retirement, death, disability, and temporary unemployment. They offer American workers and their families basic, necessary protection.

For instance, social security is the main source of continuing income for retired people—many would be destitute without it. Social security benefits keep 10 million people above the poverty level. Without these benefits, they would have to depend on relatives who often could not readily afford such support, or they would have to go on relief rolls. Without these benefits, 19 out of 20 beneficiaries would not achieve even a moderate living standard.

Over 24 million American men and women are receiving old-age, survivors, or disability insurance checks totaling $2 billion each month. Still, the social security recipient keeps body and soul together on an average of $100 a month. And the minimum benefits are now only $55 for a single person and $82.50 for a couple.

Whenever suggestions are made concerning increasing social security benefits, several inevitable but proper questions arise: Can we afford it? Should the cost be borne by payroll contributions?

In considering these important questions, we should remember that the employer's net social insurance contribution rate today is lower than it was expected to be when the social security program was enacted in 1935. I have transmitted to the chairmen of the House Committee on Ways and Means and the Senate Committee on Finance a report on this matter which in my opinion justifies additional payroll contributions for further improvements in the program.

I recommend:

That social security benefits be raised substantially to a $100 per month minimum for an individual and $150 for a couple over the next several years. This would have a dramatic effect—lifting 4.4 million people out of poverty. The first step toward this goal would be a 10-percent general boost and a jump from $55 to $80 minimum for an individual and from $82.50 to $120 for a couple. This would move 1.2 million persons out of poverty. This first step alone would take 150,000 aged men and women off the welfare rolls and greatly reduce the number of needy crippled, disabled, and blind, at an annual savings in local, State, and Federal funds of $255 million. States would then be freer to concentrate their helping efforts on the families most in need of preventive—and where it is too late—rehabilitative services.

That the maximum earnings base on which social security benefits are computed (now $7,800 a year) be completely eliminated in determining the employer's contribution.

That the maximum earnings base for determining the employee's contributions and benefits be increased by steps to $15,000 a year so that the social security system will cover about the same proportion of wages as it did in 1939.

Consideration be given to changing the ratio of employer-employee contributions, from a 50-50 basis to two-thirds from the employer and one-third

*See ch. I for discussion of matters relating to this appendix.

from the employee. This step would recognize the fact that the employer can deduct his contributions as a business expense in computing his tax, while the employee must pay an income tax on his deduction.

That the Congress consider refunding part or all of the payroll tax paid by those below the poverty level out of general Federal revenues.

That the level of unemployment insurance be raised substantially, that Federal standards be set for it, and remaining gaps in coverage be closed; that workmen's compensation benefits be improved for those who cannot work because of disabilities suffered on the job.

That the Congress enact legislation providing for payment of social security benefits to persons at age 60 on an actuarially reduced basis in either of two cases: if at any time unemployment for the United States should exceed 4½ percent for any 4 consecutive months, or if the Council of Economic Advisers advises the President that unemployment is likely to exceed 5 percent for 3 consecutive months.

That the retirement test in which there is no loss of income be increased from $1,680 a year to $1,800 and that this amount be automatically increased in the future in relation to increased earnings.

ITEM 2: ACTION ON PRIVATE PENSION LEGISLATION—1968

H.R. 18253,[1] which clarified a provision of the Self-Employed Individuals Tax Retirement Act of 1962, passed both houses in the waning days of the session, and was signed by the President on October 21 as Public Law 90–607. Its enactment should contribute to the upsurge in the establishment of private pension plans for the self-employed and their employees which began with the 1966 amendment, making contributions to such plans fully deductible for Federal income tax purposes.

Major private pension bills considered during the last weeks and months of the session but not enacted can be divided into two classifications: those relating to disclosure and fiduciary standards and those relating to vesting, funding, termination protection, and portability.

Bills regarding disclosure and fiduciary standards [2] considered during 1968 were:

S. 1024 [3] (Senator Yarborough), H.R. 5741 (Congressman Perkins), and H.R. 6498 (Congressman Dent), identical bills proposed by the administration to amend and strengthen the Welfare and Pension Plan Disclosure Act of 1958, as amended in 1962.

S. 1103 [4] (Senator Javits).

S. 1255 [5] (Senator McClellan).

Generally, these bills would require more disclosure regarding plans and their operations, and would raise standards of conduct of those who administer plans, to protect interests of participants and beneficiaries.

A 1-day hearing on these Senate bills and other Senate bills on private pensions was conducted on July 25, 1968 before the Subcommittee on Labor of the Senate Committee on Labor and Public Welfare.

Hearings on H.R. 5741 and H.R. 6498 were held by the General Subcommittee on Labor of the House Committee on Education and Labor on March 19, 20, 21, 27, 28, on April 10, and on May 8, 1968. That subcommittee reported H.R. 6498 to the full committee, with amendments, on July 24. On the same day, the Committee on Education and Labor ordered the bill, with the subcommittee amendments, reported to the House (H. Rept. No. 1867).[6] No further action was taken on the bill, and it died with adjournment.

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[1] A summary of the bill as reported to the House appears on p. 229.

[2] For purposes of this discussion, these terms may be defined as follows:

Disclosure is the requirement by law that certain vital facts concerning pension plans and their operations be made public.

Fiduciary standards are legal requirements that plan administrators protect the interests of plan beneficiaries and refrain from unjustly enriching themselves or others at the expense of beneficiaries.

[3] Digest appears on p. 230.

[4] Digest appears on p. 230.

[5] Digest appears on p. 231.

[6] H.R. 6498, as reported, is summarized on p. 231.

Major bills relating to vesting, funding, termination protection, and portability [1] considered during 1968 were:

S. 1103 (Senator Javits).

S. 3421 [2] (Senator Yarborough).

H.R. 17046 (Congressman Perkins and others).

S. 3421 and H.R. 17046 were identical bills developed by an interagency staff task force in the executive branch on the basis of recommendations of the January 1965 report of the President's Committee on Corporate Pension Funds and other private retirement and welfare programs. Those recommendations were designed to assure more workers who are nominally covered by private pension plans that they will actually receive pension benefits upon reaching retirement age.

The Subcommittee on Labor of the Senate Committee on Labor and Public Welfare heard testimony on these bills during its 1-day hearing on July 25, but no further action was taken.

ITEM 3: SUMMARIES AND DIGESTS OF PRIVATE PENSION PROPOSALS

A. EXPLANATION OF H.R. 18253 [3]

H.R. 18253 would make clear that the new definition of earned income for purposes of pension plans for self-employed individuals (sec. 204(c) of Public Law 89–809) applies to taxable years beginning after December 31, 1967. It would also provide that, in applying the 3-year averaging provisions (sec. 401(e)(3) of the code) in determining whether excessive contributions have been made to such plans, the new definition (which no longer limits "earned income" to 30 percent of the total income where capital is a material income-producing factor) is to be applied as though in effect for years beginning before January 1, 1968.

The Treasury Department has indicated that it has no objections to the bill's enactment.

* * * * * * *

When H.R. 10 was enacted in 1962, it permitted contributions each year to self-employed pension plans in amounts up to the lesser of $2,500 or 10 percent of the owner-employee's "earned income" from the business. However, where capital was a material income-producing factor, not more than 30 percent of the income from the business could be treated as "earned income" for purposes of this provision.

Since such plans can accumulate income without paying income taxes on the earnings of the invested funds, the 1962 act penalized contributions to the plans in excess of the amount generally permitted to be contributed. To avoid hardship in certain limited circumstances, those penalties are not imposed, however, where the contributions are in the form of premiums for annuity, endowment, or life insurance policies and are not greater than the average annual permissible contribution by the owner-employee for the 3 years immediately preceding the year in which the last policy contract was entered into.

The provisions relating to self-employed pension plans were liberalized in a number of respects in 1966—among them was elimination of the 30-percent limitation described above. This change was made prospective only. One effect of this prospective repeal of the 30-percent limitation has been that, for 3 years after this change, those who apply the averaging provisions described above have to continue to include in that average up to 3 years as to which the 30-percent limitation continues to apply. For those individuals, then, the effect of the 30-percent limit has not fully been repealed, in determining the maximum permissible contribution, until 1971. The committee agrees with the House that Congress

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[1] For purposes of this discussion, these terms may be defined as follows:

Vesting is giving a plan participant the right to pension benefits even though his employment is terminated before he becomes eligible to receive benefits.

Funding is the orderly accumulation of pension reserves during an employee's working career to provide sufficient money by the time of his retirement to pay his pension benefits thereafter.

Termination protection is provided by arrangements assuring plan participants that they will receive full pension benefits even if the plan terminates due to the employer's bankruptcy, merger with another concern, or other reason.

Portability is the right of an employee who leaves one employer and goes to another to receive credit for his service with the previous employer in determining his pension rights.

[2] Digest appears on p. 234.

[3] Excerpt from S. Rept. No. 1617 and H. Rept. No. 1888, identical reports on H.R. 18253.

did not intend that there be a 3-year waiting period before the repeal of the 30-percent limit became fully effective.

For the reasons indicated above this bill permits those who apply the averaging provisions to compute their averages for taxable years beginning after December 31, 1967, without regard to the now-repealed 30-percent limitation. This is accomplished by providing that for purposes of making the computations under the 3-year averaging provision the 30-percent limitation is treated as repealed for years before 1968.

The bill also removes any uncertainty as to the effective date of the repeal of the 30-percent limitation by providing that it applies to taxable years beginning after December 31, 1967.

B. DIGEST OF S. 1024 [1]

S. 1024. Mr. Yarborough; February 20, 1967 (Labor and Public Welfare).

Welfare and Pension Plan Protection Act—Sets forth the policy of protecting the interests of participants in and beneficiaries of employee welfare and pension benefit plans. Provides that annual audits of such plans be conducted by independent certified or licensed public accountants.

Imposes a minimum and uniform fiduciary responsibility of persons handling welfare and pension funds and imposes civil liability on those who breach the standard. Prevents the terms of a plan or agreement from immunizing such fiduciaries from the penalties for negligence.

Gives the Secretary of Labor additional investigatory and enforcement powers and authorizes him to bring legal actions.

Strengthens the disclosure provisions of the present law in order to establish a sound basis for evaluating fiduciary conduct.

Limits the investment of retirement funds in the securities of the employer company to 10 percent of the fund.

Authorizes the removal of any fiduciary who has participated in a breach of trust, and bars any person who has been convicted of certain crimes from serving in any fiduciary capacity for 5 years after conviction or after termination of his prison sentence.

Provides a fine of up to $1,000 and/or imprisonment of up to 6 months for anyone who willfully violates this act.

Establishes a 13-member advisory council on employee welfare and pension benefit plans to advise the Secretary of Labor with respect to carrying out his functions under this act.

C. DIGEST OF S. 1103 [2]

S. 1103. Mr. Javits; February 28, 1967 (Labor and Public Welfare): Pension and Employee Benefit Act—Establishes a U.S. Pension and Employee Benefit Plan Commission of 5 members appointed by the President, by and with the advice and consent of the Senate. Gives the Commission the duty of promoting the establishment, extension, and improvement of pension, profit-sharing-retirement, and other employee benefit plans and that of performing other functions directed or made necessary by this act. Transfers the functions of the Secretary of Labor and the Department of Labor under the Welfare and Pension Plans Disclosure Act to the Commission.

Requires every pension or profit-sharing-retirement plan established by an employer connected with commerce to register with the Commission unless such plan falls within the following exceptions: (1) Government administered plans; (2) certain income tax exempt organization plans; (3) plans established by self-employed individuals for his or his survivors' benefit; (4) plans covering not more than 25 participants; (5) plans outside the United States and for the benefit of foreigners; and (6) certain plans established primarily for providing select management employees with deferred compensation.

Gives the Commission the right to sue in Federal court to require compliance with the vesting-funding-reinsurance provisions of the act, and gives the Federal district courts equivalent jurisdiction to entertain a suit by a plan administrator to test any action of the Commission. Gives the Commission authority to sue to enforce the ethical standards established by the act.

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[1] Digest prepared by Legislative Reference Service, Library of Congress (p. A-59 of its "Digest of Public General Bills and Resolutions" for 1967.)

[2] See footnote 2 (p. A-66),

Establishes minimum vesting standards for pension plans and profit-sharing-retirement plans by requiring that an employee after 15 years of service and reaching the age of 45 must receive a nonforfeitable right to a full pension or, in the alternative, a 50-percent right after 10 years and full entitlement after 20 years of service.

Establishes minimum funding standards for such plans by requiring existing plans to amortize their unfunded liabilities within 40 years and new plans within 30 years.

Establishes a Federal pension reinsurance program to protect plans against termination and to insure retirees against loss of benefits when an employer goes out of business before the plan has been fully funded. Requires each registered pension plan to pay premiums to finance this reinsurance.

Establishes a voluntary central portability fund to enable plans to have a central clearinghouse of pension credits for persons transferring from one employer to another.

Establishes minimum standards of conduct, restrictions on conflicts of interest, and other ethical criteria which are to be followed by fiduciaries in the administration of pension plans and other plans providing benefits for employees.

D. DIGEST OF S. 1255 [1]

S. 1255. Mr. McCellan: March 13, 1967 (Labor and Public Welfare): Provides additional safeguards for the protection of employee welfare and pension benefit funds by establishing minimum standards for maintaining and managing such funds, by establishing minimum fiduciary standards of conduct, by providing sanctions and penalties for breaches of such standards, and by providing for the recovery of losses by reason of failure to maintain and abide by such standards.

E. SUMMARY OF H.R. 6498 AS REPORTED [2]

The bill amends the Welfare and Pension Plans Disclosure Act * * * making numerous changes and additions thereto. This section-by-section analysis describes the substantive differences between that act, as now in effect, and its provisions as they would be in effect upon the enactment of the bill.

SHORT TITLE

The new section 1 provides that the act may be cited as the Welfare and Pension Plan Protection Act of 1968.

FINDINGS AND POLICIES

The new section 2 adds to the statement of findings in existing law a finding that adequate safeguards should be provided with respect to the operation and administration of employee welfare and pension benefit plans. It further adds a statement that it is a purpose of the act to establish fiduciary standards of conduct, responsibility, and obligation upon specified persons concerned with employee welfare and pension benefit funds, and to provide sanctions for breaches of these fiduciary standards, as well as to provide for recovery of losses.

DUTY OF DISCLOSURE AND REPORTING

The new section 5 retains the provisions in existing law requiring descriptions of plans and annual financial reports to be published to participants and beneficiaries, and giving the Secretary authority to prescribe the form of such descriptions and reports. As amended, the section does not retain the specific statement that regulations issued thereunder may not relieve an administrator of the obligation to include in a required description or report any information relative to his plan which is required by the subsequent provisions of the act. Instead the new section gives the Secretary general authority to provide by regulation for the exemption from the reporting and disclosure requirements of the act of any class or type of welfare or pension benefit plan if he finds that application of the requirements of this act is not required in order to effectuate the purposes of the act.

[1] See footnote 2 (p. A-79).

[2] Excerpt from pp. 11-17, House Rept. No. 1867, by which H.R. 6498 was reported from the House Committee on Education and Labor.

DESCRIPTION OF THE PLAN

The new section 6 retains in large part the provisions of existing law which require the description of employee welfare or pension benefit plans to be published. The new section, however, would not require the description of the plan to be sworn to by the administrator. It also permits the Secretary to prescribe by regulation the period within which changes in required information must be reported.

ANNUAL REPORTS

The new section 7 makes a number of substantial changes in the requirements of existing law relating to annual reports on employee welfare or pension benefit plans.

The coverage of the section is extended to include all plans which are subject to the provisions of section 14, which imposes fiduciary responsibilities.

* * * * * * *

In recognition of the broadened authority of the Secretary to prescribe the form of reports, the new section does not contain a provision, which is contained in existing law, which directs the Secretary to prescribe by general rule simplified reports for plans which he finds that by virtue of their size or otherwise a detailed report would be unduly burdensome.

The new section, in subsection (h), requires the administrator of a plan to cause an annual audit to be made of any employee benefit fund established under the plan. The audit will be made in accordance with accepted standards of auditing by a certified or licensed public accountant. However, no audit is required of the books or records of a bank, insurance company, or other institution or similar institution if the books or records are subject to periodic examination by an agency of the Federal Government or of a State.

ENFORCEMENT

Under section 9 of the existing act the Secretary may, after first requiring certification as provided in section 7(b), upon complaint of violation not satisfied by such certification, or on his own motion, when he has reasonable cause to believe that investigations may disclose violation of the act, make necessary investigations, and may require persons to file with him statements as to the facts and circumstances concerning the matter to be investigated. Under the new section the Secretary may, whenever he has reasonable cause to believe that investigation may disclose violations, make such an investigation. In connection therewith he is authorized to enter such places and inspect such records and accounts and question such persons as he may deem necessary. Any information concerning the facts required to be shown in any report required by this act which the Secretary develops as a result of his investigation will be reported to interested persons or officials. The Secretary is authorized to cause periodic examinations to be made of any welfare or pension benefit plan subject to section 14 (relating to fiduciary responsibilities), but no such examination shall be made more often than once a year.

The existing section prohibits the Secretary from regulating or interfering in the management in any plan except that he may inquire into the existence and amount of investments, actuarial assumptions, or accounting practices only when it has been determined that investigation is required. The comparable provision of the bill provides that the Secretary may not regulate, interfere in the management of any plan except to the extent he exercises his authority to bring court actions to enforce section 14 (providing for fiduciary responsibilities).

Subsection (i) of this section in the bill provides that the Secretary, or any participant or beneficiary, may bring a civil action to recover the liability specified in section 14 or to enjoin violations of that section and for other appropriate relief. Such an action may also be brought to remove any person occupying a fiduciary position under section 14. Pending the replacement of such a person the court may appoint an appropriate person to carry out the duties of the person removed. These proceedings may not be brought by a participant or beneficiary of a plan, except upon leave of the court and for good cause shown. The court in these actions may, in addition to any judgment awarded to the participant or beneficiary, allow reasonable attorney fees and the costs of the action. If the Secretary brings the action, the jurisdiction of the district court over the subject matter of the action shall be exclusive and the final judgment shall be res judicata. The section gives the district courts of the United States jurisdiction to award liability specified in section 14, or to grant injunctive or other appropriate relief

in these cases. It also gives these courts jurisdiction to order the removal of a person serving as a fiduciary and to appoint a replacement, if the court finds that such person is failing to carry out his fiduciary responsibilities or is disqualified from serving.

The bill empowers the Secretary to make arrangements or agreements for cooperation or mutual assistance in the performance of his functions under this act. He is authorized to use the facilities or services of other Federal agencies or of any State or political subdivision of a State. Other Federal agencies are directed to cooperate with the Secretary and to the extent permitted by law to provide him with information and facilities. It also provides, as it does in present law, for transmittal to the Attorney General evidence developed in the performance of his functions under the act.

FIDUCIARY RESPONSIBILITY

Section 14 of the bill is a new section which imposes fiduciary responsibilities on certain persons connected with employee welfare or pension benefit plans.

Subsection (a) of this section defines an "employee benefit fund" as a fund of money or other assets established in connection with an employee welfare or pension benefit plan and includes employee contributions to it.

Subsection (b) provides that the section will not apply to: (1) plans in which benefits payable to participants or other beneficiaries are provided solely from general assets of an employer or an employee organization, (2) premiums or subscription charges for which benefits are guaranteed and which are received by an insurance carrier or service or other organization, (3) moneys deposited with an insurance carrier, repayment of which is guaranteed, or (4) any investment company registered under the Investment Company Act of 1940.

Subsection (c) of this section provides that an employee benefit fund shall be deemed to be a trust fund available only for the sole and exclusive purpose of providing benefits to participants in the plan and their beneficiaries and defraying the reasonable cost of administering the plan.

Subsection (d) provides that every person who receives, disburses, or exercises any control or authority with respect to any employee benefit fund is a fiduciary and occupies a position of trust with relation to such fund and to the participants and their beneficiaries for whose benefit the fund was established. It requires each fiduciary to discharge his duties with respect to the fund with the same degree of care and skill as a man of ordinary prudence would exercise in dealing with his own property. It further provides that no requirement of diversification shall be applied to preclude or limit investments in the case of a profit sharing plan, stock bonus, thrift and savings, or similar plan, in stock or securities of employers to the extent that such plan requires that a part or all of the plan funds be invested in such stock or securities.

Subsection (e) of this section provides that no loan shall be made from an employee benefit fund to a fiduciary related to it, or to a relative of any fiduciary, or to his employer, employee, partner, or other business associate, or to a labor organization for the benefit of whose members the fund was established, or to any official thereof, or to an employer who contributes to the fund or any official of such employer. The term "relative" as used in this subsection means a spouse, ancestor, descendant, brother, sister, and a son-, daughter-, father-, mother-, brother-, or sister-in-law.

Subsection (g) of this section provides that any fiduciary who breaches his responsibilities, obligations, or duties under this section shall be personally liable to make good to the fund any losses resulting from his breach, and to restore to the fund any profits which have been made through his use of assets of the fund.

* * * * * * *

Subsection (i) provides that each employee benefit plan must contain specific provisions for the disposition of trust funds asset upon termination. In the event of termination, the fund or any part thereof shall not be expended, transferred, or otherwise disposed of, except for the exclusive benefit of the plan participants and their beneficiaries. Notwithstanding the foregoing, after the satisfaction of all liabilities with respect to the participants and their beneficiaries under a pension plan in accordance with the Internal Revenue Code of 1954, any remaining fund assets may be returned to any person who has an interest in such assets by reason of having made financial contributions thereto.

Subsection (j) provides that exculpatory provisions in the agreement establishing an employee benefit fund or any agreement by the parties thereto may not relieve a fiduciary of his duties under this section.

PROHIBITION AGAINST CERTAIN PERSONS HOLDING OFFICE

Section 15 of the bill provides that certain persons may not serve as an administrator, officer, trustee, custodian, counsel, agent, or employer of a plan, or as a consultant to any employee welfare or pension plan for a 5-year period of time after his conviction or imprisonment for certain violations of law. An exception is provided for persons whose citizenship rights have been fully restored, or if the board of parole of the Department of Justice determines that his service in connection with the plan would not be contrary to the purposes of the act. Violations of law which will result in the loss of eligibility or conviction of or imprisonment for robbery, bribery, embezzlement, grand larceny, any crime described in section 15(b)(5)(B) of the Securities Exchange Act of 1934, in section 9(e)(1) of the Investment Company Act of 1940, any crime involving the moneys or funds of a labor organization or the funds of an employee welfare or pension benefit plan, or a violation of this act, or of section 302 of the Labor Management Relations Act of 1947, or a violation of chapter 63 or section 1027 of title 18, United States Code. Violations of this section will be punishable by a fine of $10,000 or imprisonment for not more than 1 year, or both.

OTHER PROVISIONS

In addition to the foregoing, the bill makes a number of minor technical and conforming changes to existing law. It also provides that these amendments will take effect upon the date of enactment of the act except that modifications to the reporting requirements of section 7 will take effect 1 year after the date of enactment or upon publication of implementing regulations in the Federal Register, whichever is sooner.

F. DIGEST OF S. 3421 [1]

S. 3421. Mr. Yarborough; May 2, 1968 (Labor and Public Welfare). Pension Benefit Security Act—Imposes a minimum standard for all pension plans in order to provide vested retirement to all participants who have worked for the same employer for 10 or more years after reaching the age of 25.

Requires a minimum standard of funding to assure that sufficient assets are accumulated to carry out promises to employees and their dependents.

Provides insurance against losses to pension funds caused by involuntary termination of a plan before it is fully funded.

Permits various arrangements by which such plans can make careful transitions in order to permit easy adjustment. Authorizes the Secretary of Labor to approve alternative methods of meeting standards in special cases.

Provides for continuing studies of all aspects of pension plans, including the possibility of portability of pension credits.

ITEM 4: INCREASE IN VETERANS PENSIONS

1. Compensation Increases for Service-Connected Disabled Veterans

H.R. 16027, a bill providing a $100 monthly increase in compensation payments to totally disabled veterans, and an 8-percent increase in compensation payments to other veterans with service-connected disabilities, effective January 1, 1969, was signed into law by the President on August 19, 1968 (P.L. 90–493).[2] Since the majority of veterans who receive compensation for service-connected disabilities are elderly, most of the benefit of this increase will go to older Americans. According to the Veterans' Administration, there were 2,012,149 veterans receiving compensation benefits on June 20, 1968, of which 1,659,158 were over age 50. Of this 1,659,158, the Veterans' Administration breakdown by ages is as follows:

Age group:	*Number*
50 to 54	834, 235
55 to 59	448, 167
60 to 64	238, 685
65 to 95	138, 032
Over 95	39
Total	1, 659, 158

[1] Digest prepared by Legislative Reference Service, Library of Congress (pp. A-50, A-51, "Digest of Public General Bills and "Resolutions" for 1968.)

[2] A detailed analysis of the new public law appears in the appendix at p. 235.

H.R. 16027 was reported from the House Committee on Veterans Affairs on May 14, 1968, passed the House on June 6, was reported from the Senate Committee on Finance on July 26, and passed the Senate, amended, on July 31. After differences between the versions passed by the two Houses were reconciled, the bill secured final approval by the Senate and House on August 2.

2. PROTECTION OF NON-SERVICE-CONNECTED PENSIONS FROM REDUCTION

After the social security benefit increase of 1965 and other previous social security increases, some older veterans and their survivors who received both social security and veterans' non-service-connected pensions found that the resulting reductions of their pensions left them with less total income than before the social security increases. After enactment of the social security increases of 1967, Congress recognized the need for protecting veterans and their survivors against suffering reductions in total incomes as a result of those and future increases.

The protective approach chosen by Congress was that represented by H.R. 12555, which had passed the House on December 15, 1967. The Senate Committee on Finance reported this bill, without amendment, on February 28, 1968, and it passed the Senate, without amendment, on March 11. It was signed into law by the President on March 28 (P.L. 90–275).[1]

The new public law moderates the effect of social security increases upon veterans' pensions by—

1. Increasing the monthly amounts payable under the "new law" pension and indemnity compensation programs;
2. Expanding the income limitations of these programs as well as "old law" pension; and
3. Phasing in recipients of the 1967 social security increases to a new multilevel income program.

The new multilevel income approach implements a recommendation [2] of a report of the Subcommittee on Employment and Retirement Incomes, Senate Special Committee on Aging. This report was the result of a subcommittee study and 2 days of hearings, on April 24 and 25, 1967.

ITEM 5: ANALYSIS OF PUBLIC LAW 90–493 [3]

COMPENSATION INCREASES FOR SERVICE-CONNECTED DISABLED VETERANS

H.R. 16027, AS ENACTED BY THE CONGRESS

Summary

Provides a $100 monthly increase in compensation payments to totally disabled veterans, and an 8-percent increase in compensation payments to other veterans with service-connected disabilities, effective January 1, 1969.

Cost and effect

Annual cost of $235 million, the largest single increase in the compensation program since it was first enacted; increases compensation payments to more than 1,950,000 veterans and their dependents.

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[1] Tables comparing provisions of the new public law with those of preexisting law appear on p. 236 of the appendix.

[2] Pp. 8 and 9, "Reduction of retirement benefits due to social security increases", Report of Subcommittee on Employment and Retirement Incomes, Senate Special Committee on Aging, 90th Cong., 1st sess. (Aug. 21, 1967).

[3] Prepared and issued by Senate Committee on Finance.

COMPENSATION RATES UNDER H.R. 16027

Disability	Compensation rate	
	In 1968	Effective January 1969
(a) Rated at 10 percent	$21	$23
(b) Rated at 20 percent	40	43
(c) Rated at 30 percent	60	65
(d) Rated at 40 percent	82	89
(e) Rated at 50 percent	113	122
(f) Rated at 60 percent	136	147
(g) Rated at 70 percent	161	174
(h) Rated at 80 percent	186	201
(i) Rated at 90 percent	209	226
(j) Rated at total	300	400
(k) (1) These anatomical losses or loss of use of any of these organs: 1 foot, 1 hand, blindness in 1 eye (light perception only), creative organ, both buttocks, organic aphonia, deafness of both ears—for each loss	47	47
(2) Limit for veterans receiving payments under (a) to (j) above	400	500
(3) Limit for veterans receiving payments under (l) to (n) below	600	700
(l) Anatomical loss or loss of use of both hands, both feet, 1 foot and 1 hand, blindness in both eyes (5/200 visual acuity or less), permanently bedridden or so helpless as to require regular aid and attendance	400	500
(m) Anatomical loss or loss of use of 2 extremities so as to prevent natural elbow or knee action with prosthesis in place, blind in both eyes, rendering veteran so helpless as to require regular aid and attendance	450	550
(n) Anatomical loss of 2 extremities so near shoulder or hip as to prevent use of prosthesis, anatomical loss of both eyes	525	625
(o) Disability under conditions entitling veteran to 2 or more of the rates provided in (l) through (n), no condition being considered twice in the determination, or total deafness in combination with total blindness (5/200 visual acuity or less)	600	700
(p) If disabilities exceed requirements of any rates prescribed, Administrator of VA may allow next higher rate or an intermediate rate, but in no case may compensation exceed	600	700
(q) Arrested tuberculosis, minimum monthly compensation rate	67	(1)
(r) If veteran entitled to compensation under (o) or to the maximum rate under (p), and is in need of regular aid and attendance, he shall receive a special allowance of the amount indicated at right for aid and attendance in addition to whatever he is receiving under (o) or (p)	250	300
(s) Disability rated as total, plus additional disability independently ratable at 60 percent or over, or permanently housebound	350	450

[1] Subsec. (q) is repealed by H.R. 16027; however, any veteran already receiving or entitled to receive the $67 minimum shall continue to receive this minimum payment.

ITEM 6: COMPARISON OF PROVISIONS OF PUBLIC LAW 90–275 [1] (H.R. 12555) WITH PREEXISTING LAW [2]

* * * The following table illustrates the pension provisions of H.R. 12555 as reported, as compared with those in present law:

[1] Discussed on pp. 235.
[2] Excerpt of report of Senator Long (Louisiana) from Senate Committee on Finance, pp. 5–7, S. Rep. No. 1009, 90th Cong., 2d sess.

Income increment	Veteran alone		Veteran with dependent		Widow alone		Widow with 1 child [1]	
	Existing law	H.R. 12555	Existing law	H.R. 12555	Existing law	H.R. 12555	Existing law	H.R 12555
$100	$104	$110	[2] $109	[2] $120	$70	$74	$86	$90
$200	104	110	[2] 109	[2] 120	70	74	86	90
$300	104	110	[2] 109	[2] 120	70	74	86	90
$400	104	108	[2] 109	[2] 120	70	73	86	90
$500	104	106	[2] 109	[2] 120	70	72	86	90
$600	104	104	[2] 109	[2] 118	70	70	86	90
$700	79	100	[2] 109	[2] 116	51	67	86	89
$800	79	96	[2] 109	[2] 114	51	64	86	88
$900	79	92	[2] 109	[2] 112	51	61	86	87
$1,000	79	88	[2] 109	[2] 109	51	58	86	86
$1,100	79	84	84	107	51	55	67	85
$1,200	79	79	84	105	51	51	67	83
$1,300	45	75	84	103	29	48	67	81
$1,400	45	69	84	101	29	45	67	79
$1,500	45	63	84	99	29	41	67	77
$1,600	45	57	84	96	29	37	67	75
$1,700	45	51	84	93	29	33	67	73
$1,800	45	45	84	90	29	29	67	71
$1,900		37	84	87		23	67	69
$2,000		29	84	84		17	67	67
$2,100			50	81			45	65
$2,200			50	78			45	63
$2,300			50	75			45	61
$2,400			50	72			45	59
$2,500			50	69			45	57
$2,600			50	66			45	55
$2,700			50	62			45	53
$2,800			50	58			45	51
$2,900			50	54			45	48
$3,000			50	50			45	45
$3,100				42				43
$3,200				34				41

[1] Plus $16 for each additional child.
[2] Add $5 for 2 dependents or $10 for 3 or more dependents.

B. DIC Program

Service-connected compensation (DIC) is paid to parents on the basis of income. Existing rates and those proposed are shown by the tables below:

IF THERE IS ONLY 1 PARENT

Total annual income		Monthly payment (H.R. 12555)	Monthly payment (law)
More than—	But equal to or less than—		
	$800	$87	$87
$800	900	81	69
$900	1,000	75	69
$1,000	1,100	69	69
$1,100	1,200	62	52
$1,200	1,300	54	52
$1,300	1,400	46	35
$1,400	1,500	38	35
$1,500	1,600	31	18
$1,600	1,700	25	18
$1,700	1,800	18	18
$1,800	1,900	12	
$1,900	2,000	10	

IF THERE ARE 2 PARENTS, BUT THEY ARE NOT LIVING TOGETHER

Total annual income		Monthly payment to each parent (H.R. 12555)	Monthly payment (law)
More than—	But equal to or less than—		
	$800	$58	$58
$800	900	54	46
$900	1,000	50	46
$1,000	1,100	46	46
$1,100	1,200	41	35
$1,200	1,300	35	35
$1,300	1,400	29	23
$1,400	1,500	23	23
$1,500	1,600	20	12
$1,600	1,700	16	12
$1,700	1,800	12	12
$1,800	1,900	11	----
$1,900	2,000	10	----

IF THERE ARE 2 PARENTS WHO ARE LIVING TOGETHER, OR IF A PARENT HAS REMARRIED AND IS LIVING WITH HIS SPOUSE

Total combined annual income		Monthly payment to each parent (H.R. 12555)	Monthly payment (law)
More than—	But equal to or less than—		
	$1,000	$58	$58
$1,000	1,100	56	46
$1,100	1,200	54	46
$1,200	1,300	52	46
$1,300	1,400	49	46
$1,400	1,500	46	46
$1,500	1,600	44	35
$1,600	1,700	42	35
$1,700	1,800	40	35
$1,800	1,900	38	35
$1,900	2,000	35	35
$2,000	2,100	33	23
$2,100	2,200	31	23
$2,200	2,300	29	23
$2,300	2,400	26	23
$2,400	2,500	23	23
$2,500	2,600	21	12
$2,600	2,700	19	12
$2,700	2,800	17	12
$2,800	2,900	15	12
$2,900	3,000	12	12
$3,000	3,100	11	----
$3,100	3,200	10	----

ITEM 7: EXCERPTS OF SECRETARY COHEN'S REPORT, ENTITLED "THE RETIREMENT TEST UNDER SOCIAL SECURITY" [1]

BACKGROUND

WHY THE LAW CONTAINS A RETIREMENT TEST

In a work-related society a basic problem is the insecurity arising from the interruption of work income, which, of course, affects not only the worker but those members of his family who are dependent on his earnings. While a combination of approaches, including group and individual insurance plans and government-sponsored programs, are used in the United States for preventing economic insecurity, the old-age, survivors, and disability insurance program—commonly called social security—is the basic mechanism for preventing insecurity arising from interruption in income from work.

Social security is a social insurance system under which workers and their dependents are insured against the loss of work income resulting from the worker's death, disability, or retirement. The benefit payments made when that loss occurs

[1] Discussed on p. 14.

are designed to partially replace the earnings that are lost, and thus to help prevent the economic insecurity that would otherwise result.

Necessary in any insurance system—private or social—is some way to measure whether, and the extent to which, the loss insured against has occurred. One of the mechanisms used in the social security program is the retirement test. The assumption underlying this test is that if a beneficiary's earnings from work are below certain limits, the loss of earnings insured against has occurred, wholly or partly.

The same general assumption applies throughout the social security cash benefit programs. The disability insurance part of the program takes into account, in evaluating disability, not only the medical condition of the beneficiary, but also his earnings, if any, from work. If a disabled beneficiary has substantial earnings from actual work activity, he is not considered to have suffered a loss of work income sufficient to call for the payment of benefits even though his physical condition may be indicative of severe disability. In the survivors insurance part of the program a sufficient loss of work income is not considered to have occurred if the earnings of the survivors are above certain limits.

* * * * * * *

Any test of retirement for social insurance purposes must be a compromise between two conflicting goals. The principle that social insurance benefits should be paid only to those suffering a loss of work income must be balanced with the need to avoid creating disincentives for those who wish to work. The retirement test, then, must be a compromise between these two objectives. While preventing payment of benefits to people with relatively substantial earnings, the amount of earnings allowed without any withholding of benefits should be high enough to allow those beneficiaries who can work at low-paying or part-time jobs to do so and still get part or all of their benefits.

The retirement test as it stands today prevents the payment of benefits to people with substantial earnings from work, but does not prevent payment merely because a beneficiary has some earnings. It thus does not completely remove incentives to work. The present test must be considered a rough approach to the problem of paying benefits when there has been significant loss of income while avoiding disincentives to work—a problem that is much too complex for any simple solution.

One of the difficulties arises because of the tremendous variation in the circumstances of the beneficiaries. It is questionable whether a retirement test geared to each individual case—e.g., one that would pay benefits to a person who during his working lifetime had a $20,000-a-year job and after "retirement" is able to make $5,000 a year as a consultant, while denying benefits to a $6,000-a-year worker who after retirement manages to pick up something more than $1,500 at odd jobs—would be accepted by the public.

There is no question that the present test is difficult for most beneficiaries—especially the aged—to understand, both as to operation and as to purpose. One result of its complexity is that it is difficult to administer. Because the operation and purpose of the test are widely misunderstood, administration is made even more difficult.

One of the major factors to be considered in evaluating any proposed change in a social insurance program is the cost of the proposed change relative to its potential benefits and relative to the cost of other possible changes in the program. The cost of total elimination of the retirement test for all beneficiaries, including those under 65, is 0.70 percent of taxable payroll—enough to finance a 7 percent across-the-board increase in social security cash benefits.

* * * * * * *

AUTOMATIC ADJUSTMENT OF THE EXEMPT AMOUNT

It would be possible, of course, to establish an exempt amount that would not become outdated if earnings levels continue to rise in the future as they have in the past. This could be done by providing for an automatic adjustment of the exempt amount to rises in earnings levels. If the exempt amount were increased under such a provision, a corresponding increase should also be made in the monthly test and in the $1-for-$2 adjustment band. Such a change would not require new financing. As earnings levels rise, income to the system increases more than the corresponding benefit liabilities, and the excess of income would more than cover the cost of adjusting the exempt amount.

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ITEM 8: RAILROAD RETIREMENT

Early in the 1968 session, Congress acted quickly to provide railroad retirement benefit increases to keep that retirement program abreast of the social security benefits resulting from the Social Security Amendments of 1967. H.R. 14563, a bill to accomplish this result, was reported from the House Committee on Interstate and Foreign Commerce on January 17, 1968, and passed the House on January 25. When the bill reached the Senate, it was ordered placed on the calendar and passed the Senate on January 30. It was signed on February 15 as Public Law 90–257.

Summary of Public Law 90–257, Railroad Retirement Increase Act

PRINCIPAL PURPOSE OF THE BILL [1]

Title I of the bill provides an increase in railroad retirement benefits for persons who will not receive an increase in either their railroad retirement or social security benefits as a result of the recent amendments to the Social Security Act. This increase, subject to certain offsets explained hereafter, will equal 110 percent of the increases the affected individuals would have received under the Social Security Act had that act been applicable to the railroad service involved rather than the Railroad Retirement Act. Many persons automatically receive increases in railroad retirement benefits when social security benefits increase, because their benefits are computed under the social security formula, which was increased by last year's amendments. These individuals are not affected by the bill. All other beneficiaries will receive increases of $10 or more, in the case of retired employees, or $5 or more in the case of wives, widows, parents, and children (before any reductions for early payment of benefits).

Title I also makes certain disabled widows and widowers eligible for benefits, makes certain additional family members eligible for benefits, provides an increase in the credit for future military service, and liberalizes the earnings test for persons eligible for disability annuities, under the Railroad Retirement Act. The cost of these benefits will be financed out of increases in the income of the railroad retirement fund arising out of the recent Social Security Act amendments and will not require a further increase in railroad retirement taxes.

Title II of the bill would increase by $2.50 per day benefits for unemployment and sickness, and would provide some restrictions on eligibility for those benefits.

The bill reflects the terms of an agreement entered into by representatives of railway labor and management and is supported by the administration.

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[1] Excerpt from p. 2, H. Rept. No. 1054, 90th Cong., Second sess.

Appendix 5

MATERIAL RELATED TO HEALTH OF THE ELDERLY*

ITEM 1: 1968 HEALTH LEGISLATION

Several major health bills were enacted by Congress during 1968. While these bills relate to the health of Americans of all ages, they would particularly benefit the health of the elderly.

1. HEALTH MANPOWER ACT OF 1968—PUBLIC LAW 90-490 (AUG. 16, 1968)

Hearings [1] of our Subcommittee on Health of the Elderly have elicited much testimony that one of the most serious impediments to delivery of health services to this age group is the severe shortage of health personnel. The challenges facing the Nation with regard to training of health professionals was discussed as follows in the Senate committee report on S. 3095, the bill which was enacted into this public law: [2]

"Although we are beginning to make progress in expanding our training capacity for the health professions the shortages continue to be acute. In 1968 there are 311,000 active physicians and 100,000 active dentists. An additional 80,000 physicians and 25,000 dentists will be required by 1975, according to estimates of the Bureau of Labor Statistics of the Department of Labor. The Bureau also estimates that an additional 3,000 optometrists, 6,000 pharmacists, and 1,000 podiatrists will be required in 1975 over and above the 1966 level of active workers.

* * * * * * *

"Our 95 schools of medicine and five schools of osteopathy accommodated some 10,000 admissions in 1967, approximately one-half of the number of students who applied. Proportionately fewer students can enter a career in medicine today in comparison with past periods. If we are to give the youths of 1975 the same opportunity to become a physician that prevailed in 1960, we will have to expand our training capacity to accommodate 15,000 freshman admissions."

To meet this challenge, the new public law extends and improves programs relating to training of health professions, including nursing and allied health professions. In almost every case, existing authorizations were extended and increased, to provide greater Federal support for programs which have already proven effective in reducing shortages of medical personnel.

2. HEALTH SERVICE AMENDMENTS OF 1968—PUBLIC LAW 90-574 (OCT. 15, 1968)

This new law extended and improved provisions of the Public Health Service Act relating to regional medical programs, migratory workers, alcoholic and narcotic addict rehabilitation, health facility construction and modernization, as well as certain of its miscellaneous provisions. Of these the most significant to the elderly are the regional medical programs and the health facility construction and modernization program (Hill-Burton).

Concerning the regional medical programs, the Senate report on H.R. 15758, the bill which was enacted as Public Law 90-574, commented: [3]

*See ch. II for discussion of matters related to this appendix.

[1] "Costs and Delivery of Health Services to Older Americans", hearings before Subcommittee on Health of the Elderly, Senate Special Committee on Aging, June 22, 1967 (Washington); Oct. 19, 1967 (New York) and Oct. 16, 1968 (Los Angeles), 90th Cong., First and Second sess.

[2] Pp. 3 and 4, S. Rept. 1307, 90th Cong., Second sess. (June 21, 1968).

[3] Pp. 2-4, Senate Report 1454, 90th Cong., Second sess. (July 24, 1968).

"BACKGROUND

"The legislation authorizing the planning and establishment of regional medical programs to combat heart disease, cancer, stroke, and related diseases was approved by this committee and passed by the Congress in 1965. The original legislation was based on the findings of the President's Commission on Heart Disease, Cancer, and Stroke, which reported that these diseases were exacting a heavy toll in death, disability, and economic costs. The Commission found that medical science has created the potential to reduce these tolls but that the benefits of these advances in medical science need to be made more widely available to victims of these diseases throughout the Nation if this potential is to be realized. The legislation authorized grants for the planning and establishment of regional medical programs which would bring together the cooperative efforts of medical schools, hospitals, physicians, and other health resources and personnel for the purpose of making more widely available the latest advances in the diagnosis and treatment of these diseases. Through these cooperative arrangements on a regional basis, the skills of modern medicine could be mobilized against the threats of these diseases which cause over 70 percent of all deaths.

"ACCOMPLISHMENTS

"The committee is pleased to report that during the hearings on this bill the committee was provided with evidence of substantial progress in achieving the goals set forth 3 years ago. Planning grants have been awarded to 54 regional medical programs which cover the entire population of the Nation. Twenty-two of these programs have moved sufficiently far in their planning to receive grants for the initial stages of operation of their programs. Over 7,000 individuals are now actively engaged in the programs, including not only the staff employed by the regional medical programs but thousands of health professionals and interested citizens who are contributing their time to the work of committees and task forces which are helping to develop and implement regional plans for the fight against these diseases. Nineteen hundred persons serve on the regional advisory groups required by the law who must advise on the development of the programs and approve all operational activities before they can be funded by a grant. About 1,000 medical institutions are participating, including every medical school and over 800 hospitals. The involvement of both medical schools and community hospitals is helping to make possible the development of close and continuous contact between the advances of medical science and the application of those advances in the community. The committee was pleased to learn that the American Hospital Association recently sponsored a successful invitational conference which brought together leaders in the hospital field and representatives of the regional medical programs to explore means for achieving further involvement of hospitals so that the benefits of the regional programs can extend into many additional communities.

"Also helping to extend the impact of the programs is the participation of almost 800 health organizations, including medical societies, health departments, hospital councils, heart associations, and cancer societies. The committee is pleased to learn of this widespread participation because it believes that the cooperation of all health resources will be necessary if the regional medical programs are to make their important contribution to evolving regional patterns of improved health capability, regionally planned and implemented.

"EXAMPLES OF ACTIVITIES

"Regions have found that many different types of activities can contribute to their objectives, such as demonstrations of advanced diagnostic and patient care techniques, training and continuing education of health personnel, development of communication and patient data networks, application of computer and other modern technology to health care, and research into better means for organizing and delivering advances in health care. A few examples illustrate the progress being made. In one region a coordinated approach has been developed to provide training and expert consultation which will insure the effective use of coronary care units in each hospital for improved care of victims of heart disease. By working together with the support of the regional medical program, each of the 29 hospitals in the region will be able to offer better care than each hospital could achieve alone. In another region, an advanced capability for monitoring the condition of

patients acutely ill with heart disease through the use of modern computer techniques is made available to additional cooperating hospitals through a direct wire hookup that links the outlying hospitals to the central computer capability. Through another regional medical program, high voltage radiation therapy for the treatment of cancer patients is now available in an area previously far removed from such capability, and expert consultation in radiation physics is being provided by a distant medical center. Still another region now provides a team of physicians and other health personnel who are available for onsite consultation in the care of stroke patients. This team also provides training for those responsible for the continuing care of the patient. Many regional medical programs have mounted innovative programs for continuing education of health personnel, including the use of banks of prerecorded tapes on special diagnostic or treatment problems available to all physicians in the region through a simple dial-in system.

"EXTENSION OF THE PROGRAM

"The many activities now underway in regional medical programs—all directed toward the improved care of people afflicted with or threatened by heart disease, cancer, stroke, and related diseases—are a measure of the promise of this important new health program. All testimony heard by the committee and statements submitted to the committee by national health organizations, including the American Medical Association, the American Hospital Association, the American Heart Association, the American Cancer Society, and the Association of American Medical Colleges, strongly support the extension of this legislation. The initial accomplishments provide a firm foundation on which the future progress of these programs can be built. Extension of the program is vitally needed to capitalize on these initial efforts and to sustain and extend the cooperative participation of thousands of institutions, individuals, and organizations.

"NEED FOR ADEQUATE FUNDING

"The committee firmly believes, however, that the momentum of the programs must be supported by adequate funding . . ."

Public Law 90–574, accordingly, extended the authorization for the regional medical programs for 2 years, with authorizations of $65 million for fiscal year 1969 and $120 million for fiscal year 1970.

Public Law 90–574 extended for 2 years beyond June 30, 1969, the Hill-Burton program of grants for construction and modernization of hospitals and other medical facilities. The following information on this program was presented in the Senate committee report on H.R. 15758: [4]

"The Hill-Burton program operates today under the 1964 hospital and medical facilities amendments, Public Law 88–443. These amendments extended the hospital and medical facilities survey and construction program through June 30, 1969. The original Hospital Survey and Construction Act was passed in 1946 as Public Law 79–725, title VI of the Public Health Service Act.

"Supporting legislation for this continuing program has always included two elements: (1) assistance to States in preparing inventories of existing health care facilities as a basis for determining their need for additional facilities, and for developing comprehensive plans for construction of needed facilities, and (2) provision of incentive, through Federal financial assistance to the States, for construction of public and voluntary nonprofit facilities. In its initial years the program was directed toward hospitals and public health centers, giving relatively greater support to low income and rural areas.

"The amounts of money appropriated for this program have varied over the years. Appropriations for the initial years of 1948 and 1949 were $75 million for each year. This amount was increased, reaching approximately $290 million in 1968. The annual appropriations have exceeded $200 million since 1962.

"In its 21 years of existence, the program expended $2.9 billion in support of construction and modernization of health care facilities whose total costs came to $9.2 billion."

3. NATIONAL EYE INSTITUTE—PUBLIC LAW 90-489 (AUGUST 16, 1968)

The need for this legislation establishing a National Eye Institute as part of the National Institutes of Health was explained on the Senate floor by Senator Lister

[4] P. 11, Senate Report 1454, 90th Cong., 2d sess. (July 24, 1968).

Hill, chairman of the Senate Committee on Labor and Public Welfare and of its Subcommittee on Health, as follows: [5]

"There are over 400,000 blind persons in the United States, and it is estimated that some 90 million Americans—nearly one-half of the entire population—suffer from some sort of eye disorder or impaired vision. More than 12 million schoolchildren require eye care; 3,500,000 people in this country have a permanent, noncorrectable, visual defect; and 1,500,000 are blind in one eye according to the legal definition of this condition. More than 32,000 Americans lose their vision each year, so that in the 20-year period from 1940 to 1960 the blind population in the United States increased by 67 percent while the general population increased by only 36 percent. Over one-half million Americans will become blind in the next 10 years if the present trend continues. The cost or blindness in addition to the human tragedy runs to more than $1 billion a year.

"An expanded program of research to determine the causes of blindness and to develop effective prevention and treatment techniques, is essential.

"In addition to research focused on the cause, cure, and prevention of eye diseases, the proposed National Eye Institute will also focus attention on the special health problems and other special requirements of the blind. For example, broad demographic studies designed to produce urgently needed comprehensive information about the health, age, distribution, economic, and social characteristics of blind persons, as well as public attitudes would be extremely useful in the development of governmental and nongovernmental service programs."

4. Mortgage Insurance for Nonprofit Hospitals—Public Law 90–448 (August 1, 1968)

Title XV of the Housing and Urban Development Act of 1968 establishes a new FHA program (sec. 252 of the National Housing Act) under which the Secretary of Housing and Urban Development will insure mortgages covering new or rehabilitated hospitals (including initial equipment). The mortgage may not exceed $25 million or 90 percent of replacement cost and the hospital must be owned and operated by one or more nonprofit organizations. (Recently completed hospitals not yet permanently financed are eligible subject to a limit of $20 million on the aggregate of such mortgages.)

5. Nursing Home Care for Veterans—Public Law 90–429 (July 26, 1968)

This new public law increases the reimbursement rate for veterans in community nursing homes from 33⅓ percent to 40 percent of the Veterans' Administration general hospital per diem rate. The following explanation of the need for this legislation was provided in the House committee report on the bill: [6]

"Section 620 of title 38, which was section 2 of Public Law 88–450, authorizes the Administrator of Veterans' Affairs to transfer any veteran patient in a Veterans' Administration hospital that has received maximum hospital benefits, and who requires protracted nursing home care, to a community nursing home at Government expense. The period of such care for which the Veterans' Administration may pay cannot generally exceed 6 months, and the cost of this nursing care may not exceed one-third of the cost in a Veterans' Administration general-medical hospital. This means that the present cost on a per diem basis may not exceed $12 at the present time. Costs have increased in this field since the enactment of Public Law 88–450 . . ."

ITEM 2: STATEMENT BY HON. WILBUR J. COHEN, SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, DECEMBER 31, 1968 ON MEDICARE PART B PROGRAM

Section 1839(b) of the Social Security Act requires me to promulgate during the month of December 1968 the premium rate that will apply to medicare's supplementary medical insurance plan during the period July 1, 1969, through June 30, 1970.

At the present time the premium rate is $8 a month—$4 paid by the beneficiary, and $4 by the Federal Government.

[5] P. S.10102, Congressional Record, vol. 114 (Aug. 2, 1968).
[6] P. 1 of H. Rept. 1378, 90th Cong., 2d sess. (May 14, 1968).

The original monthly rate provided in the 1965 law was $6 a month—$3 each. The $6 rate was increased to $8 under a promulgation made last December effective for the period April 1, 1968, to June 30, 1969.

Last year when the rate went up $1 each, about a third of the increase was needed to take account of the expected continuing rise in physicians' fees. And now this is again a crucial factor in determining the premium rate for the fiscal year 1970.

I have spent long hours over many days with my staff and a number of outside advisers discussing current medical prices and trends and what assumptions to make. No decision in recent weeks has troubled me more. As might be expected, I have received a wide variety of advice, and those who have advised me feel strongly about it. But the law requires the Secretary to make the determination and the promulgation. And the law limits the Secretary's discretion; it even says the premium rate for the individual must be a multiple of 10 cents.

The Chief Actuary of the Social Security Administration, Mr. Robert J. Myers, my friend and colleague of 34 years standing, advises me that he believes that physicians' fees will rise about 5 percent in calendar year 1969 over 1968 and 1½ percent in 1970 over 1969 and that medical utilization under the program will increase about 2 percent in 1969 and 1½ percent in 1970. If these increases are fully recognized as a liability of the medicare program, the result of these assumptions would be to require a premium increase to $8.80 ($4.40 each), allowing for a contingency margin of 10 cents. Indeed, Mr. Myers informs me he would feel much safer with a greater contingency margin by adopting a $9 monthly premium rate ($4.50 each). So would I.

The Commissioner of Social Security and the top staff of the Social Security Administration charged with the administration of the medicare program believe that a rate of less than $8.80 would be adequate for the period in question, in all probability, only if the carriers are directed to give quite limited recognition to any physician fee increases that do take place during the next 18 months. That is, they do not disagree with Mr. Myers assumptions as to the probable trend in physicians' fees and medical utilization under the program but point out that it would be possible nevertheless to limit somewhat the liability of the medicare program for making payments. I agree that we must find a way to limit the financial liability of the medicare program.

Before making a decision I consulted with the Director of the Bureau of the Budget, and asked some 50 physicians, nurses, economists, management, labor and consumer representatives to meet with me last Friday to give me their advice on this matter. Over a period of 5½ hours the advice I received ranged from $8 to $8.80 a month.

Before coming to a conclusion I carefully considered these points:

1. An increase of the monthly premium rate to the nearly 20 million aged from $4 to $4.40 would increase the cost to the aged beneficiaries by about $100 million during the fiscal year 1970. About 5.8 million of the aged social security beneficiaries have incomes below the poverty line and about 3 million more are in the near-poor group. About 15 of the 20 million aged have incomes so low they do not pay an income tax. Any increase in the premium rate without an increase in social security benefits will be a hardship for many senior citizens.

2. An increase in the monthly premium rate from $4 to $4.40 would result in an increase of about $100 million for the fiscal year 1970 from the Federal general revenue budget. This would not be such good news to Mr. Nixon, Mr. Finch, or their colleagues. I am reluctant to saddle them with such a burden so early in their administration.

3. States would have to pay the additional premiums for about 1 million aged public assistance beneficiaries for whom they "buy-in" for medicare's supplementary medical insurance, thus adding further costs to the Federal-State assistance programs. Many States have not planned for any substantial increase.

4. Any increased premium based on an assumption of as much as 4½-percent increase in physicians' fees is likely to act as a further inflationary factor. Any such estimate is likely to be viewed as a minimum prediction of increase—one which the Federal Government has approved. No one can say with any reasonable certainty what the effect of any proposed increase would be on other parts of the $50 billion medical care industry. Thus, any increase under medicare also may be reflected in an increase in medicaid costs and in the premiums that people have to pay for private insurance. Insofar as it is humanly possible within the process that the law imposes on me, I want to avoid further fanning the flames of inflation throughout our entire medical care system.

Mindful of the provisions of the law and my responsibilities to beneficiaries, physicians, and the public generally for a sound program in the months ahead, I must again repeat my request to the physicians of the country to show unusual restraint in setting their fees in the coming months. I believe this is in their own self-interest. Indeed, having studied very carefully the course of physicans' fees and other prices and wages during this decade, I do not see the need for any further increase in physicians' fees in the period immediately ahead.

Briefly, medicare was enacted in the face of a price history that showed a great deal of stability in the relationship between physicians' fees and the prices for other items and wages. In the 5 years preceding medicare enactment, the percentage changes annually of physicans' fees averaged 2.6 percent as compared with 2.8 percent for average hourly earnings of production workers and 1.2 percent for the cost of living.

In the period 1965–67 the average annual increase in physicians' fees was 7 percent. During this same period average hourly earnings have increased only 4.3 percent and cost of living only 2.8 percent. A very marked imbalance has developed between the rate at which physicians' fees have been escalating and the rates at which other indicators have been moving during these years. The American people are deeply concerned about this development.

Moreover, and even more significantly, total physician net incomes have increased even faster than the increase in fees for particular services. Based on data from *Medical Economics*, median physicians' incomes increased 11 percent in 1966 over 1965 and 8 percent in 1967 over 1966. Physicians have not been economically disadvantaged by medicare.

Utilization of physicians' services has increased, and this has resulted in the aged receiving more care than in the past. This is good but we must take special care now not to unwisely utilize a very scarce resource. The increased demand for physicians' services due to the flu epidemic has taxed available resources. We must always be prepared for unusual demands but always carefully husband our resources. I believe that with the cooperation of medical, labor, and consumer groups we could have a more efficient utilization of existing medical resources. I do not believe it is necessary for utilization to increase 2 percent in 1969 and 1½ percent more during 1970. I especially urge physicians, patients, families and friends to cooperate in eliminating unnecessary utilization of physicians' services and I am asking the carriers and intermediaries in their professional review of claims to exercise special diligence during this period. I will also recommend some legislative changes to the Congress to assist in this matter.

After extensive discussion with a number of carrier representatives of various interested parties, the Social Security Administration earlier this month issued guidelines to medicare carriers covering standards of performance in the processing of medicare claims. Generally these guidelines are designed to obtain a greater degree of uniformity in the development of the customary charges of individual physicians as well as the level of prevailing charges in the carriers' respective areas, and they are also designed to specify uniformly longer periods of time in which an individual fee must be charged before it can be deemed to be established as the customary fee, as well as specifying a minimum period between the time that a fee is established as a prevailing one in the locality and the time when a change in that fee can be recognized. The expected effect of the immediate implementation of these additional guidelines will be to slow down the rate at which carriers introduce new and higher prices into their reasonable charge "screens."

Premium Rate Promulgated for Period July 1969 Through June 1970

I believe that building on these actions and with additional administrative steps designed to limit program liability it should be possible to limit medicare recognition of physicians' fee increases. I believe further that utilization can and must be held in these two years to a level that makes it possible for me to promulgate a rate of $8.

I have directed the Commissioner of Social Security, Mr. Robert M. Ball, to give the necessary instructions to carriers in determining the "reasonable charges" to be paid physicians to make every effort to keep payments for services in line with an $8 a month income increase for the fiscal year 1970. This will take some hard doing but I believe it can be done. It is worth doing under the circumstances.

If the Social Security Administration is not successful in limiting the liability of the program as I assume it can, the Congress has at least 6 to 12 months to remedy the situation without any substantial adverse effect on the financing of

the SMI program. I am sure the Congress will want to review the operations of the program.

The interest earnings of the trust funds are available as a margin for contingencies and, if not needed to pay benefits and administrative expenses in the current period, they will reduce the unfunded liability for the past deficiency in the premium rate. Interest earnings are the equivalent of another 8 cents per capita in available income.

The program has sufficient reserves so that it can meet all benefit payments and administrative expenses now and in the period to which the promulgated premium rate applies even if it turns out that the rate is set too low to meet the costs arising during the premium period.

The way the supplementary medical insurance program is now designed it requires the collection of a fixed dollar premium every month from each enrollee to meet liabilities currently accruing as services are used. Hence it appears that future Secretaries of Health, Education, and Welfare will be faced each year with the need to increase premiums to the extent that fees and other factors affecting costs can be expected to go up. I do not believe this is desirable. Therefore, I believe the law should be amended.

I am recommending that the Congress consolidate the financing of part A and part B of the medicare program and finance the entire cost by a combined employer and employee payroll contribution and a Federal revenue contribution. This would eliminate the cost to the aged person after age 65 and place the cost on individuals during their working lives when they can better afford to pay it.

I have asked Commissioner Ball to submit to the chairmen of the House Committee on Ways and Means and the Senate Finance Committee current information on the finances of the SMI program as it becomes available so the committees can be fully informed of the operations under the program and take such action as may be necessary.

The following telegram has been sent today to national medical, business, labor and other leaders:

I have today promulgated the rate of $8 a month for the supplementary medical insurance program of medicare—$4 for the insured persons and $4 for the Federal Government for the period July 1, 1969 to June 30, 1970. I took this step in the face of actuarial advice that physicians' fees are likely to increase substantially next year and in 1970 over current levels. I concluded, however, that it is both feasible and desirable to limit the liability of the medicare program.

To stay within the new rate will require restraint on both fees and utilization by all parties concerned. I urge your wholehearted cooperation on this important matter.

WILBUR J. COHEN,
Secretary of Health, Education, and Welfare.

ITEM 3: ARTICLE FROM WALL STREET JOURNAL, NOVEMBER 17, 1968, GIVING INFORMATION ON SSA COST REDUCTION EXPERIMENTS

BID TO SLOW HEALTH-CARE COST RISES BEGUN WITH TESTS OF MEDICARE "PROFIT SHARING"

(By Jonathan Spivak)

WASHINGTON.—Federal "medicare" men are beginning a major effort to restrain increases in health-care costs that are plaguing Government health programs and millions of patients.

The administrators are undertaking novel profit-sharing partnerships with some of the hospitals and doctors that provide care for the aged. These experimental arrangements will offer financial incentives for economy and efficiency; the hospitals and doctors will be assured a share in any savings they make through greater productivity. But their earnings will fall if they let costs rise or make wasteful use of scarce and expensive medical facilities.

At the start, the medicare "incentive reimbursement" experiments, authorized last year by a cost-conscious Congress, will be undertaken on only a small scale and voluntary basis. The first tests, involving several hundred thousand of medicare's 19 million beneficiaries, will begin within the next few months in Connecticut

and New York City; the New York sponsors are Group Health Insurance Plan of Greater New York, Associated Hospital Service of New York, and the Greater New York Hospital Association.

The effort is fraught with both philosophical problems and practical pitfalls. But if the concept proves workable, administrators hope to extend the profit-and-loss principle throughout the entire medicare program, which spends more than $5 billion a year on health care, and ultimately to dozens of other Government and non-Government medical endeavors. The benefits could be far reaching: Further increases in medicare taxes might be avoided, and the rising costs of Federal-State "medicaid" welfare programs and of private health insurance plans might be restrained.

ANNUAL COST TARGETS

Although differing in detail, the incentive plans all establish, in advance, annual cost targets to be met by hospitals and doctors. If actual costs turn out less than the target, the savings will be shared—perhaps 50–50—by the Government with the providers of service. If expenses exceed estimates, medicare payments to hospitals and doctors will be reduced. In contrast, current payments are based on a review of actual audited hospital costs and on prevailing physicians' fees.

In one rather typical approach, the Connecticut Hospital Association will establish target budgets for routine services, such as food, laundry, and pharmacy, performed in its member institutions. These functions, considered most amenable to direct control, constitute 59 percent of total hospital costs. The targets will be set by boards composed of hospital officials and other professionals, but consumer representatives will help oversee the results. If costs exceed the targets, the penalty will be loss of medicare's 2 percent extra payments designed to cover unexpected contingencies above regular costs of caring for aged patients.

"The whole theory is if you want to profit, you've got to be willing to suffer the cost," declares Arthur E. Hess, deputy commissioner of the Social Security Administration, which oversees the health insurance for the aged program.

The Nixon administration is likely to encourage such cost-cutting initiatives. During the campaign the Republican candidate declared: "More effort is needed to reduce dependence on costly hospitalization through better use of expensive facilities and increased use of outpatient care. Also needed is a reexamination of reimbursement formulas and experimentation with financial incentives to assure that the program encourages efficiency at all levels."

Since the enactment of medicare in mid-1966, medical costs have been rising more than twice as rapidly as in previous years. During the year ended July 1, 1968, hospital costs increased 15.4 percent and physician fees climbed 6.1 percent, compared with a rise of only 3.3 percent in the Consumer Price Index.

Higher wages for hospital workers, more expensive medical procedures, and growing demand for medical care are largely to blame. But many experts believe medicare's generous payment arrangements also have played a part. Hospitals receive their full costs for care of aged patients, plus the 2 percent to cover contingencies. Physicians are paid their customary fees as long as these don't strikingly exceed those of associates, and are free to raise charges repeatedly. "It's a blank-check approach; it hasn't worked in any other enterprise," bitterly complains a top Blue Cross official. (Hospital administrators, however, insist that under medicare they only recover their costs of caring for the aged. and say the basic problem is the rising expense of delivering high-quality medical care.)

During the first year of the 3-year profit-sharing experiments, the Social Security Administration will be more than generous with its partners, offering them a relatively fat slice of the savings. The reason: The Government can't force hospitals and doctors to participate in incentive plans and the inducements must be strong to encourage them to abandon medicare's assured income. "There's a certain amount of gamble," declares Herbert E. Anderson, executive vice president of the Connecticut Hospital Association.

But later on, the Social Security Administration will take a bigger share of any savings. "It stands to reason in any public program you can't have uncontrolled gains," asserts Thomas Tierney, the agency's medicare chieftain.

Whatever the details, it's hoped the experiments will speed the adoption of moneysaving innovations in health care. Among them:

Automation of certain medical tests to reduce labor costs.

Better scheduling of patients to avoid prolonged hospital stays before surgery and prompter transfer after surgery to less expensive nursing homes.

Sharing of expensive equipment, such as radiation units, by hospitals and other cooperative arrangements to avoid duplication of services.

Application of industrial engineering techniques to hospitals' housekeeping functions, particularly building maintenance, food service and laundry.

More use of technicians and other less highly trained personnel, under professional direction, to perform certain medical duties currently discharged by doctors.

Stricter case-by-case review to prevent unnecessary medical treatment and hospitalization.

DON'T OFFER QUICK CURES

Even the most enthusiastic advocates of incentives, however, don't believe the experiments offer quick cures to the Nation's medical-cost maladies. "We expect the aggregate cost in the community to continue to go up," declares Sam Shapiro, director of research for New York's Group Health Insurance Plan, "but our rate of increase would be substantially slowed." Says Rudolf J. Pendall, executive director of the Hospital Council of Maryland: "The basic question is how much can you squeeze out of hospital costs; I don't think there is that much."

The biggest obstacle to large-scale introduction of incentives is the reluctance of hospitals and doctors. Many see no reason to abandon existing medicare payment arrangements. Among physicians, only group practitioners, a small segment of the profession, are eager to sponsor experiments. The mechanics of medicare profit-sharing remain murky and many uncertainties must be resolved: Can quality of service be preserved when cost is a criterion? Can the Social Security Administration distinguish the economies resulting from incentive arrangements and those that would have been introduced anyway? Should successful incentives be imposed on all health-care providers or be left voluntary?

Whatever the problems, the agency will vigorously promote the experiments because they seem the most acceptable means of limiting medicare outlays and enforcing a rudimentary form of cost control. Without new approaches, social security experts worry that medicare's massive expenditures will simply perpetuate current methods of delivering medical care.

Appendix 6

MATERIAL RELATED TO CONSUMERS*

ITEM 1: MAJOR CONSUMER LEGISLATION IN 1968

A. Legislation Enacted

1. *Truth-in-Lending Act, Public Law 90-321 (May 29, 1968).*—Designed to help consumers make informed decisions when they obtain credit. Requires the disclosure to consumers of useful information about credit, and restricts garnisheeing of wages and loan-shark activities.

2. *Interstate land sales, title XIV, Housing and Urban Development Act of 1968, Public Law 90-448 (August 1, 1968).*—Implemented recommendations of Special Committee on Aging's Subcommittee on Frauds and Misrepresentations Affecting the Elderly (now known as Subcommittee on Consumer Interests of the Elderly).[1] Requires that persons selling subdivided undeveloped land in interstate commerce or through the mails file a statement with the Department of Housing and Urban Development giving certain required information. Information required includes the title of the land, its physical nature, and the availability of roads and utilities. Requires that prospective purchasers be furnished with a property report based on the statement and approved by Department of HUD. Exempts subdivisions of fewer than 50 lots or with lots of more than 5 acres each. Authorizes Secretary of HUD to sue for injunctions against violations. As enforcement measures, provided criminal penalties and civil liabilities.

3. *Wholesale Poultry Products Act, Public Law 90-492 (August 18, 1968).*—Extends Federal poultry inspection standards to poultry sold within a State. Authorizes the Secretary of Agriculture to cooperate with State agencies to set up inspection programs for poultry shipped intrastate, with standards equal to or higher than Federal standards for inspection of poultry shipped interstate. Extends Federal inspection to poultry production in States which do not establish a Federal level program.

4. *Radiation Control for Health and Safety Act of 1968, Public Law 90-602 (October 18, 1968).*—Authorizes the Secretary of Health, Education, and Welfare to prescribe performance standards for electronic products to limit radiation emission, requires manufacturers to certify that their products conform to these standards, prohibits importation of nonconforming products, and requires manufacturers to repair or replace defective products or to refund the customer's money. Besides TV sets, the bill covers such equipment as lasers, microwave ovens and other electronic products.

5. *Automobile insurance study: Public Law 90-313 (May 22, 1968).*—Directs the Secretary of Transportation, in cooperation with other Federal agencies, to conduct a comprehensive 24-month study and investigation of the automobile accident compensation system.

6. *Food stamp program.*—On October 8, 1968, Public Law 90-552 was enacted to extend and increase authorizations for the Federal food stamp program which was authorized during 1964. Legislation of this type was requested by a letter of February 28, 1968, from Secretary of Agriculture Orville L. Freeman.

B. Legislation Considered but Not Enacted

1. *Deceptive sales:* S. 3065 (Magnuson) would have authorized temporary injunctions or restraining orders by the Federal Trade Commission against advertising, acts, or practices which are unfair or deceptive to the consumer. It was

*See ch. III for discussion of matters related to this appendix.

[1] Pp. 45, 46, Frauds and Deceptions Affecting the Elderly, Report to the Special Committee on Aging, 89th Cong., first sess. (Jan. 31, 1965).

reported by the Senate Commerce Committee on June 21, and passed the Senate on July 11, after adoption of a floor amendment deleting authority for the FTC to seek temporary restraining orders in such cases. However, it was not reported from committee in the House, and it expired with adjournment.

2. *Home improvement frauds:* Senate Joint Resolution 130 (Magnuson) proposed to direct the Federal Trade Commission to conduct a 1-year investigation into alleged unfair practices in the home improvement industry, and directed the FTC, over a 3-year period, to intensify and expand its enforcement of FTC regulations aimed at preventing frauds by the home improvement industry. It was reported by the Senate Commerce Committee on June 21 and passed the Senate on July 11. However, it was not reported from committee in the House, and it expired with adjournment.

3. *Mutual funds:* S. 3724 (Sparkman) would have provided increased regulation of the Nation's mutual fund industry. It would have limited sales commissions to "reasonable" levels, placed a 5-percent ceiling on the charges to investors who purchase mutual fund shares, and limited and restricted "front-end loads". The bill was reported from the Senate Banking and Currency Committee on July 1 and passed the Senate July 26. However, it was not reported from committee in the House, and it expired with adjournment.

4. *Door-to-door sales:* S. 1599 would have allowed customers of door-to-door salesmen 24 hours in which to reconsider and cancel their purchases over $25. It was reported by the Senate Commerce Committee on July 17, 1968, but no further action was taken.

5. *Wholesome fish:* S. 2958 (Magnuson and Hart) and H.R. 15155 (Staggers) would have authorized Federal-State cooperative programs to improve inspection of fish and to take other steps toward assuring wholesome fish for consumers. Committees in both the Senate and House held hearings, but no further action was taken.

C. Investigations

1. *Gas station games:* Investigation was conducted by the Subcommittee on Activities of Regulatory Agencies Relating to Small Business, the House Select Committee on Small Business. Hearings were held on June 20 and July 11.

2. *Automobile insurance:* Investigation was conducted by the Subcommittee on Antitrust and Monopoly, the Senate Judiciary Committee. Hearings were held on June 25, 26, and 28 and on July 9, 19, and 22.

ITEM 2: INTRODUCTION TO RETIRED COUPLE'S BUDGET FOR A MODERATE SECURITY STANDARD, AUTUMN 1966

(Bulletin No. 1570–4, B.L.S., 1968)

The retired couple's budget described in this bulletin is a companion to the budget for a younger, four-person family published in the "City Worker's Family Budget for a Moderate Living Standard, Autumn 1966." Bulletin No. 1570–1.

All benchmark estimates of living costs are based on specific family situations. The cost estimates of the retired couple's budget are for an urban family of two persons—a husband age 65 or over and his wife—who are presumed to be self-supporting and living independently. The budget also specifies that both husband and wife are in reasonably good health for their age and able to take care of themselves, and that each is covered by hospital and medical insurance under the Federal medicare program. Two thirds of these families are homeowners, living in houses which are mortgage free. The couple has average inventories of clothing, housefurnishings, major durables, and other equipment. Even at a comparable standard of living, benchmark cost estimates for younger and larger families will be higher, and estimates for single persons will be lower, than those for the retired couple. In other words, there is no single answer to the question, "How much does it cost to live?" Family size, age, and type have a significant effect on spending patterns, manner of living, and family needs.

The other major consideration—in addition to family composition—in developing family budgets is the living standard for which cost estimates are made. "Standards of living" refer to the goals we set for ourselves as consumers of goods and services and as users of leisure time. The living standard represented by the current retired couple's budget is described as moderate. It provides for the maintenance of health and social well-being, and participation in community

activities. This generalized concept of a moderate standard has been translated into a list of commodities and services which can be priced. (See app. A.)* Examination of the lists provides the clearest insight into what the moderate standard comprises.

The content of the new budget for a moderate standard is based on the manner of living and consumer choices in the decade of the 1960's. The list of goods and services included was derived in several ways. Nutritional and health standards, as determined by scientists and technicians, were used for the food-at-home and the shelter components. The selection among the various kinds of food and housing arrangements meeting the standards was based on actual choices made by families as revealed by surveys of consumer expenditures. The medicare program shaped part of the standard for medical care. Where scientific standards have not been formulated or legislation enacted, analyses of the data reported in the Bureau's survey of consumer expenditures in 1960–61 and related consumption studies were used to determine the specific items, and the quantities and qualities thereof, to be included in the budget. These analytical procedures result in basing some parts of the budget upon inferences about the collective judgment of consumers as to the kinds and amounts of consumption required, rather than upon scientific standards. In such analyses, some exercise of the budgetmaker's own judgment is involved; however, in this budget, such judgment has been confined to selection of the basic data and determination of the procedures to be followed in deriving the items and quantities making up these parts of the budget. The specific decisions that were made with respect to each component of the new retired couple's budget are documented in this bulletin.

The moderate living standard does not show how an "average" retired couple actually spends its money, nor does it show how a couple should spend its money. Individual families may spend more on one item and less on others than the amounts indicated in the budget. Furthermore, some families can and do spend less than the total amount specified in this budget without feeling deprived and without impairing their health or their ability to contribute constructively to our society. In general, however, the representative list of goods and services comprising the standard reflects the collective judgment of families as to what is necessary and desirable to meet the conventional and social as well as the physical needs of families of the budget type in the present decade.

The new retired couple's budget is the third study for this family type which translates a generalized concept of a moderate standard of living into a list of commodities and services that can be priced. The original budget for an elderly couple, developed by the Social Security Administration to parallel the original city worker's family budget prepared by BLS, was priced in 13 large cities in 1946, 1947, and 1949. The quantities and qualities of goods and services included in that budget were based on the manner of living and standards prevailing in the early 1940's. The budget was repriced by BLS in 34 large cities in October 1950, but it was discontinued after that date because it was outmoded.

In 1960, the Bureau issued the interim budget for a retired couple. It was based on a new list of goods and services representing modest but adequate living in accordance with standards prevailing in the 1950's. Because the basic data used in the analysis related to the early 1950's, and because of the limited scope of this revision, it was considered interim, pending a more complete review of the procedures and the availability of data from the Bureau's survey of consumer expenditures in 1960–61. The interim budget was priced only once, in autumn 1959, in 20 large cities.

Both of the earlier budgets were for a family of the same size, age, and type as that in the new budget. Similarly, the living standard in all three studies provides for the maintenance of health and social well-being, and participation in community activities. For the most part, the procedures used to translate this generalized concept of the living standard into a list of goods and services were also the same, but the kinds and quantities of items comprising the standard differ, because the budgets reflect the conditions of living in three different decades. Changes in educational levels, cultural developments growing out of travel and migration, and growth in purchasing power affect the level of living of American families and their ideas about what constitutes a moderate living standard.

Technological advances also influence the composition of the standard. New types of consumer goods and services are developed, mass production increases their availability, and mass communication and advertising media stimulate the demand for them. As real incomes rise, certain aspects of living, once considered

*Retained in committee files.

attainable only by a few, come within the reach of many and are accepted as part of the American way of life. For senior citizens in particular, a rising level of social concern for their welfare and the adequacy of their income and resources has been an additional factor in changing their own expectations and attitudes toward retirement. In a dynamic society, therefore, the relative position of a moderate living standard on a scale of all living standards may remain fixed, but the description of what constitutes that standard will be ever changing.

The present study differs from the earlier budgets in two major respects. These differences affect the level of the 1966 costs and comparative living cost indexes, particularly in relation to the costs and indexes of the 1959 interim budget.

1. For the first time, the budget has been priced in a sample of medium-sized and small cities. Thus, it is possible to estimate the average U.S. urban budget cost and to compare metropolitan and nonmetropolitan area costs. (See app. B.)*

2. Costs of maintaining an owned home (mortgage free) have been included in the moderate standard. Shelter costs in the earlier budgets were limited to rental housing. Use of rental housing only was appropriate for large cities in terms of the 1940 modest standard of the original budget, but it was recognized as a limitation in the 1959 interim budget in terms of the standard of the 1950's. The addition of homeowner costs provide, for the first time, comparative budget costs for renter and owner families and intercity indexes of homeowner maintenance costs for equivalent housing.

The effects of these and other changes on the moderate standard are discussed in detail in this bulletin.

A list of the Bureau's previous budgets and related references is provided in appendix C*, including the Report of the Advisory Committee on Standard Budget Research, June 1963. The report summarizes the recommendations of a special committee of experts, representing users of standard budgets in State and local welfare administration, academic research, labor unions, and business organizations. The committee advised the Bureau on the direction that its research on standard budgets should take, and its recommendations formed guidelines for the Bureau in the development of the current budget.

The following bulletins in the current series report results of other phases of the standard budget research program:

Bulletin 1570–1 gives the autumn 1966 costs of the city worker's family budget for a moderate standard of living.

Bulletin 1570–2 will describe the revised equivalence scale for estimating budget costs for families of different size, age, and type.

Bulletin 1570–3 will report the autumn 1966 budget pricing procedures, specifications, and average prices.

Subsequently, there will be bulletins on the spring 1967 costs for the moderate standard, and for a lower and a higher standard for the four-person family and for the retired couple. The lower standard budget will represent a minimum of adequacy. Substantial downward adjustments will be made in the content and/or manner of living of the moderate standard, where this is possible without compromising the family's physical health or self-respect as members of their community.

In contrast with the moderate budgets, the lower standard budgets will not conform in certain respects to prevailing customs and buying practices—that is, to the collective judgments of families of these types concerning what is necessary for a satisfactory standard of living. The lower standard budgets are expected to be more appropriate than the moderate budgets for use in establishing goals for public assistance and income maintenance programs in the current decade.

The higher standard budget, while not connoting real affluence, will represent a more comfortable level and manner of living than the moderate standard, and a concept of economic success to which numerous American families aspire. The higher standard will be useful in measuring the ability of self-supporting families to pay for social and health services in unusual circumstances, and in general economic analysis.

In the future, estimates of the annual cost of the three standard budgets for the four-person family and for the retired couple will be made as of the spring of the year and published periodically for the same metropolitan areas and regional classes of nonmetropolitan areas as those included in the present study. The budget quantities and weights will remain fixed, however, for longer periods of time. While living standards are constantly changing, and over time the accumulated change may be dramatic, year-to-year variations are often difficult to identify and the basic data to measure such differences as do occur are not available.

*Retained in committee files.

This bulletin was prepared by Jean C. Brackett under the supervision of Helen H. Lamale, Chief of the Division of Living Conditions Studies, and the general direction of Arnold E. Chase, Assistant Commissioner. Elizabeth Ruiz supervised the research for all budget components except food and medical care, for which Mary H. Hawes was responsible. Other staff members whose work contributed substantially to the project were Miriam A. Solomon, Roseann C. Cogan, Alice B. Curry, and M. Louise McCraw.

ITEM 3: RETIRED COUPLE'S BUDGET FOR A MODERATE STANDARD OF LIVING, AUTUMN 1966

(News release issued by Department of Labor, June 2, 1968)

A moderate standard of living for a self-supporting, retired couple in U.S. urban areas in the autumn 1966 required an annual expenditure of $3,869, or about $200 less than estimated income.

That's a major finding of a study—"Retired Couple's Budget for a Moderate Standard of Living, Autumn 1966"—released today by the Labor Department's Bureau of Labor Statistics.

The couple was defined in the Bureau of Labor Statistics study as a husband, age 65 or over, and his wife, self-supporting, living independently, enjoying fairly good health, receiving hospital and medical care protection under medicare, and occupying a mortgage-free home.

The couple also possessed an average inventory of clothing, housefurnishings, major durables, and other equipment.

Costs of living, the survey found, averaged $4,006 in metropolitan areas, and $3,460 in small cities. These figures represent a range from $4,434 in Honolulu to $3,246 in smaller cities in the South.

Since the retired couple's budget was priced in late 1966, however, the "all items" Consumer Price Index has increased 4.7 percent, indicating that increasing prices probably added about $180 to the 1966 cost of the budget.

Shelter costs for a couple maintaining a five- or six-room, mortgage-free house came to a U.S. urban average of $771 for insurance, taxes, repair and replacement expenses, fuel and utilities. Comparable rental housing costs averaged $950.

Annual U.S. urban food costs averaged $1,072, with the New York and Hartford metropolitan areas averaging about $1,200, and Durham, N.C. and Nashville, Tenn. about $980.

Food-at-home costs were roughly $100 higher in Northeastern cities than in the North Central and Western cities. Costs in the latter two regions ran about $45 above the costs in the Southern cities.

The medical care budget, $284 for urban United States, $288 for metropolitan areas, and $274 for nonmetropolitan areas, included the couple's out-of-pocket expenses for hospital and medical care covered by medicare, the premium cost for medical insurance, and the costs of other medical services and supplies not covered by medicare.

Out-of-pocket costs under medicare comprised 52 percent of the total medical care component at the urban U.S. level. The largest part of these costs was the same in all cities: $72 premium cost for medical insurance, plus an estimated average charge of about $18 per couple for hospital services.

Clothing and personal care costs averaged $346. These costs were lowest in the South as a result of variations in the kinds and quantities of clothing required by climate as well as price differentials. However, within the Southern region costs ranged from a high of $358 in Washington, D.C., to a low of $299 in Austin, Tex.

Availability of public transportation affected the proportion of retired couples owning automobiles. Thus, in the New York metropolitan area, 25 percent of the couples were assumed to own automobiles; in Boston, Chicago, and Philadelphia, 40 percent; in all other metropolitan areas, 60 percent; and in small cities, 68 percent.

Transportation costs for auto owners and those who rely on public transportation were highest in Honolulu and San Francisco, and lowest in the New York area. For auto owners alone, however, costs were as high in New York as in San Francisco.

The list of goods and services making up the retired couple's budget is based on criteria of adequacy translated into pricing lists that reflect the buying practices of retired couples.

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Where such criteria have not been developed, the budget reflects the collective judgment of retired couples as to what is necessary for a healthful, self-supporting mode of living that allows normal participation in the life of the community in accordance with current American standards.

The budget figure is above the subsistence level, or what would be necessary to carry families through a limited period of stringency. On the other hand, it is not a luxury budget, and does not represent an "ideal" way of living.

The new "Retired Couple's Budget" is the third study for this family type. The original "Budget for an Elderly Couple" was developed by the Social Security Administration and was priced in 13 large cities in 1946, 1947, and 1949. In autumn 1950 it was priced in 34 cities. The second budget, "The Interim Budget for a Retired Couple," was priced in autumn 1959 in 20 cities. None of these budgets was intended to show how a couple spends or should spend its money.

The present study differs from the earlier budgets in two major aspects.

First, the budget has been priced in a sample of medium-sized and small cities for the first time. Thus, it is possible to estimate U.S. urban budget costs, and to compare metropolitan and nonmetropolitan costs.

Second, costs of maintaining an owned, mortgage-free home have been included in the budget, also for the first time. Shelter costs in the earlier budgets were limited to rental housing. The addition of homeowner costs provides comparative budget costs for renter and owner couples and intercity indexes of homeowner maintenance costs for equivalent housing.

In the 18 cities priced in all three studies, the total cost for a renter couple averaged $1,790 in 1950, $3,061 in 1959, and $4,126 in 1966. Compared with 1950, the new standard reflects approximately a 60-percent rise in prices, plus a 70-percent increase resulting from an upgrading of the content of the moderate standard.

As real incomes rise, certain aspects of living, once considered attainable only by a few, come within the reach of many and are accepted as part of the American way of life. Hence, among other changes, the new standard provides for more varied diets at home and more meals away from home, increased ownership and use of automobiles, more comprehensive medical care, and a higher level of personal and home services.

Detailed budget cost estimates for urban United States, 39 metropolitan areas, and nonmetropolitan areas in four regions are available in Bulletin No. 1570–4, Retired Couple's Budget for a Moderate Living Standard, Autumn 1966. The 44-page bulletin may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, or regional offices of the Bureau of Labor Statistics. Price, 35 cents. (Charts on the "Retired Couple's Budget" appear in ch. III, p. 36–37.)

Appendix 7

MATERIAL RELATED TO OLDER WORKERS*

ITEM 1: DEPARTMENT OF LABOR LEAFLET ON AGE DISCRIMINATION ACT [1]

THE AGE DISCRIMINATION IN EMPLOYMENT ACT OF 1967

(Public Law 90–202, 81 Statute 602, effective June 12, 1968)

The Age Discrimination in Employment Act of 1967 promotes the employment of the older worker based on ability rather than age; prohibits arbitrary age discrimination in employment; and helps employers and employees find ways to meet problems arising from the impact of age on employment.

The Secretary of Labor is responsible for administering and enforcing the act. In addition, the Secretary will provide a program of education and information concerning the needs and abilities of older workers and their potential for continued employment and contribution to the economy. This program will include the publication of the results of studies and encourage the expansion of opportunities and advancement of older persons through public and private agencies. The Secretary will sponsor and assist State and community information and education efforts.

THE LAW

Protects individuals 40 to 65 years old from age discrimination by—

Employers [2] of 25 or more persons in an industry affecting interstate commerce.[3]

Employment agencies serving such employers.

Labor organizations with 25 or more members in an industry affecting interstate commerce.[4]

IT IS AGAINST THE LAW

For an employer—

To fail or refuse to hire, or to discharge, or otherwise discriminate against any individual as to compensation, terms, conditions, or privileges of employment, because of age;

To limit, segregate, or classify his employees so as to deprive any individual of employment opportunities, or adversely affect his status as an employee, because of age;

To reduce the wage rate of any employee in order to comply with the act.

For an employment agency—

To fail or refuse to refer for employment, or otherwise discriminate against, any individual because of age, or to classify or refer anyone for employment on the basis of age.

For a labor organization—

To discriminate against anyone because of age by excluding or expelling any individual from membership, or by limiting, segregating, or classifying its membership on the basis of age, or by other means;

To fail or refuse to refer anyone for employment so as to result in a deprivation or limitation of employment opportunities or otherwise adversely affect the individual's status as an employee because of age;

To cause or attempt to cause an employer to discriminate against any individual because of age.

*See ch. VI for discussion of matters related to this appendix.

[1] WHPC Publication 1230 (February 1968).

[2] The term "employer" does not include the United States, a corporation wholly owned by the Government of the United States, or a State or a political subdivision thereof.

[3] 50 or more prior to June 30, 1968.

[4] 50 or more prior to July 1, 1968.

For employers, employment agencies, or labor organizations—

To discriminate against a person for opposing a practice made unlawful by the act, or for making a charge, assisting, or participating in any investigation, proceeding, or litigation under it;

To use printed or published notices or advertisements indicating any preference, limitation, specification, or discrimination, based on age.

EXCEPTIONS

The prohibitions against discrimination because of age do not apply:

Where age is a bona fide occupational qualification reasonably necessary to the normal operations of the particular business;

Where the differentiation is based on reasonable factors other than age;

Where the differentiation is caused by observing the terms of a bona fide seniority system or any bona fide employee benefit plan. This applies to new and existing employee benefit plans, and to the establishment and maintenance of such plans. However, no employee benefit plan shall excuse the failure to hire any individual.

Where the discharge or discipline of an individual is for good cause.

Recordkeeping and posting requirements

Employers, employment agencies, and labor organizations must post an officially approved notice in a prominent place where employees may see it, and maintain the records required by the Secretary of Labor.

Enforcement

The act is enforced by the Secretary of Labor, who can make investigations, issue rules and regulations for administration of the law, and enforce its provisions by legal proceedings when voluntary compliance cannot be obtained.

Prohibited acts under the age discrimination law are to be deemed prohibited also by the Fair Labor Standards Act. Amounts owing to any person as a result of a violation are to be treated as unpaid compensation under the provisions of the Fair Labor Standards Act which authorize enforcement through civil actions in the courts.

The Secretary or any aggrieved person may bring suit under the act. Suits to enforce the act must be brought within 2 years after the violation, or in the case of a willful violation, within 3 years.

Before the Secretary begins court action, the act requires him to attempt to secure voluntary compliance by informal conciliation, conference, and persuasion. Before an individual brings court action, he must give the Secretary not less than 60 days' notice of his intention.

This notice must be filed within 180 days of the occurrence of the alleged unlawful practice except, when a State has taken action in accordance with its own laws prohibiting age discrimination, then an individual must file within 300 days of the alleged violation. The law provides that after receiving such a notice, the Secretary will notify the prospective defendants and try to eliminate any alleged unlawful practice by informal conciliation, conference, and persuasion.

Following are methods to recover amounts owed which result from violations of this act:

1. The Secretary is authorized to supervise the payment of amounts owed;

2. In certain circumstances, the Secretary may bring suit upon written request of the individual;

3. An individual may sue for payment, plus attorney's fees and court costs. In the case of willful violations, an additional amount up to the total of the amount owed, may be claimed as liquidated damges. (An employee may not bring suit if he has been paid the amount owed under the supervision of the Secretary, or if the Secretary has filed suit to enjoin the employer from retaining the amount due the employee.)

4. The Secretary may obtain a court injunction to restrain any person from violating the law, including the unlawful withholding of proper compensation.

The courts, in enforcement actions, are authorized to grant any relief appropriate to carry out the act's purposes, including among other things, judgments compelling employment, reinstatement, or promotion.

Interference with representatives of the Secretary of Labor engaged in duties under the act may be prosecuted criminally and the violator subjected to a fine of not more than $500 or imprisonment, or both.

Additional information

Inquiries about the Age Discrimination in Employment Act of 1967 will be answered by mail, telephone, or personal interview at any office of the Wage and Hour and Public Contracts Divisions of the U.S. Department of Labor. Offices are listed in the telephone directory under the U.S. Department of Labor in the U.S. Government listing. These offices also supply publications free of charge.

Offices listed in italics are staffed by investigation personnel whose duties frequently require them to be away from the office. Telephone messages and requests for information may be left at these offices when regular personnel are not on duty. Personal appointments may be arranged by either telephone or mail.

Alabama: Andalusia, Anniston, Birmingham, Dothan, Florence, Gadsden, Huntsville, Mobile, Montgomery, Opelika, Selma, Tuscaloosa.
Alaska: Anchorage.
Arizona: Phoenix, Tucson.
Arkansas: El Dorado, Fayetteville, Fort Smith, Hope, Jonesboro, Little Rock, Pine Bluff.
California: Bakersfield, Fresno, Hollywood, Long Beach, Los Angeles, Modesto, Monterey, Oakland, Redding, Riverside, Sacramento, San Diego, San Francisco, San Jose, San Mateo, Santa Ana, Santa Rosa, Stockton, West Covina, Whittier.
Colorado: Denver, Pueblo.
Connecticut: Bridgeport, Hartford, New Haven, New London.
Delaware: Wilmington.
District of Columbia: College Park. Md.
Florida: Clearwater, Cocoa, Fort Lauderdale, Fort Myers, Jacksonville, Lakeland, Leesburg, Miami, North Miami, Orlando, Pensacola, St. Peterburg, Tampa, West Palm Beach.
Georgia: Albany, Athens, Atlanta, Augusta, Columbus, Gainesville, Hapeville, Macon, Rome, Savannah, Thomasville, Valdosta.
Hawaii: Honolulu.
Idaho: Boise.
Illinois: Chicago, Springfield.
Indiana: Evansville, Indianapolis, South Bend.
Iowa: Burlington, Cedar Rapids, Davenport, Des Moines, Fort Dodge, Mason City, Sioux City, Waterloo.
Kansas: Pittsburg, Salina, Topeka, Wichita.
Kentucky: Ashland, Lexington, Louisville, Middlesboro, Pikeville.
Louisiana: Alexandria, Baton Rouge, Hammond, Houma, Lafayette, Lake Charles, Monroe, New Orleans, Shreveport.
Maine: Portland.
Maryland: Baltimore, College Park, Hagerstown, Salisbury.
Massachusetts: Boston, Lowell, Springfield, Worcester.
Michigan: Detroit, Grand Rapids, Lansing.
Minnesota: Minneapolis.
Mississippi: Biloxi, Columbus, Clarksdale, Greenwood, Hattiesburg, Jackson, Tupelo.
Missouri: Cape Girardeau, Columbia, Joplin, Kansas City, St. Joseph, St. Louis, Springfield.
Montana: Great Falls.
Nebraska: Grand Island, Lincoln, Omaha.
Nevada: Reno.
New Hampshire: Manchester, Laconia.
New Jersey: Camden, Newark, Paterson, Trenton.
New Mexico: Albuquerque, Las Cruces, Roswell.
New York: Albany, Bronx, Brooklyn, Buffalo, Hempstead, New York, Rochester, Syracuse.
North Carolina: Asheville, Charlotte, Durham, Fayetteville, Goldsboro, Greensboro, Hickory, High Point, Raleigh, Wilmington, Winston-Salem.
North Dakota: Bismarck.
Ohio: Cincinnati, Cleveland, Columbus.
Oklahoma: Ardmore, Enid, Lawton, Muskogee, Oklahoma City, Tulsa.
Oregon: Eugene, Medford, Portland, Selma.
Pennsylvania: Allentown, Altoona, Chester, Du Bois, Erie, Greensburg, Harrisburg, Indiana, Johnstown, Lancaster, Lewistown, McKeesport, New Castle, Philadelphia, Pittsburgh, Reading, Scranton, Uniontown, Washington, Wilkes-Barre.

Rhode Island: Providence.
South Carolina: Charleston, Columbia, Florence, Greenville, Spartanburg.
South Dakota: Aberdeen, Rapid City, Sioux Falls.
Tennessee: Bristol, Chattanooga, Columbia, Jackson, Johnson City, Knoxville, Memphis, Nashville.
Texas: Abilene, Amarillo, Austin, Beaumont, Corpus Christi, Dallas, El Paso, Fort Worth, Galveston, Harlingen, Houston, Laredo, Longview, Lubbock, Lufkin, Midland, Odessa, Paris, San Antonio, Texarkana, Tyler, Victoria, Waco, Wichita Falls.
Utah: Ogden, Salt Lake City.
Vermont: Burlington, Montpelier.
Virginia: Alexandria, Norfolk, Richmond, Roanoke, Waynesboro.
Washington: Seattle, Spokane, Tacoma.
West Virginia: Bluefield, Charleston, Clarksburg, Huntington, Logan.
Wisconsin: Madison, Milwaukee, Oshkosh.
Wyoming: Casper, Cheyenne.
Puerto Rico: Arecibo, Caguanas, Hato Rey, Mayaguez, Ponce, Santurce.
Canal Zone, Virgin Islands: Santurce, Puerto Rico.
American Samoa, Eniwetok Atoll, Guam, Johnston Island, Kwajalein Atoll, Wake Island: Honolulu, Hawaii.

ITEM 2: SECTION-BY-SECTION ANALYSIS OF S. 4180 AND H.R. 20429*

(Middle-Aged and Older Workers Full Employment Act of 1969)

Section 101.—Statement of findings upon which bill is based.
Section 102.—Statement of purpose of the bill.

TITLE II

Section 201.—Would establish in the Department of Labor a bureau to be know as the Midcareer Development Service, to administer title II of the proposed act.

Section 202.—The Secretary of Labor, through the Midcareer Development Service, would be authorized to make loans and grants (and to guarantee loans) for training designed to upgrade the work skills and capabilities of middle-aged persons who are at least 45 years of age. The assistance provided would be available not only for paying all or part of the cost of training, but also for allowances for subsistence and other expenses.

Section 203.—The Secretary of Labor, with the cooperation of the Secretary of Health, Education, and Welfare, would be authorized to develop and operate a program of training an adequate number of persons to become qualified to train and retrain older workers in skills needed in the economy.

Section 204.—The Secretary of Labor would be authorized to recruit and train personnel for a special unit to be made available, upon request, to a locality in which a substantial number of persons is unemployed as a result of the closing of a plant or factory or a permanent large-scale reduction in force, to provide such persons with recruitment, placement, and counseling services.

Section 205.—The Secretary of Labor would be directed to establish and operate counseling services with respect to employment and training opportunities for persons who are at least 45 years of age who are unemployed and seeking work.

Section 206.—The Secretary of Labor would be authorized to recruit and train retired personnel directors to serve in programs to increase employment opportunities for persons who are at least 45 years of age.

Section 207.—The Secretary of Labor would be authorized and directed to conduct a thorough study of programs authorized by the Manpower Development and Training Act of 1962 and other similar federally assisted training programs to determine whether such programs are responsive to the needs of persons who are at least 45 years of age, and would be directed to report his findings and recommendations not later than July 1, 1970.

Section 208.—Would permit payments under title II to any person, public agency, or private nonprofit institution or organization, pursuant to a grant or loan, to be made in installments, and in advance or by way of reimbursement, with necessary adjustments on account of overpayments or underpayments.

*See ch. VI, p. 63, for additional discussion.

TITLE III

Section 301.—Statement of purpose of title III.

PART A

Section 311.—Would authorize a program of job opportunities for older Americans with Federal contractors. Whenever the Secretary of Labor with the cooperation of Federal contractors and potential contractors would find that the manpower requirements of any contract would not readily be met by present employees of a contractor or his subcontractors or other qualified workers in the local labor area, the Secretary would be authorized to make arrangements for providing appropriate training of older workers and others designed to meet the employment needs involved.

Section 312.—The Secretary of Labor would be directed to consult with and advise the Director of the Office of Economic Opportunity and the heads of other departments and agencies responsible for the administration of programs under the Economic Opportunity Act of 1964 to maximize employment opportunities for older persons with programs supported by that act.

Section 313.—The Secretary of Labor would be authorized through the Federal-State employment service to make grants to or contracts with nonprofit volunteer agencies to assist older persons to obtain part-time or temporary employment but no grant to or contract with such an organization could exceed 50 percent of its total expenses relating to employment of older workers.

PART B

Section 321.—Would authorize the Secretary of Labor to establish and administer a program for part-time work opportunities in community services, known as the community senior service program. The Secretary would assist and cooperate with national voluntary agencies, State and local public and private agencies in developing such programs and would enter into agreements providing for the payment by him of up to 90 percent of the cost of a State or local program. Only individuals aged 55 and over would provide services in the program (except for administrative purposes) and such services would be performed in the community where the employee resides or in nearby communities. Local projects would be required, among other requirements, to permit or contribute to an undertaking or service in the public interest that would not otherwise be provided; to avoid displacement of employed workers or impairing existing contracts for services; and to employ only those who do not have opportunity for other suitable public or private paid employment, other than projects supported under the Economic Opportunity Act or under this program.

Section 322.—Would authorize a program of "voluntary service by retired persons," similar in most respects to the program which would be authorized by section 321, except that those who serve would not be compensated for their services and would receive no more in connection with their service than reimbursement for transportation, meals, and other out-of-pocket expenses incident to their services. The Secretary of Labor would be permitted to enter into agreements with the Secretary of Health, Education, and Welfare to administer programs under this section.

Section 323.—Would direct the Secretary to obtain from State employment services certain information needed by him in administering community senior service programs. Would permit the Secretary to request State agencies on aging to recommend a program for the use of community senior service program funds in their respective States. Would direct the Secretary to encourage sponsors of such programs to use personnel available from programs under the Economic Opportunity Act of 1964. Would authorize the Secretary to make delegations, other than promulgation of regulations, to agencies within the Department of Labor, and to utilize the services and facilities of any Federal agency and of any other public or nonprofit private agency or institution.

Section 324.—Makes it clear that those serving under community senior service programs would not be Federal employees for purposes of provisions of law relating to Federal employment, including those relating to hours of work, rates of compensation, leave, unemployment compensation, and Federal employee benefits.

Section 325.—The Secretary would be directed to establish criteria designed to achieve an equitable distribution of community senior service program assistance funds among the States. More than 12 percent of the total funds for such programs could not be distributed to any State.

TITLE IV

Section 401.—Statement of purpose for title IV.

Section 402.—Would authorize the Secretary to conduct research, development, and demonstration projects, in order to obtain information relating to employment opportunities for older workers, either through services and facilities within his authority or through grants to public or nonprofit private agencies, institutions, or organizations. Directs the Secretary to report not later than 2 years after enactment of the act his findings and recommendations based on such research, development, and demonstration projects.

Section 403.—Would empower the President to appoint a Commission on Lifelong Adult Education, to be composed of 12 members appointed from among persons outside the Government, to make a comprehensive study of continuing educational and training opportunities to enhance employability of older workers and to benefit them in other ways. The Commission would report its findings and recommendations to the President and the Congress by June 30, 1970.

Section 404.—The Secretary of Labor would be directed to study the feasibility and advisability of establishing a program of transitional allowances for unemployed workers between the ages of 55 and 65 who have inadequate financial resources, have exhausted their unemployment compensation and have no prospects of employment, and to report his findings and recommendations to the Congress and the President on or before February 1, 1970.

Section 405.—The Secretary of Labor would be directed to submit a report to the Congress by February 28, 1970, on means of eliminating the gaps and inadequacies in workmen's compensation and disability insurance systems, health insurance, and pension plans, particularly as they affect adversely the employment of older workers.

Section 406.—Would authorize the employment of experts and consultants for the preparation of reports required by sections 403 and 404.

TITLE V

Sections 501 and 502.—Would authorize the Secretary of Labor to take certain described actions to facilitate performances of his duties under the act.

Section 503.—Would authorize to be appropriated for fiscal year 1969 and each of the 4 succeeding fiscal years "such sums as may be necessary to carry out the provisions of this act."

TITLE VI

Section 601.—The Civil Service Commission would be authorized and directed to undertake a study of part-time employment in the executive branch and to make a report on or before July 1, 1969, of its findings and recommendations regarding part-time employment in the executive branch for older individuals. The Commission would also be authorized to undertake a study of the feasibility of redesigning positions in the executive branch (without impairing the effectiveness or efficiency of operations) with a view to increasing the number of positions available to older individuals at the subprofessional level, and to report its findings and recommendations to Congress on or before January 1, 1970.

Section 602.—The Civil Service Commission would be authorized and directed to undertake special work and training programs to provide middle-aged persons who are unemployed or whose income is within the low-income area with job opportunities in the executive branch, including opportunities for new types of careers in the fields of health, education, welfare, neighborhood development, and public safety.

Section 603.—Would amend the present provision of law which inhibits employment in the executive branch of individuals over 55 by prohibiting involuntary retirement of Federal employees who have reached the age of 70 unless they have 15 years of Federal service. For the present requirement that such an individual be permitted to remain in employment until he has completed 15 years of service, this section would substitute a 5-year requirement, which would still permit him to qualify for a civil service retirement annuity before being involuntarily retired after reaching age 70. The amendments made by this section would apply only to those who are appointed or reappointed after the enactment of the proposed act.

Section 604.—Would strengthen the present statute which prohibits establishing a maximum-age requirement for entrance into the competitive service by—

Adding a prohibition against failing or refusing to hire any individual because of such individual's age;

Permitting age discrimination in Federal employment where age is a "bona fide occupational qualification reasonably necessary to the effective performance of the duties of the position concerned";

Clarifying the duty of the Comptroller General to investigate all complaints of establishment of maximum age requirements for entrance into the competitive service or of failing or refusing to hire any individual because of such individual's age; and

Giving the Comptroller General power to stop the payment of compensation of an employee who discriminates on the basis of age, until the employee is no longer in violation of the prohibition against age discrimination in Federal employment.

ITEM 3: REPORT ON THE NATIONAL INSTITUTE OF INDUSTRIAL GERONTOLOGY[1]

The National Institute of Industrial Gerontology

(By Theodor Schuchat)

The National Institute of Industrial Gerontology was established in January 1968 by the National Council on the Aging, a nonprofit organization of persons professionally concerned with the problems of older people. The institute shares offices with the NCOA at 315 Park Avenue South, New York, N.Y. 10010.

Industrial gerontology—the science of aging as it relates to work—originated in Europe and in Great Britain. The English have led the way in testing, selection and placement of older workers. The work of the Nuffield Foundation in England has long outdistanced any comparable work in the United States. The Research Unit into Problems of Industrial Retraining at the University of London has studied postal employees in particular and has conducted research and demonstration on the unlearning theory. Good work has also been done by the Unit for Research on Occupational Aspects of Aging at the University of Liverpool.

The institute, which was set up under a contract with the U.S. Employment Service, will carry out similar research on the "occupational aspects of aging and industrial retirement," according to Edwin F. Shelley, president of NCOA and former chairman of its committee on employment and retirement. Its focus will be on the employment and retirement problems of middle-aged and older workers.

EMPLOYMENT AND RETIREMENT COMMITTEE

NCOA established its Committee on Employment and Retirement when the organization was founded in 1950. The first committee, made up of representatives from industry, organized labor, government, and higher education, was concerned with mandatory versus flexible retirement ages and with retirement criteria. As its work progressed, the committee became concerned also with employment problems of the middle-aged and older worker. Subcommittees were established to focus on technological change and the older worker, and training and retraining of older workers.

With support from the Office of Manpower Policy, Evaluation, and Research of the United States Department of Labor, in 1963 NCOA initiated six experimental and demonstration projects on the training and placement of older workers. The purpose was to test different ways of preparing unemployed workers, age 50 or older, for job placement. NCOA learned that, with intensive counseling and intensive job development efforts, middle-aged and older workers can be placed in jobs, but it was also clear that the public occupational training programs were generally ill-prepared to admit middle-aged and older workers, and these workers themselves often lacked motivation to take conventional training courses.

SEMINARS

In October 1965, NCOA sponsored a seminar on automation, manpower, and retirement to consider the impact of industrial change on the middle-aged and older worker, the proceedings of which were published.[2] NCOA also held a 3-day

[1] Reprinted from the December 1968 issue of "Pension & Welfare News."

[2] Kreps, Juanita M. (ed.) Technology, Manpower and Retirement Policy, Cleveland: World Publishing Co., 1966.

meeting in Washington, D.C., in January 1966 at which experts discussed many aspects of training and placing middle-aged and older workers.[3] Several monographs on special aspects of retraining have since been prepared as a basis for discussion and possible application on an experimental basis.

NCOA is convinced that the U.S. Employment Service, a Federal-State agency, is a major instrument for dealing with the older worker's employment problems and that involvement of industry, organized labor, and other community groups in cooperation with the public employment service will be essential. Hence the National Institute of Industrial Gerontology was established to carry out research and action programs in this field.

OLDER WORKER CONFERENCES

As a first step, a conference was held on January 3, 1968, with representatives of State employment services offices who are specialists in the older worker field. Plans were made to organize existing material from disciplines of psychology, sociology, and economics into a "curriculum" of industrial gerontology.

Recent Federal programs to train youth for employment and develop jobs for them emphasize the need for scientific understanding of young people as candidates for jobs. In the same way, the considerable amount of new gerontological information should be reaching those who are counseling and placing middle-aged and older workers. Counseling and guidance courses tend to be centered around the handling of the school-age child. These courses leave a gap in the training of employment experts, who are frequently dealing with adult job seekers who have 20 or more years of work experience.

TRAINING MATERIALS

For use of the employment service staff and others, the institute has published a collection of training materials developed by specialists in various disciplines. It is presented in a notebook format so that the materials can be utilized either in short-term seminars concentrating on older worker employment problems, or in conjunction with a longer curriculum of training for counselors and other employment personnel.

The material in this document was prepared primarily for employment service personnel. It should also be useful to others dealing with middle-aged and older people in the employment context—voluntary agencies, personnel officers, and those enforcing age discrimination statutes, for example.

A seminar on industrial gerontology was sponsored by the National Council on the Aging in April 1968 in cooperation with the W. E. Upjohn Institute for Employment Research. The seminar was attended by State employment service older worker specialists and research specialists from universities in those States. One of the purposes of the seminar was to bring these two groups together so that applied research programs can be developed.

The institute will assist USES in implementing the curriculum it has developed and will develop a procedure for providing a flow of current information about the older worker to the State agencies. In addition, the institute will develop and maintain a body of knowledge which can be applied by practitioners in government, industry, organized labor, and voluntary agencies. The institute will also survey research, highlighting the practical implications for employment practitioners, and develop research and action programs in retirement preparation and retirement income.

Norman Sprague, who was director of the NCOA employment and retirement program, is director of the new institute. Mr. Sprague was appointed to this post on July 1, 1967. He had been director of the employment and retirement program of the NCOA since 1961.

Mr. Sprague received a B.A. in economics from Duke University, attended the University of Zurich, Switzerland, and did further graduate work at New York University. Subsequently, he directed programs in the New Jersey Department of Labor and Industry dealing with labor statistics, workmen's compensation, vocational rehabilitation, and employment. He was assistant to the director of the New Jersey Division of Aging and on the staff of the Seton Hall College of Medicine before joining the NCOA.

Miss Irma Rittenhouse, formerly director of research in the New York Division of Employment, will be deputy director. Miss Rittenhouse graduated from Barnard College and did graduate work in economics at Columbia University.

[3] Proceedings of the National Conference on Manpower Training and the Older Worker, New York: The National Council on the Aging. January, 1966.

Prior to joining the staff of the National Institute of Industrial Gerontology, Miss Rittenhouse had been director of research for the New York Division of Employment and had extensive experience in research, administration, and university teaching.

ITEM 4: LETTER OF SECRETARY WIRTZ ON LOWER AND UPPER LIMITS OF AGE DISCRIMINATION IN EMPLOYMENT ACT

U.S. DEPARTMENT OF LABOR,
OFFICE OF THE SECRETARY,
Washington, November 27, 1968.

Hon. HUBERT H. HUMPHREY,
President of the Senate,
Washington, D.C.

DEAR MR. PRESIDENT: I have the honor to present herewith my recommendation with respect to the appropriateness of the lower and upper age limits incorporated in the Age Discrimination in Employment Act of 1967 (Public Law 90–202).

This act includes a requirement (sec. 3(b)) that the Secretary of Labor shall recommend to the Congress not later than 6 months after the effective date of the act (June 12, 1968) any measures he may deem desirable to change the lower or upper age limits set forth in section 12. Section 12 provides that "The prohibitions in this act shall be limited to individuals who are at least 40 years of age but less than 65 years of age."

The legislative history indicates that the impetus for the study of the 40- to 65-year age limits provided under the Age Discrimination in Employment Act was brought about at least in part by the interest in the case of airline stewardnesses. Some airlines had been requiring their stewardnesses upon reaching a certain age, usually 32 to 35, to either transfer to ground jobs or resign. The stewardnesses claimed and were able to support the claim that this requirement was unrelated to their abilities to perform their jobs. The House committee report states:

"The case presented by the stewardesses reveals an apparent gross and arbitrary employment distinction based on age alone. It deserves mention again, that the only reason the committee bill does not specifically address this discrimination is in the interest of the major objective of the bill. In lieu of such provision, the committee added section 3(b), however, and expects the Secretary—pursuant to the subsection—to undertake study in this area, making whatever recommendations he deems appropriate." (H. Rept. No. 805, Oct. 23, 1967, p. 7.)

Additionally the Senate floor debate indicates that the report should include a determination as to whether this was a unique problem and to make recommendations for a solution. (Congressional Record, Nov. 6, 1967, p. S15894.)

Intensive research in current literature and checks with agencies involved in discrimination problems have not disclosed any other occupational groups in which present practice results in age discrimination involving groups of workers under 40 years of age. The general counsel of the EEOC has informed us that the Commission has had no other experience with problems of age discrimination below the age of 40. It is our judgment, therefore, that the stewardess problem in unique.

The stewardess problem appears to be well on the way to solution through the issuance of a decision by the EEOC in the case of *June Dodd* v. *American Airlines, Inc.* (issued Aug. 8, 1968) and through modifications of collective bargaining agreements as they affect the employment of stewardesses. The EEOC decision in the case cited above held that the company had violated title VII of the Civil Rights Act when it terminated the employment of a stewardess because of her age. The agreement reached on August 11, between the Transport Workers Union and American Airlines, permits the airline to continue to offer stewardesses the opportunity to transfer to ground jobs, at higher base rates, or retirement with increased severance pay upon reaching age 32. However, the stewardesses now have the additional option of continuing to fly, if they so choose.

With respect to the currently applicable 40-year lower age limit, I believe the rationale for this lower age limit, as described in the House committee report is very persuasive:

"Section 12 limits the prohibitions in the act to persons who are at least 40, but less than 65 years of age. The committee altered the lower age limit from 45 in the original bill to 40, in that testimony indicated this to be the age at which age discrimination in employment becomes evident. It is also the lower age limit found

in most State statutes bearing on this subject. The committee declined to further lower the age limitation, notwithstanding the highly effective and persuasive presentations made by witnesses representing airline stewardesses—some of whom are not permitted to continue as stewardesses after age 32. Although the committee recognized the significance of the problem, it was felt a further lowering of the age limit proscribed by the bill would lessen the primary objective; that is, the promotion of employment opportunities for older workers." (H. Rept. No. 805, Oct. 23, 1967, p. 6.)

With respect to the upper age limit of 65, many of the problems encountered appear to be related to compulsory retirement. The ADEA requires that a study be made of institutional and other arrangements giving rise to involuntary retirement. This study is now under way and will form the basis of a separate report to the Congress.

Questions have also been raised with respect to the legality of imposing upper age limits below age 65 when a safety factor is involved. This problem had been raised, at the time the legislation was enacted, with respect to rules set by regulatory agencies for public safety. Since the act became effective, a question was raised with respect to regulations of the Federal Aviation Administration which do not permit airline pilots to engage in carrier operations, as pilots, after they reach age 60. The Department of Labor has taken the position that Federal regulatory requirements which provide for compulsory retirement without reference to an individual's actual physical condition will be recognized as constituing a bona fide occupational qualification when such conditions or qualifications are clearly imposed for the safety and convenience of the public and therefore not a violation of the spirit or letter of the ADEA.

Consideration was also given to the desirability of eliminating age limits. Of the 26 States and Puerto Rico which have laws relating to age discrimination, five set no age limits—Alaska, Hawaii, Illinois, Nebraska, and Maine. An examination of the legislative history makes clear, however, that the Federal statute was designed to do more than just bar discrimination because of age. It was designed to make clear that the hiring and promotion of the older worker must be based on ability and not on age. As Congressman Carl Perkins, chairman of the House Committee on Education and Labor, stated:

"H.R. 13054, a bill to bar arbitrary discrimination in employment based on age, in fact is more than a bill to bar age discrimination. It is a bill to promote employment of middle aged and older persons based on their ability. We do not undertake to tackle the whole problem of age discrimination in employment in this bill, but we feel that we strike at the heart of the situation, that is, attacking discriminatory practices between ages 40 and 65 where discrimination is most prevalent. In this bill we require a clear and unequivocal statement of public policy supported by an extensive research and educational effort and backed up by civil enforcement procedures." (Congressional Record, Dec. 4, 1967, p., H.16164.)

The age limits presently included in the statute encompass approximately half of all persons 25 years of age or older and almost three-fifths of the labor force 25 years of age or older. Any broadening of the age span might limit the effectiveness of the statute in promoting the interests of the older worker. Changes in the age limits would therefore seem to be inappropriate.

This new law has only been in effect for 6 months. After the statute has been operative for a longer period, the age limits will be reexamined in the light of administrative experience.

Sincerely,

W. WILLARD WIRTZ, *Secretary of Labor.*

Appendix 8

MATERIAL RELATED TO RESEARCH*

ITEM 1: SENATE FLOOR STATEMENT MADE JULY 15, 1968, INTRODUCTION OF RESEARCH IN AGING BILL (S. 3784)[1]

S. 3784—INTRODUCTION OF BILL TO ESTABLISH AN AGING RESEARCH COMMISSION

Mr. WILLIAMS of New Jersey. Mr. President, in the midst of this troubled period in our Nation's growth, I want to call the attention of the Senate to a task which holds immeasurable promise for harmony and orderly development, for all men, everywhere. The task is the investigation of aging—that complex biological, psychological, and social process which touches us all—one of the true common denominators among men. I am introducing a bill today which I believe could set us on a course of immense productivity and discovery in basic human research.

This bill would establish an Aging Research Commission, which would plan a 5-year program of intensive coordinated research into the origins of the aging process.

For some time now, the Special Committee on Aging has been exploring the plight and the promise of millions of elderly Americans. We have heard from hundreds of men and women over 65 who suffer inadequate health services, insufficient income, and unpleasant housing conditions. As chairman of the committee, I have taken particular notice of a recurrent parallel between poverty, ill health, and despair among the elderly, and a deterioration and decay in their energy, enthusiasm, and vigor.

There is little chance for us to break this cycle among the elderly, unless we begin today to unearth some of the basic data about aging as a process. What we need immediately is a body of accurate information about the basic physical changes which accompany the aging process. We need exploration into the mysteries of the cell and the gene.

Because we do not know the secrets of aging, we are being forced to repair rather than prepare. For example, recent developments in biological medicine, as well as in surgical techniques—including heart transplants and banks of substitute organs—have emphasized restorative medicine. These are systems to repair damage which has already been done.

How much more productive it would be if we could unlock the secrets of body deterioration. A large-scale investigation into the basic processes of aging could yield such an incredible storehouse of information about man's development, that a whole new era of medical insight and competence could be born. Social scientists, physicians, and gerontological experts agree that basic research into the process of aging could possibly lead to mastery over the process which makes men old.

Present efforts in aging research are simply not going to get this important job done. There are two reasons for the inadequacy of the present research effort:

First, because the level of funding is unrealistically low—current total Federal expenditures for basic aging research come to about $7.4 million annually, or less than 5 cents per person;

Second, because aging research has never been concentrated, never given visibility as a research area; and in consequence, many highly trained and dedicated researchers have overlooked the challenges in the field. There is not cohesion to tie all of the research together. Interdisciplinary projects and exhaustive studies would be much more effective if they were incorporated into an overall, coordinated research effort.

*See ch. XI for discussion of matters relating to this appendix.
[1] Reintroduced by Senator Williams as S. 870, Feb. 4, 1969.

The Federal Government is already at work to provide coordinated facilities in aging research. The new Gerontology Research Center within the National Institute of Child Health and Human Development of the National Institutes of Health will house more than 300 scientists and supporting personnel. It should provide a start for the effort needed to carry out biological research into the process of aging.

Now we need to match this new physical facility with an equally innovative approach in overall research planning. I believe the bill I am introducing will provide that kind of approach. It would establish a commission which would be responsible for drawing up a 5-year program of intensive aging research.

It would authorize this commission to set up an information bank which would contain information and statistical data concerning developments on the biological aspects of aging.

The bill would also create a biological research board within the commission which, under the supervision of the commission, will prepare a gerontological quinquennial research plan.

It would provide a vehicle for creating the strong governmental leadership necessary for a program offering such a dramatic impact upon our whole social structure, and upon the individual lives of each of us.

These proposals would open the door to a new era of high-level, energetic research in the basic human processes which lead to aging. There was a call for this kind of concerted effort from the 1961 White House Conference on Aging. Biological science and general medicine have given us so many techniques to employ, so much skill and dedication ready to be used, that it would be a tragic waste of time and energy if we were to let this research collapse for lack of cohesion and focus.

The bill I am introducing today would bring together all of the accumulated wisdom and expertise of the past, and focus this creative force on the immediate task of unearthing the mysteries of aging. We have it in our grasp, this elusive life force called aging; and it is up to us, as representatives of the concerned public, to provide the tools and materials needed to solve the riddle of why people grow old.

Mr. President, I have received letters and statements in support of a gerontological research "master plan" from a number of distinguished scientists and educators. I ask unanimous consent that some excerpts be reprinted in the Record. I also ask unanimous consent that an analysis of the bill be printed in the Record at the close of my remarks.

The ACTING PRESIDENT pro tempore. The bill will be received and appropriately referred; and, without objection, the excerpts and analysis will be printed in the Record.

The bill (S. 3784) to promote the advancement of biological research in aging through a comprehensive and intensive 5-year program for the systematic study of the basic origins of the aging process in human beings, introduced by Mr. Williams of New Jersey, was received, read twice by its title, and referred to the Committee on Labor and Public Welfare.

The excerpts and analysis, presented by Senator Williams of New Jersey, are as follows:

"EXCERPTS FROM STATEMENTS IN SUPPORT OF A COORDINATED RESEARCH PLAN

"Dr. Linus Pauling, noted scientist and researcher, now professor of molecular chemistry at the University of California at San Diego:

" 'The possibilities of decreasing (this) suffering through research on senescence are in my opinion large enough to justify the expenditure of hundreds of millions of dollars per year, in addition to the expenditures now being made. The progress in molecular biology and medicine during recent years has been tremendous. Many fundamental discoveries have been made that suggest promising programs of developmental research. In addition, more money should be provided to support work in basic science, especially in the fields of molecular structure and molecular biology, because there is an excellent chance that additional very important discoveries can be made.' "

(Letter to Senator Williams, commenting on the needs in the field of aging research.)

"Dr. Bernard L. Strehler, professor of biology, University of Southern California:

" 'I hope that the need for an understanding of the origin of the aging process and its direct relevance to other areas of biology and medicine is self-evident. I

hope I have been sufficiently explicit in demonstrating that the present effort to understand this problem is far less than might have been hoped or expected. * * * I hope that you will give consideration to the proposal for an international gerontological quinquennium.' "

(Statement at hearings on "Long-Range Program and Research Needs in Aging and Related Fields," Washington, D.C., December 6, 1967.)

"Dr. F. Marott Sinex, chairman, Department of Biochemistry, Boston University:

" 'One of the most important things which Congress can do . . . is to focus attention of laymen and scientists on the aging challenge. Statements that aging research will be supported by responsible public leaders are effective in making scientists regard aging as a major problem. Congress and this committee can give aging research visibility.' "

(Statement submitted to December 1967 hearings.)

ANALYSIS OF AGING RESEARCH COMMISSION PROPOSAL

I. What are the major provisions of the bill?

The bill would establish an Aging Research Commission, which would be responsible for preparing a 5-year research program (to be known as the Gerontological Quinquennial Research Plan). It would instruct the Commission to gather, analyze, interpret and organize all of the available information on the biology of aging. The bill mandates the Commission to file a written report with the President 1 year after its inception.

II. Who would sit on the Research Commission?

The Commission would be made up of two biological scientists, two administrators from relevant areas, and one sociologist. In addition, a Biological Research Board, acting as a supplementary agency within the Commission, would carry out the specific task of drafting the 5-year program of research; this Board would be composed of eight authoritative researchers in the field of aging.

III. What kinds of problems will the Commission attempt to face?

The Commission will be looking into the whole range of issues involved in the aging process-biological, psychological, physical, and social. It will be designed to coordinate all of the energy and resources now at work on the problems of aging, and direct these elements in a single, all-out attack on the secrets of growing old.

IV. Who would be affected by the work of the Commission?

All men and women, everywhere, would be affected; because all men and women share the common characteristic of aging. The Commission would attempt to devise means to unearth the deepest mysteries of cellular growth and change, basic bodily chemistry, and complex psychological processes. These are traits of every man and woman, regardless of time or place or social status.

V. What are the dimensions of the Commission's task?

As proposed, the Commission would sit until June 30, 1969, at which time it would submit its report to the President. It is expected that the period of the quinquennial study would be from 1970 to 1975. At present, there are 19 million Americans over age 65; by 1975, there will be more than 21 million.

ITEM 2: SOCIAL AND REHABILITATION SERVICE NEWS RELEASE ON GRANT OF FUNDS FOR STUDY OF RESEARCH AND SERVICE PRIORITIES, DECEMBER 13, 1968

Leading scholars and scientists will propose research and service priorities on behalf of older people during the next decade under a grant from the Social and Rehabilitation Service's Administration on Aging.

In announcing the $49,987 grant to the Gerontological Society, St. Louis, Federal Social and Rehabilitation Administrator Mary E. Switzer said it will help identify major problems, review what is already known about them, and determine what must be done to solve them.

The grant will support establishment of a committee of experts in psychology, psychiatry, social welfare, economics, sociology, and anthropology. The committee will review existing knowledge and gaps in research in social gerontology, identify top priority problem areas, and suggest research and development goals

for the next decade. It will also propose mechanisms for implementing these goals by public and private agencies.

Dr. Robert J. Havighurst, professor of education and human development, University of Chicago, will be project director, and Mrs. Bernice L. Neugarten, professor of human development, University of Chicago, and president of the Geronotological Society, will be principal research investigator for the society.

Work will be carried on in Chicago and in St. Louis. Each member of the committee will prepare an extensive analysis in his own field on existing and needed research. The committee will also prepare an integrated report of total needs for use by public and private research and service agencies, organizations, and institutions.

Commissioner on Aging William D. Bechill pointed out it is particularly important to make a systematic review of research needs relating to the problems of older Americans at this time in preparation for the next White House Conference on Aging, which is authorized for 1971.

PUBLIC INFORMATION OFFICE FACT SHEET

What: Award of $49,987 for a 1-year research grant by the Gerontological Society under title IV of the Older Americans Act for a project entitled "Committee on Research and Development Goals in Social Gerontology."

Where: St. Louis, Mo.

Why: To develop guidelines for the stimulation and implementation of research and development programs.

Significance: America's foremost scholars, doctors, and practitioners working in the field of aging will assess and set forth the research and development needs in social gerontology. R. & D. efforts throughout the United States will be stimulated and given direction through the blueprint for research over the next 5 to 10 years to be produced. Those planning for and participating in the Second White House Conference on Aging will have the benefit of a review of the status of knowledge and of research potentials in this field.

Program content: The Gerontological Society proposed to review the needs for research in the area of social gerontology; to identify the four or five areas in which the need for research and development is the greatest; to delineate a set of research and development goals to be met within the next 5-year period; and to define alternate mechanisms for systematic implementation of those goals, both by private and government agencies.

For further information: Dr. Robert J. Havighurst, University of Chicago, 5801 South Kenwood, Chicago, Ill. 60637.

Appendix 9

MATERIAL RELATED TO TRAINING

ITEM 1: THE DEMAND FOR PERSONNEL AND TRAINING IN THE FIELD OF AGING

SUMMARY AND RECOMMENDATIONS OF REPORT PREPARED BY THE SURVEYS AND RESEARCH CORPORATION FOR THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

There are 23 recommendations in the report. They cover a broad spectrum, ranging from the training of lay personnel for specialized tasks to the education of doctoral and post-doctoral level researchers, teachers, and practitioners. The report recommends actions for the Administration on Aging, other Federal agencies, State and community agencies, and educational institutions. It was recommended that the Administration on Aging, among other actions, take the following steps:

1. Establish a "Manpower Data Center" to assemble and publish data on manpower supply, utilization, and demand in the field of aging;
2. Work in cooperation with other Federal agencies to encourage educational institutions to increase the supply of faculty members engaged in graduate studies in aging, to introduce graduate and under graduate studies in aging, to strengthen their curricula in this subject, and to provide short-term training in gerontology;
3. Expand its public information program to call attention to the urgent need for personnel in aging and the availability of training opportunities for those who are interested in working in the field of aging.

Some of the recommendations would doubtless require additional appropriations for aging training programs.

Among these are recommendations for increases of Federal support for graduate degree programs in aging, and for short courses and institutes.

ITEM 2: STATE OF NEW JERSEY, DEPARTMENT OF COMMUNITY AFFAIRS, DIVISION ON AGING

TITLE V PROJECT

The Older Americans Act Title V project in New Jersey has accomplished its stated purposes—1) the development of a resource faculty from institutions of higher education within the state for use in short-term training in basic aging concepts and, 2) actual use of this faculty in short-term practitioner orientation. This in itself has greatly enhanced the education program of the Division on Aging. However, equally important aspects of a concomitant nature were generated through the seminars that developed the resource faculty, some of which are outlined below.

1. Faculty attending the seminar have begun to work within their institutions to have aging content included in appropriate curricula and course offerings.
2. Several seminar participants have designed research proposals in their fields which are being considered by appropriate national agencies for support. The dimension of adding to the body of knowledge regarding aging through research expands the project to one of knowledge development as well as knowledge dissemination, One research proposal involves seven faculty members from one institution as principal investigators for age related factors in a multi-aspected study of an animal colony. While only one of these men was a participant in the Title V seminar, he was able to generate sufficient interest among his colleagues to develop the proposal.
3. Another institution represented in the project is developing course offerings in social gerontology while still another is exploring the development of daytime

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offerings especially designed for older adults. Along the same lines, a third institution is giving leadership to education programs at a senior center in the community and working to permit seniors to audit regular courses on campus.

4. Many of the seminar participants have requested membership in the Gerontological Society and are expressing professional interest in aging through the preparation of articles and papers on aging in their own professional organizations.

Perhaps the most important thing we learned from this project is that faculty do not want to relinquish their discipline identity to become gerontologists but are very willing to include aging information in their disciplines and to apply their special competencies to aging where appropriate. However, the limitations of a project leave the question of how many others could be involved were there more seminars as an interesting area for contemplation. We believe that there are probably many others whose competencies could be directed to the special needs of aging education and research through this device.

Appendix 10

OFFICIAL STATEMENTS BY REPUBLICAN AND DEMOCRATIC PRESIDENTIAL CANDIDATES IN 1968 ON PROPOSED PROGRAMS IN AGING

After presidential candidates were nominated in 1968, the National Council on the Aging invited both the Republican and Democratic Parties to send statements summarizing programs of their candidates for President. The NCOA Public Policy Bulletin of October 1968 published the statements without editorial comment. The statements are reprinted here:

Mr. Nixon's Statement on Aging, Forwarded to NCOA by the Nixon-Agnew Campaign Committee

I always have had a deep and abiding concern for the problems of older persons and have recognized the financial plight with which many are confronted. In fact, many of the social security, housing, medical aid for the indigent, and other aged programs were initiated during the Eisenhower-Nixon administration.

To those retired Americans who brought this country through two wars and a great depression, we have a deep and continuing obligation. As President, I will not rest in my search for ways in which we as a people honor that obligation. Among the pledges I have made and renew here are:

Automatic cost-of-living increases in social security and railroad retirement benefits to protect retired Americans from the ever-present fear that their pensions will be destroyed or devalued by irresponsible Federal spending policies.

An increase in the ceiling on earnings for social security recipients and ultimate elimination of that ceiling. The present law penalizes persons who want to help themselves. Also, compulsory retirement, without regard for the individual's desire and ability to continue to work, can be a prime factor in the health deterioration of the retiree.

An increase in a widow's benefit from 82½ percent to 100 percent of her late husband's pension.

Extension of social security benefits to include all our older citizens, a goal the Republican Party has supported since the presidential year 1944. The time has come to follow through on that commitment by a gradual extension in universal coverage from age 72 to 65.

Permitting persons who work past age 65 to continue building up social security credits so their ultimate benefits will reflect this added contribution.

Close appraisal and improvement of medicare to help alleviate the financial and administrative difficulties that have plagued the program. The program offers good potential, if well administered.

Careful reassessment and improvement of medicaid, especially at the local level, with full professional guidance. There also is a need for simplification of literature and application forms. I favor the basic philosophy of medicaid—that of helping medical indigents to meet medical expenses and will exert every means to make the program more effective.

Restoration of the 100-percent income tax deduction for nonreimbursable drug and medical expenses incurred by persons age 65 and over to help cope with rising medical costs.

Use of computer technology in a national computer job bank to match every possible pair of older willing hands with a task that needs doing in this country.

Expansion of existing programs such as SCORE (the Service Corps of Retired Executives) and the foster grandparent plan, which makes use of the volunteer services of older Americans.

Stimulating the building of improved housing and nursing home facilities for elderly citizens through the enlistment of private enterprise and the voluntary

institutions that abound within our society. The remodeling of existing housing for use by older persons also should be further encouraged.

Establishment of a White House Conference on Aging to probe the problems facing older Americans and to discuss and recommend new programs and ideas to use the talents of retired Americans, and to expand the horizons of their opportunities within our society.

Vice President Humphrey's Program for Older Americans, Forwarded to NCOA by Older Americans for Humphrey and Muskie

I ask you to join me in enacting a "bill of rights" for older Americans and their families, because I believe that men and women who have devoted their lives to building this Nation deserve to share in the greatness of their achievement.

Together we have accomplished much under Democratic administrations of the past 8 years. Together we must finish the job.

I pledge my administration to an orderly society in which the person and property of the individual are secure and the dignity, worth and contributions of the individual are recognized.

We will build not only for the older American today, but also for a better civilization tomorrow.

Eighteen and a half million Americans now receive social security benefits. For more than half, it provides a poverty income for people who deserve a living income. That is not worthy of America.

As President, I would call for increasing social security benefits by 50 percent across the board—with graduated increases from the present monthly minimum of $55 to $100 for an individual and from $82.50 to $150 for a couple during the next 4 years.

We would begin with at least a 15 or 20 percent general boost and a $70 minimum for an individual and $105 for a couple.

The first increase alone would lift at least 1.3 million people out of poverty immediately.

I shall also propose—and we urgently need—a built-in system of automatic increases—to permit retired people to share in the rising standard of living. Then, these benefits should be made inflation proof—by raising them automatically to reflect price increases.

In addition, we must liberalize the social security provisions which reduce benefits for people who are able to work. They earned their social security—and they need it. I say, let them have it.

And let this country have the benefits of their productivity in a paying job.

And finally, I believe, it is time to ease the burden which social security contributions place upon our working people, by financing part of the increase I propose from general tax revenues.

Medicare works and it works well. Now, it is time to perfect it. We must put the medical payments portion of the program on the same insurance prepayment financing basis as the hospital part. This will make it unnecessary for older citizens to pay $4 a month out of their retirement incomes for medical insurance.

We must provide protection under medicare from the heavy costs of prescription drugs. And we must extend the umbrella of medicare to cover social security disability beneficiaries who, like older people, have high-medical costs at a time when their income is sharply reduced.

I believe these programs are sound and sensible. I shall put them before the Congress—and see that America gives its older citizens the kind of protection our resources permit, and our dignity as a civilization demands.

My vision of America is one of unity—of people helping people. My vision is an America where human resources are cherished—and put to good use to develop other human resources. And, if we ever needed unity—if we ever needed to put everything we have into the pursuit of human excellence—it is today.

I shall, therefore, propose to the Congress establishment of a National Senior Citizens Community Service Corps, in which people at, or near retirement age, can earn money, or serve as volunteers in jobs vital to the growth of America. For some, it will mean a whole new career. For others, it will mean a chance to pass on the skills and wisdom of a lifetime to young people who find themselves rootless in an uncertain age.

There is an essential strength and greatness in the American people. In this campaign, I mean to call forth this strength and greatness. We are faced by stubborn and difficult problems, this is no time for easy answers, and I will offer none. But, it is a time for mobilizing the full resources of this Nation to accomplished and unfinished business of America.

Appendix 11

LEGISLATIVE HISTORY: PROPOSED AMENDMENTS TO THE OLDER AMERICANS ACT OF 1965

At the request of the Department of Health, Education, and Welfare, companion bills to amend the Older Americans Act of 1965 were introduced in the Senate and House ("Older Americans Act Amendments of 1968"). The House bill, H.R. 17867, was introduced by Congressman Dominick Daniels and others on June 13, 1968, while the Senate measure, S. 3677, was introduced by Senator Harrison Williams and others on June 24.

A hearing on S. 3677 was held by the Special Subcommittee on Aging of the U.S. Senate Committee on Labor and Public Welfare on July 1. Hearings on H.R. 17867 were held on July 15 and 18 by the Select Subcommittee on Education of the House Committee on Education and Labor. After House subcommittee consideration, a revised bill, H.R. 19747, was introduced by Congressman Daniels, and was reported by the Select Subcommittee on Education to the U.S. House of Representatives Committee on Education and Labor. It was reported from that committee on September 25, and passed the House on October 3.

As passed by the House, H.R. 19747 would have:

1. Increased from 3 to 4 years the period for which any project may receive grants under title III. The Federal matching for the fourth year would have been at the rate of 40 percent.[1]

2. Added two new requirements for State plans on aging: (a) a requirement that the plan provide for statewide planning, coordination, and evaluation of programs and activities related to the purposes of the act and, (b) a requirement that the State plan provide satisfactory assurance that there will be expended each year from State funds for carrying out the plan, at least as much as was expended for that purpose from State funds during the fiscal year 1968.

3. Raised from $25,000 to $75,000 ($35,000 in the case of the Virgin Islands, Guam, and American Samoa) the amount of a State's allotment which may be used for administering its plan.[2]

4. Enabled the Secretary of Health, Education, and Welfare to determine the amount of a State's title III allotment which will not be required for carrying out the State plan and which will therefore be available for reallotment to other States.

5. Extended the Secretary's authority to permit him to make contracts with profitmaking corporations for research and development projects and for training of persons to serve in programs for the elderly.

6. Permitted the Secretary to assist States to develop and operate statewide, regional, metropolitan area, or other areawide model projects for carrying out the purpose of title III.

7. Authorized a new program of "service roles in retirement", under which the Secretary would provide assistance for the development and operation of projects to provide opportunities for persons 60 years old or older to render supportive services to children and older persons having exceptional needs.

H.R. 19747 was referred to the Senate Committee on Labor and Public Welfare, but Congress adjourned before action was taken within that Committee on H.R. 19747 or S. 3677.

[1] As proposed by the administration, Federal matching for the fourth year would have been at 50 percent, same as for the third year.

[2] As proposed by the administration, the increase would have been from $25,000 to $100,000 ($50,000 in the case of the Virgin Islands, Guam, and American Samoa).

COMMITTEE HEARINGS AND REPORTS

(One asterisk indicates committee's supply exhausted; copies are available for purchase from Superintendent of Documents, Government Printing Office, Washington, D.C. 20402. Two asterisks indicate all supplies exhausted. Three asterisks indicate limited quantity, single copy available from committee supply.)

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- Part 2. Newark, N.J., October 16, 1961.
- Part 3. Philadelphia, Pa., October 18, 1961.
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- Part 1. Washington, D.C., December 11, 1963.
- Part 2. Los Angeles, Calif., January 9, 1964.
- Part 3. San Francisco, Calif., January 11, 1964.

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- Part 1. Washington, D.C., October 22, 1962.
- Part 2. Newark, N.J., October 26, 1962.
- Part 3. Camden, N.J., October 29, 1962.
- Part 4. Portland, Oreg., December 3, 1962.
- Part 5. Los Angeles, Calif., December 5, 1962.
- Part 6. San Francisco, Calif., December 7, 1962.

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Part 2. Los Angeles, Calif., January 10, 1964.**
Part 3. San Francisco, Calif., January 13, 1964. (Cat. No. Y4: Ag4:Em7, 20¢)
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Part 3. Los Angeles, Calif., October 24, 1961.
Part 4. Las Vegas, Nev., October 25, 1961.
Part 5. Eugene, Oreg., November 8, 1961.
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Part 8. Spokane, Wash., November 17, 1961.
Part 9. Honolulu, Hawaii, November 27, 1961.
Part 10. Lihue, Hawaii, November 27, 1961.
Part 11. Wailuku, Hawaii, November 30, 1961.
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Part 13. Kansas City, Mo., December 6, 1961.
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Part 2. Boston, Mass., January 20, 1964.
Part 3. Providence, R.I., January 21, 1964.
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War on poverty as it affects older Americans:**
Part 1. Washington, D.C., June 16–17, 1965.
Part 2. Newark, N.J., June 10, 1965.
Part 3. Washington, D.C., January 19–20, 1966.
Detection and prevention of chronic disease utilizing multiphasic health screening techniques: Washington, D.C., September 20, 21 and 22, 1966.* (Cat. No. Y4:Ag4:D63,$1.75.)
Consumer interests of the elderly: (Cat. No. Y4:Ag4:C78/pts.)
Part 1. Washington, D.C., January 17–18, 1967, 60¢.
Part 2. Tampa, Fla., February 2–3, 1967, 25¢.
Tax Consequences of Contributions to Needy Older Relatives: Washington, D.C., June 15, 1966.***
Needs for Services Revealed by Operation Medicare Alert: Washington, D.C., June 2, 1966.* (Cat. No. Y4:Ag4:Se6/4, 30¢)
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Part 1. Washington, D.C., June 22–23, 1967.—$1.
Part 2. New York, N.Y., October 19, 1967.—70¢.
Part 3. Los Angeles, Calif., October 16, 1968.—[1]
Retirement and the Individual: (Cat. No. Y4:Ag4:R31/3).
Part 1. Washington, D.C., June 7–8, 1967.—$1.25.
Part 2. Ann Arbor, Mich., July 26, 1967.—55¢.

[1] Price not determined at time of this printing

Reduction of Retirement Benefits Due to Social Security Increases: Washington, D.C., April 24–25, 1967. (Cat. No. Y4:Ag4:R31/2, 35¢.)

Rent Supplement Assistance to the Elderly: Washington, D.C., July 11, 1967. (Cat. No. Y4:Ag4:R 29, 20¢.)

Long-Range Program and Research Needs in Aging and Related Fields: Washington, D.C. December 5–6, 1967. (Cat. No. 4: Y4:4Aq4: P94 Pt. 1)—$1.50.

Hearing Loss, Hearing Aids, and the Elderly: Washington, D.C., July 18 and 19, 1968. (Y4:AG4:H35.) $1.50.

Adequacy of Services for Older Workers: Washington, D.C., July 24, 25, and 29, 1968. (Cat No. Y 4:AG4:SE6/6/6 Pt. 1.) $1.25.

Usefulness of the Model Cities Program to the Elderly: (Cat. No. Y4, AG4:M72/Pts.)

Part 1. Washington, D.C., July 23, 1968—60¢.
Part 2. Seattle, Wash., October 14, 1968.[1]
Part 3. Ogden, Utah, October 24, 1968.[1]
Part 4. Syracuse, N.Y., December 9, 1968.[1]
Part 5. Atlanta, Ga., December 11, 1968.[1]

Usefulness and Availability of Federal Programs and Services to Elderly Mexican-Americans.[1] (Cat. No. —.)

Part 1. Los Angeles, Calif., December 17, 1968.
Part 2. El Paso, Tex., December 18, 1968.
Part 3. San Antonio, Tex., December 19, 1968.
Part 4. Washington, D.C., January 14–15, 1969.

Hearings before the Special Subcommittee on Aging of the U.S. Senate Committee on Labor and Public Welfare, available from the Special Committee on Aging are:

"Amend the Older Americans Act of 1965—S. 2877 and S. 3326", May 24, 25, and June 15, 1975.

"Older Americans Act Amendments of 1967—S. 951", June 12, 1967.

"Older Americans Community Service Program—S. 276", September 18 and 19, 1967.

"White House Conference on Aging in 1970—S.J. Res. 117", March 5, 1968.

"Amending the Older Americans Act of 1965—S. 3677", July 1, 1968.

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[1] Price not determined at time of this printing.

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